BRUNSWICK FAMILY MEDICINE

Welcome Letter

Dear Sir or Madam,

First we would like to take the time to thank you for choosing our practice! We will do our best to provide you with the best medical care possible.

Brunswick Family Medicine operates as a Patient Centered Medical Home (Please see page 2 for "What is a Patient Centered Medical Home?"). Patients are asked to choose a particular provider as their personal clinician to ensure continuity of care. **Please make sure you choose your preference of provider on page 7 of this packet.** All routine office visits will be scheduled with this provider. Appointments needed on a same day basis (sick & acute issues) will be scheduled with your provider if he/she is available, otherwise will be scheduled with an available provider.

Enclosed are our New Patient forms. Please carefully complete all areas and return them to us as soon as possible so that our providers may review your paperwork. Once our providers have completed their review, we will contact you to schedule a New Patient Appointment.

At the time of your New Patient Appointment you will need to ***bring your medications in their original bottles,*** no matter the frequency at which they are taken (including vitamins/supplements), ***insurance cards, and a photo ID***.

Again, thank you for choosing our practice we look forward to working with you.

Sincerely,
Brunswick Family Medicine Staff

3960 Executive Park Blvd., Ste 600
Southport, NC 28461

Phone: 910-454-4343
Fax: 910-457-9209

5106 Wrightsville Ave.
Wilmington, NC 28403

Phone: 910-395-6400
Fax: 910-457-9209

www.brunswickfamilymedicine.com

Patient Centered Medical Home Information

WHAT is a Patient Centered Medical Home?

A Patient Centered Medical Home is a model of care that puts Brunswick Family Medicine patients at the forefront of care. Patients receive personalized and coordinated care through a direct relationship with their chosen provider. As a primary care provider, our clinicians manage each patient's health with the help of the patient, their family, and any other specialists needed along the way. The Patient Centered Medical Home works best when all team members do their part. As the patient, it's important to communicate with your primary care provider, disclosing your full medical history including services provided by other doctors. Your provider will use evidence-based care to implement the latest medical advancements, while providing you with the tools necessary to manage your own health. Your care team can treat most urgent care issues, preventing expensive and prolonged Emergency Room visits. Your care team will also assist you in the coordination of your care across multiple settings, thus reducing the risk for duplication of costly medical tests and procedures. At Brunswick Family Medicine, the patient is at the center of our practice.

HOW to Contact *Your* Patient Centered Medical Home?

If you need medical advice or care during business hours, or need to schedule an appointment to discuss your healthcare needs, please call to speak with the office. Our office hours vary according to location, please refer to our website for office hours and contact information. For afterhours care, you can call (844) 820-9725. Your call will be relayed to the provider on call via secure message. If you need to be seen after hours, you can contact any Medac Urgent Care in Wilmington. Brunswick Family Medicine has an agreement with this facility and they will provide our patients with afterhours care. You will need to verify your insurance coverage with the facility. Neither Brunswick Family Medicine nor Medac will accept responsibility for non-covered services rendered. Please contact Medac, or visit their website, for their hours of operation.

Notice of Privacy Practices

BRUNSWICK FAMILY MEDICINE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.

The Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that relates to your past, present or future physical or mental health or condition and related care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care service to you to pay your health care bills, to support the operation of provider's practice, and any other use required by law.

Treatment: We will use and disclose your protected information to provide, coordinated, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to whom you have been referred to ensure that provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that you're relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situation include: Public Health issues as required by law; Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirement; Criminal Activity, Military Activity and National Security; Worker's Compensation; Required Uses and Department of Health and Human Service to investigate or determine our compliance with the requirement of Section 164.500.

Other Permitted and required Uses and Disclosures

Will Be Made Only with Your Consent, Authorization or Opportunity of Object unless required by law. You may revoke this authorization, at any time, in writing, except that your provider or the except to the extent that your physical or the provider's practice has taken an action on the use or disclosure indicated in the authorization.

Your Rights

The following is a statement of your rights to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also require that any part of your protected health information not be disclose to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use disclosure of your protected health information, your protection health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice this notice alternative i.e. electronically.

You may have the right to have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.

We reserve the right to change the term of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate you filing a complaint.

This notice was published and become effective on/or before July 1, 2006.

Financial Policy

BRUNSWICK FAMILY MEDICINE

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy or your financial responsibility.

FULL PAYMENT OF PATIENT OBLIGATIONS IS DUE AT TIME OF SERVICE

We accept: Cash, Check, and Credit Cards

- Always bring your current health insurance card to the office.
- Please notify us at time of check-in of any changes in insurance, address, telephone number or family status.
- Please pay your copay, co-insurance, deductible or balance on account at the time of check-in.
- You will be expected to pay in full if:
  - You do not have insurance;
  - We do not participate with your plan; or
  - You are unable to present a current member identification card from your insurance carrier.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits please be aware that some, and perhaps all, of the services provided may be non-covered services under your plan and you will be 100% responsible for these charges. It is your responsibility to:

- Ensure our providers actively participate with your insurance carrier
- Know your benefit coverage, as well as your dependents, prior to received services
- Ensure that all pre-approval requirements are met to avoid denials or out-of-network benefits

We will not be held liable for ensuring the accuracy of your insurance information, including, but not limited to verifying current coverage and eligibility, obtaining authorizations, or confirming co-pay, coinsurance, and/or deductible information. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due at time of treatment. In the event that your insurance coverage relates to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred.

To summarize, your financial responsibility pertains to:

- Denied and Non-covered services
- Services deemed not medical necessary by your insurance company
- Co-payments, deductibles, co-insurance
- Pending claims due to lack of patient and/or guarantor information
- Non-Insurance and/or out-of-network benefits

COPAY, COINSURANCE, DEDUCTIBLE: We are required by our insurance contracts to collect all co-pays and other patient responsible amounts, at the time of service. If there is a balance on your account, you will receive a statement and the balance is due prior to your next visit. If you have not met your deductible, we will collect a deposit of $85. If additional balances are accrued you will receive a statement and the balance is due prior to your next visit.

SELF-PAY PATIENTS: Self-Pay patients are required to make a deposit of $85 at the time of service. If additional charges are accrued you will receive a statement and the balance is due prior to your next visit.

RETURNED CHECKS: There is a fee (currently $35) for any checks returned by the bank. We have the right to change this fee without notification.

MISSED APPOINTMENT/"NO SHOW": Unless you contact our office at least 3 hours prior to your scheduled appointment time, you are considered a "no show" for that appointment. When we reserve appointment time for patients who do not come, we deprive other patients in need of care. After your 3rd no show visit you may be dismissed from our practice and asked to find a new provider within 30 days. Extenuating circumstances will be considered.

FORM COMPLETION (DMV, TRIP INSURANCE, etc.): An appointment may be required any time you need a form completed by the provider in order to ensure proper information is given. A fee *may* be assessed for all forms requiring the provider to complete and/or sign. The first 5 pages will be completed for $10 and each additional page will be $5. At the time the patient presents paperwork to be completed, the form completion fee will be calculated and is to be paid at that time. Forms will not be completed unless fees have been paid. The form fees are in addition to any copay/coinsurance/deductible amount due when appointments are necessary.

LAB/X-RAY/DIAGNOSTIC SERVICES: We are not responsible for any billing or billing issues associated with any lab tests, x-rays, or diagnostic services. These services are provided by an outside provider. Please contact them directly with any questions or concerns regarding your bill.

PAYMENTS: Unless other arrangements are approved by us, the balance on your account is due and payable when the statement is issued and is past due if not paid upon receipt. All balances must be paid or arrangements must be made prior to your next visit.

INSURANCE RELEASE: You understand that your health plan may not cover services rendered. You are responsible for all charges not covered.

DIVORCE: In the case of divorce or separation, the parent authorizing treatment for child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

COPIES AND TRANSFER OF RECORDS: All past due balances will be collected prior to medical records being copied or transferred. We will transfer records to a new primary care provider at no cost as a courtesy to the patient one time. All additional transfers will be done for a fee.

Patient Information

Date: _____

Provider Choice: □ Slade A. Suchecki, DO – MDVIP provider □ Sherrie G. Cass, FNP-C – Traditional provider

Patient Name: □Mr. □Mrs. □Miss □Ms. □Dr. _____
First Name Middle Initial Last Name

Address: _____
City State Zip Code

□ **Home Phone #:** _____ □ **Cell Phone #:** _____ □ **Work Phone #:** _____
**Please check the box next to your contact preference May we text reminders to your cell phone? □ Yes □ No

Email Address: _____ Would you like to sign up for our patient portal? □ Yes □ No

Date of Birth: _____ **SSN:** _____ **Gender:** □ Male □ Female

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Race: □ White □ Black/African American □ Asian □ American Indian □ Other: _____ □ Declined

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Other: _____ □ Declined

Preferred Pharmacy: (name & location) _____ **Phone:** _____

Emergency Contact: (name & relationship to patient) _____ **Phone:** _____

Billing Information

Person Responsible for the Charges: _____ □ Self □ Spouse □ Parent □ Other

Mailing Address: _____
City State Zip Code

Home Phone #: _____ **Cell Phone #:** _____ **Work Phone #:** _____

Primary Insurance Carrier: _____ **Policy Number:** _____

Policy Holders Name: _____ **Policy Holders Date of Birth:** _____

Secondary Insurance Carrier: _____ **Policy Number:** _____

Policy Holders Name: _____ **Policy Holders Date of Birth:** _____

Authorization

By signing below I understand and agree to the below statements:

1. I understand that I am financially responsible to Brunswick Family Medicine for all charges regardless of insurance coverage. If insured, I agree to provide updated insurance information. I will pay any and all copayments, co-insurance, deductible, and/or charges not covered, approved or considered necessary by my insurance company upon notification. If un-insured, I agree to pay all charges at the time of service or upon notification by Brunswick Family Medicine. I hereby agree to pay all costs and reasonable attorney's fees in the event my account is turned over to an attorney for collection.
2. I hereby authorize payment directly to Brunswick Family Medicine or its affiliates of the surgical and/or medical benefit, if any, otherwise payable to me for services rendered.
3. I authorize Brunswick Family Medicine or its affiliates to release any information acquired in the course of my examinations and/or treatment to my insurance carriers, third party payers, or others involved in processing and collection of any claims submitted on my behalf.
4. I have received a copy of the HIPAA, Privacy Notice, and Financial Policy from Brunswick Family Medicine.

Signature of Patient or Parent or Guardian: _____ Date:_____

HIPAA Consent

In regards to HIPAA our office is not allowed to release any of your medical information to others unless we have your written consent.

I, _____, give permission for the following to have access to my medical information.

Name: _____ Relation to Patient: _____ Phone Number: _____

Name: _____ Relation to Patient: _____ Phone Number: _____

Name: _____ Relation to Patient: _____ Phone Number: _____

Name: _____ Relation to Patient: _____ Phone Number: _____

Are we allowed to leave messages on your answering machine or voicemail? (ex. Lab results, xray results, confirm appointments, etc.)

(Please circle one)

YES **NO**

Preferred Number for Appointment Confirmations: _____

From time to time we may need to mail something to you. Is this okay?

(Please circle one)

YES **NO**

Signature of Patient or Parent or Guardian: _____ Date:_____

No Show Policy

BRUNSWICK FAMILY MEDICINE

Patient Name: _____ Date of Birth: _____

Brunswick Family Medicine, PA has a formal policy regarding "no shows". A "no show" is defined as a scheduled appointment that the patient does not keep and does not call to cancel.

POLICY:

We understand that there are extenuating circumstances beyond your control that may lead to missed appointments, but we request that you call us as much in advance as possible to cancel (*at least* 3 or more hours prior to appointment time).

When we reserve appointment time for patients who do not come, we deprive other patients in need of care. After your 3rd no show visit you may be dismissed from our practice and asked to find a new provider within 30 days.

By signing below I acknowledge that I fully understand the above policy. I am aware that possible termination from Brunswick Family Medicine, PA may occur if I miss 3 scheduled appointments without giving proper notice.

Signature of Patient or Parent or Guardian: _____ Date:_____

PCMH Patient/Provider Contract

BRUNSWICK FAMILY MEDICINE

Patient Name: _____ **Date of Birth:** _____

Good communication between patients, providers and provider support staff is the key to better health & outcomes. Our providers and staff are committed to providing you the highest quality medical care. This can best be accomplished by a clear understanding about our responsibilities to you, and your rights and responsibilities as a patient in our practice.

Our Responsibilities to You:

- **Provide timely access** to appointments with your clinican of choice when the office is open and information about Urgent Care Facilities when the office is closed.
- **Listen to your questions and concerns** and give responses in a way you can understand.
- **Make management and treatment plans** for your condition easy for you to understand.
- **Make sure you have a good understanding** of all medications prescribed.
- **Refer you to specialists** and assist you in getting appointments.
- **Give you disease-specific educational materials** to assist in self-management.

Your Responsibilities to Us:

- **Ask questions** about your conditions and take an active role in your care.
- **Give detailed history** of your entire family.
- **Review your health history & medications** each time you come in for a visit and provide updated information of any changes have occurred.
- **Take all medications as prescribed** as directed by your provider, and provide information about OTC and Herbal Medications that you are taking.
- **Keep all scheduled appointments** with your provider and other specialist(s).
- **Discuss and be involved** in your treatment plan with your provider, follow orders as given.
- **Call your provider *first*** with medical problems, unless it is a medical emergency.
- **Avoid using the Emergency Room** in non-emergency situations. Instead use Urgent Care Facilities, lists are available upon request.
- **Bring all discharge papers** from Emergency Room and Urgent Care visits.
- **Inform your provider** of all self-referred visits, or special test(s). Bring documents when available.
- **Provide updated information** such as phone numbers, addresses & insurance information as quickly as possible when there is a change.

PLEASE NOTE: Same day appointments are available as needed. When the office is closed, we have an answering service that will contact the provider on call to address medical issues, which cannot wait until regular office hours. It is important that you keep all scheduled appointments and notify us at lease 3 hours or more in advance if you need to cancel or reschedule appointments.

Urgent or Emergent Care: Please attempt to call the provider on call before going to an after-hours urgent care facility or to an emergency room unless you believe you have a serious problem requiring immediate medical attention.

By signing below, you indicate that you have read this document, that it is your wish to join our medical home and to do your best to abide by the statements listed above. This is not a legally binding contract, but is intended to provide a framework upon which we can build a relationship that will allow you to maximize your health state in a comfortable and welcoming environment.

Signature of Patient or Parent or Guardian: _____ Date:_____

Signature of Provider: _____ Date:_____

Medication Formulary Benefit Consent

Patient Name: _____ **Date of Birth:** _____

Formulary Benefit data is maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

Having access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know what drugs are covered by your insurance plan is very helpful and beneficial to us as your primary care provider.

By signing below, you give your permission for Brunswick Family Medicine to access your pharmacy benefits data electronically. This consent will enable us to:

1. Determine the pharmacy benefits and drug copays for a patient's health plan.
2. Check whether a prescribed medication is covered (in formulary) under a patient's plan.
3. Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
4. Determine if a patient's health plan allows electronic prescribing to mail order pharmacies, and if so, e-prescribe to these pharmacies.
5. Download a histories list of all medications prescribed for a patient by another provider.

In summary, we ask your permission to obtain formulary information and information about other prescriptions by other providers using this electronic system.

Signature of Patient or Parent or Guardian: _____ Date:_____

Patient Record Sharing Consent

With Patient Record Sharing, we can securely exchange your medical records with other participating providers regardless of where you receive care. Your records will only be exchanged with healthcare organizations where you've been treated.

Patient Record Sharing will benefit you in the following ways:

1. Providers at Brunswick Family Medicine (and other offices you visit that are using Patient Record Sharing) can receive a more comprehensive view of your care and see what tests other providers have performed, so you won't receive duplicative care.
2. Time is valuable. Spend less of it waiting for your medical records to be sent to providers or offices.
3. In case of an emergency (although we hope there never is), the healthcare organization where you go for emergency care may have access to relevant health information, helping them promptly provide appropriate care.

□ I choose to have my records shared through Patient Record Sharing at this time and give my permission to Brunswick Family Medicine to share my records from their office with other connected providers that I see.

Signature of Patient or Parent or Guardian: _____ Date:_____

□ I choose to opt out of Patient Record Sharing at this time.

Signature of Patient or Parent or Guardian: _____ Date:_____

Health History Questionnaire

BRUNSWICK FAMILY MEDICINE

Patient Name: _____ **Date of Birth:** _____

SOCIAL HISTORY

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Alcohol Use: □ Current Use □ Never □ Quit (when? _____) Usage Information: How much? _____ Type? _____

Tobacco Use: □ Current Use □ Never □ Quit (when? _____) Usage Information: How much? _____ Type? _____

Drug Use: □ Current Use □ Never □ Quit (when? _____) Usage Information: How much? _____ Type? _____

GENERAL INFORMATION ABOUT YOU

Employment: □ Full-Time □ Part-Time □ Self □ Stay-At-Home □ Retired
Occupation (past or present) _____

Children:_____

Hobbies:_____

Exercise: (type & how often)_____

Do you have a Living Will?: □ Yes □ No (if yes, please provide us a copy)

CURRENT MEDICATIONS *(name of medication, dosage (mg's), and directions on how to take) - use back for additional*

Please included all prescriptions, over-the-counter medications, vitamins, and supplements

NAME OF MEDICATION	DOSAGE OF MEDICATION	NAME OF MEDICATION	DOSAGE OF MEDICATION

ALLERGIES

Please name and give type of reaction

LIST OF OTHER PROVIDERS

Please included all names, specialty, and phone number

Health History Questionnaire

BRUNSWICK FAMILY MEDICINE

YOUR MEDICAL HISTORY

Which of the following conditions are you **currently** being treated or ***have been*** treated for in the past?

Allergy/Dermatology
____ Seasonal Allergies
____ Food Allergies
____ Household Allergies
____ Environmental Allergies
____ Chicken Pox
____ Shingles
____ Eczema
____ Frequent Ear Infections
____ Frequent Sinusitis
____ Psoriasis

Cancer
____ Bone
____ Breast (side?_____)
____ Brain Tumor
____ Cervical
____ Colon
____ Endometrial
____ Hepatic Carcinoma
____ Leukemia
____ Lung
____ Lymphoma
____ Ovarian
____ Pancreatic
____ Renal
____ Skin
____ Thyroid
____ Uterine

Cardiovascular
____ Arrhythmia
____ Carotid Artery Stenosis
____ Congestive Heart Failure
____ Deep Vein Thrombosis
____ High Cholesterol
____ High Blood Pressure
____ Heart Attack
____ Blood Clots
____ Heart Murmur
____ Phlebitis
____ Vascular Disease
____ Valvular Disease

Endocrine
____ Cushing's Disease
____ Diabetes – Type I
____ Diabetes – Type II
____ Gestational Diabetes
____ Hyperthyroidism
____ Hypothyroidism

Renal/Gynecological
____ Renal Failure (acute or chronic)
____ Endometriosis
____ Urinary Incontinence
____ Abnormal PAP
____ Polycystic Kidney Disease
____ Polycystic Ovarian Disease
____ Kidney Stones
____ Recurrent UTI's
____ Erectile Dysfunction

Gastrointestinal
____ Gallstone Disease
____ Cirrhosis
____ Colon Polyps
____ Crohn's Disease
____ GERD/Acid Reflux
____ Hepatitis
____ Irritable Bowel Syndrome
____ Pancreatitis
____ Stomach Ulcer(s)
____ Ulcerative Colitis
____ GI Bleed
____ Diverticulosis

Hematologic
____ Anemia
____ Iron Deficiency
____ Sickle Cell Anemia
____ Vitamin B12 Deficiency

Pulmonary
____ Asthma
____ Chronic Bronchitis
____ COPD/Emphysema
____ Croup
____ Pneumonia
____ Pulmonary Embolism
____ Sleep Apnea
____ Sarcoidosis
____ Tuberculosis
____ Cystic Fibrosis

Musculoskeletal
____ Chronic Pain (where? _____)
____ Fibromyalgia
____ Fractures (where? _____)
____ Gout
____ Rheumatoid Arthritis
____ Osteoarthritis
____ Osteopenia
____ Osteoporosis
____ Polymyalgia
____ Sjogren's Diseases
____ Lupus

Neurological
____ Alzheimer's
____ ADD
____ ADHD
____ Autism
____ Cerebral Palsy
____ Stoke
____ Dementia
____ Disc Disease
____ Down Syndrome
____ Headache – migraine
____ Headache – tension
____ Huntington's Disease
____ Meningitis
____ Mental Retardation
____ Multiple Sclerosis
____ Muscular Dystrophy
____ Parkinson's Disease
____ Neuropathy
____ Seizure Disorder
____ TIA

Other
____ Immunodeficiency
____ Glaucoma
____ Cataract
____ Obesity
____ Vitamin D Deficiency

YOUR SURGICAL HISTORY

	details & dates		**details & dates**
Cosmetic Procedure(s)		Shoulder Surgery or Replacement	
Appendectomy		Hip Surgery or Replacement	
Gall Bladder Removal		Knee Surgery or Replacement	
Colon Resection		C-Section	
Hysterectomy		Cataract Removal	
Lung Resection		Hernia Repair	
Tonsil/Adenoidectomy		Pacemaker Implantation	
Thyroidectomy		Valve Replacement	
Myringotomy (ear tubes)		Other:	

Health History Questionnaire

BRUNSWICK FAMILY MEDICINE

FAMILY HISTORY

Please put a checkmark in all applicable boxes

Were you adopted? Yes No

Illness	Father	Mother	Sibling (Brother/ Sister)	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other (Aunts, Uncles)
Heart Disease									
High Cholesterol									
High Blood Pressure									
Diabetes									
Heart Attack									
Stroke									
Kidney Disease									
Liver Disease									
Bleeding/Clotting Disorders									
Asthma									
Anemia									
Colon/Bowel Problems									
Cancer *(specify type)*									
Thyroid Disease									
Depression/Anxiety									
Seizures/Epilepsy									
Other (specify)									
Deceased? (include age & cause)									

SLEEP DISORDER SYMPTOMS ASSESSMENT

1. Do you snore on most nights (more than 3 times per week) □ Yes □ No
2. Do you, or have you been told, you stop breathing while sleeping? □ Yes □ No
3. Do you wake suddenly during the night? □ Yes □ No
4. Do you suddenly wake-up gasping for air? □ Yes □ No
5. Do you wake up in the morning feeling tired? □ Yes □ No
6. Do you wake up in the morning with a headache? □ Yes □ No

Please check any of the following that you have:

- □ High Blood Pressure
- □ Heart Disease
- □ Stroke
- □ Insomnia
- □ Frequent Urination at Night (nocturia)
- □ Diabetes
- □ Depression
- □ Overweight

Are you currently using a CPAP (for sleep apena)? □ Yes □ No

If yes, how long have you been using it? _____

When & Where was your most recent sleep study performed? _____

Where do you receive your CPAP supplies from? _____

PLEASE PROVIDE US A COPY OF YOUR MOST RECENT SLEEP STUDY - we are unable to sign for supplies, etc. without a copy on file!

Preventative Services Checklist

BRUNSWICK FAMILY MEDICINE

Patient Name: _____ **Date of Birth:** _____

PLEASE INCLUDE A DATE (as specific as possible) FOR ALL YES ANSWERS

MISCELLANEOUS

Living Will	□ Yes	□ No	Date: _____	
Annual Exam	□ Yes	□ No	Date: _____	Provider: _____
Medicare Wellness	□ Yes	□ No	Date: _____	Provider: _____

EYES/SKIN/TEETH

Eye Exam	□ Yes	□ No	Date: _____	Provider: _____
Dermatology Exam	□ Yes	□ No	Date: _____	Provider: _____
Dental Cleaning	□ Yes	□ No	Date: _____	Provider: _____

GASTRO

Colonoscopy	□ Yes	□ No	Date: _____	Provider: _____
Cologuard	□ Yes	□ No	Date: _____	Provider: _____
Stool Cards	□ Yes	□ No	Date: _____	Provider: _____
Endoscopy	□ Yes	□ No	Date: _____	Facility: _____

DIAGNOSTIC TESTING

Mammogram	□ Yes	□ No	Date: _____	Facility: _____
CXR or CT Chest	□ Yes	□ No	Date: _____	Facility: _____
Bone Density	□ Yes	□ No	Date: _____	Facility: _____

CARDIAC

EKG	□ Yes	□ No	Date: _____	Provider: _____
Abdominal Aortic Ultrasound	□ Yes	□ No	Date: _____	Facility: _____
Nuclear Stress Test	□ Yes	□ No	Date: _____	Facility: _____
Carotid Artery Doppler	□ Yes	□ No	Date: _____	Facility: _____
Calcium Scoring	□ Yes	□ No	Date: _____	Facility: _____
Stress Echo	□ Yes	□ No	Date: _____	Facility: _____
Echocardiogram	□ Yes	□ No	Date: _____	Facility: _____
Exercise Stress Test	□ Yes	□ No	Date: _____	Facility: _____

MALES ONLY

PSA	□ Yes	□ No	Date: _____	Provider: _____

FEMALES ONLY

Pap Smear	□ Yes	□ No	Date: _____	Provider: _____

OTHER

Urologic Exam	□ Yes	□ No	Date: _____	Provider: _____
HIV Testing	□ Yes	□ No	Date: _____	Provider: _____
Sleep Study	□ Yes	□ No	Date: _____	Provider: _____

VACCINES

Shingles - Zostavax	□ Yes	□ No	Date: _____	Facility: _____
Shingles - Shingrix #1 of 2	□ Yes	□ No	Date: _____	Facility: _____
Shingles - Shingrix #2 of 2	□ Yes	□ No	Date: _____	Facility: _____
Flu	□ Yes	□ No	Date: _____	Facility: _____
Pneumococcal 13	□ Yes	□ No	Date: _____	Facility: _____
Pneumococcal 23	□ Yes	□ No	Date: _____	Facility: _____
Tetanus	□ Yes	□ No	Date: _____	Facility: _____

Narcotic/Controlled Medication Notice

BRUNSWICK FAMILY MEDICINE

Patient Name: _____ **Date of Birth:** _____

I, _____, do understand that Brunswick Family Medicine providers will not automatically prescribe narcotic/controlled substance-based medication to any patient. It is up to each provider to exercise professional judgment regarding whether to prescribe narcotic/controlled substance-based medication to patients in accordance with Brunswick Family Medicine policies and procedures and all applicable laws (see North Carolina Controlled Substances Act, NCGS §90).

Should it be determined that I require such a prescription, I shall be required to execute a "Controlled Medication Treatment Agreement", the terms of which will be explained to me. If applicable, I will be required to renew this agreement on an annual basis or when any changes are made (e.g., change in dosage or the addition of a new medication that is a narcotic or controlled substance).

Violation of any executed Controlled Medication Treatment Agreement will result in discharge from the practice.

I also understand that providers will not write prescriptions for any narcotic/controlled-substance based medications during my initial visit without a full evaluation in which the provider determines necessity **and** a review of all appropriate records from previous providers. Brunswick Family Medicine may also choose to coordinate my care with other experts, including but not limited to pain management specialists, neurologists and psychiatrists when managing chronic pain.

Signature of Patient or Parent or Guardian: _____ Date:_____

PLEASE LIST ALL NARCOTIC/CONTROLLED SUBSTANCE-BASED MEDICATION YOU ARE CURRENTLY TAKING BELOW WITH THE NAME & PHONE NUMBER OF THE PRESCRIBING PROVIDER AND THE DATE THE MEDICATION WAS LAST FILLED.

Name of Medication	Provider & Phone Number	Date of Last Fill
Name of Medication	Provider & Phone Number	Date of Last Fill
Name of Medication	Provider & Phone Number	Date of Last Fill
Name of Medication	Provider & Phone Number	Date of Last Fill

Authorization for Disclosure of Health Information

BRUNSWICK FAMILY MEDICINE

RELEASE TO BRUNSWICK FAMILY MEDICINE

Patient Name: □Mr. □Mrs. □Miss □Ms. □Dr. _____
First Name Middle Initial Last Name

Home Phone #: _____ **Cell Phone #:** _____ **Date of Birth:** _____

Address: _____
City State Zip Code

I, the above patient, hereby authorize the below to disclose the following information from my health record:

Practice Name: _____

Phone Number: _____ **Fax Number:** _____

Address: _____
City State Zip Code

Information to be disclosed:

□ Complete health record □ Laboratory tests □ Diagnostic reports
□ Hospital records □ Progress notes and/or Consultation reports
□ Appointment information □ Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

Brunswick Family Medicine

□ **3960 Executive Park Blvd., Ste. 600**
Southport, NC 28461
910-454-4343 (phone)
910-457-9209 (fax)

□ **5106 Wrightsville Ave.**
Wilmington, NC 28403
910-395-6400 (phone)
910-457-9209 (fax)

The purpose of disclosure:

□ Transfer of Care □ Moving □ Referral □ Continuation of Care □ Other: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I fail to specify an expiration date, event, or condition, this authorization will expire in 180 days.

The facility, its employees, officers and providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Parent or Guardian: _____ Date:_____

Signature of Witness: _____ Date: _____