

ACCOUNT # \_\_\_\_\_

**CONFIDENTIAL**

**PATIENT INFORMATION**

DATE \_\_\_\_\_

NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
LAST FIRST MI

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**PLEASE CIRCLE**      MINOR      SINGLE      MARRIED      DIVORCED      WIDOWED      SEPARATED

PATIENT'S OR PARENT'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SPOUSE OR PARENT'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_

PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

**RESPONSIBLE PARTY**

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?      YES      NO      (PLEASE CIRCLE)

**INSURANCE INFORMATION**

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_ ID# \_\_\_\_\_

**DO YOU HAVE ANY ADDITIONAL INSURANCE?       YES       NO      IF YES, COMPLETE THE FOLLOWING.**

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_ ID# \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

I give consent to White Lake Family Practice PLLC, its Nurse Practitioners, and other healthcare providers to examine, evaluate, and treat as deemed necessary for the above named patient.

**x** \_\_\_\_\_  
SIGNATURE OF PATIENT OR PARENT IF MINOR

\_\_\_\_\_  
DATE

**BRIEF HISTORY**

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released **ONLY** with your written consent.

Last Name	First Name	Age	Sex	Date
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ALLERGIES: Please list type and reaction.

Name of Drug	Reaction	Name of Drug	Reaction

ILLNESS/INJURY: Please check if you have ever had:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> HIGH BLOOD PRESSURE       | <input type="checkbox"/> HEART DISEASE                | <input type="checkbox"/> CHEST PAINS / ANGINA | <input type="checkbox"/> KIDNEY DISEASES              |
| <input type="checkbox"/> HEART ATTACK              | <input type="checkbox"/> CARDIAC PACEMAKER            | <input type="checkbox"/> STROKE               | <input type="checkbox"/> AIDS OR HIV INFECTION        |
| <input type="checkbox"/> RHEUMATIC FEVER           | <input type="checkbox"/> HEART MURMUR                 | <input type="checkbox"/> HAYFEVER / ALLERGIES | <input type="checkbox"/> THYROID PROBLEMS             |
| <input type="checkbox"/> SWOLLEN ANKLES            | <input type="checkbox"/> ABDOMINAL BLEEDING           | <input type="checkbox"/> TUBERCULOSIS         | <input type="checkbox"/> HEPATITIS / JAUNDICE         |
| <input type="checkbox"/> FAINTING / SEIZURES       | <input type="checkbox"/> DIVERTICULOSIS               | <input type="checkbox"/> RADIATION THERAPY    | <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE |
| <input type="checkbox"/> ASTHMA                    | <input type="checkbox"/> ANEMIA                       | <input type="checkbox"/> GLAUCOMA             | <input type="checkbox"/> STOMACH TROUBLES / ULCERS    |
| <input type="checkbox"/> LOW BLOOD PRESSURE        | <input type="checkbox"/> EMPHYSEMA                    | <input type="checkbox"/> RECENT WEIGHT LOSS   | <input type="checkbox"/> RESPIRATORY PROBLEMS         |
| <input type="checkbox"/> EPILEPSY / CONVULSIONS    | <input type="checkbox"/> CANCER                       | <input type="checkbox"/> LIVER DISEASE        | <input type="checkbox"/> OTHER _____                  |
| <input type="checkbox"/> LEUKEMIA                  | <input type="checkbox"/> ARTHRITIS                    | <input type="checkbox"/> KIDNEY STONES        | _____   |
| <input type="checkbox"/> DIABETES                  | <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT | <input type="checkbox"/> GALL STONES          | _____   |
| <input type="checkbox"/> BROKEN BONES (list) _____ |   |   |   |

OPERATIONS: List the names and dates of all operations you have had.  NONE

Year	Name of Operation	Type of Anesthetic, if known	Complications

Have you ever had a blood transfusion?  Yes  No Date: \_\_\_\_\_

**ACKNOWLEDGEMENTS**

List any hospital admissions or medical conditions not listed above: \_\_\_\_\_  
 \_\_\_\_\_

FEMALES ONLY: Are you pregnant?  Yes  No

DRUGS: Please list all drugs you take and their dosages.

DRUG	DOSAGE	DRUG	DOSAGE

Do you now or have you ever smoked?  Yes  No Do you use illegal drugs, such as cocaine, marijuana, etc.

Yes  No  Type: \_\_\_\_\_

Do you drink alcohol?  Yes  No  No \_\_\_\_\_

Type: \_\_\_\_\_ Ounces: \_\_\_\_\_

Patient Signature (parent if patient is a minor) \_\_\_\_\_

White Lake Family Practice, PLLC  
1921 White Lake Dr.  
Elizabethtown, NC 28337  
Phone (910) 862-6491  
Fax (910) 862-7641

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1. Payment is expected when services are rendered. We accept check, cash, Mastercard, Visa, American Express, and Discover.
2. I understand that insurance companies require that the practice collects the appropriate copayment or deductible at the time of each office visit.
3. All returned checks for NSF (non-sufficient funds) and/or closed accounts, will pay the cost of the amount owed, plus an additional \$35.00 for bank fees.
4. I authorize use of this form on all my insurance submissions.
5. I authorize release of information to all my insurance carriers.
6. I understand that I am responsible for my bill.
7. I authorize my nurse practitioner to act as my agent in helping me obtain payment from my insurance carriers.
8. I authorize payment directly to my nurse practitioner.
9. I permit a copy of this authorization to be used in place of the original.
10. Accounts with a remaining balance after insurance has been adjudicated [paid, applied to deductible] after 90 days, will be referred to Green Flag Profit Recovery Transworld Systems. A referral fee will be added to your account.

#### **INSURANCE**

We will assist you in filing claims in every reasonable way, but please remember that your insurance represents a contract between you (or your employer) and a health insurance company. We will always look to you in our dealings and ask you to deal on your own behalf in disputes with your insurance carrier.

Please be sure to provide us with complete details regarding your coverage and filing requirements and advise us of any changes. Your cooperation is necessary in filing claims for you.

We will do everything possible to assure that you receive full benefits from your insurance policy, but, if for some reason your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time. Any balance remaining due after insurance payment has been received will be billed and due within 30 days.

#### **SIGNATURE ON FILE**

By signing below, I do hereby state that I have read and understand these acknowledgements and will adhere to these terms and conditions.

\_\_\_\_\_  
Patient Signature and/or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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**INFORMATION RELEASE FORM**

Social Security Number

\_\_\_\_\_

Date of Birth

\_\_\_\_\_

I, \_\_\_\_\_, give my permission to White Lake Family Practice to:

1) Leave message on my answering machine at home.

YES

NO

2) Leave a message at my place of employment.

YES

NO

3) Mail lab / pathology result to my home address.

YES

NO

Address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4) Discuss my medical condition with any member of my household.

YES

NO

If yes, whom:

\_\_\_\_\_

Relationship:

\_\_\_\_\_

\_\_\_\_\_

Relationship:

\_\_\_\_\_

Patient Name:

\_\_\_\_\_

Signature of Patient or Responsible Party:

\_\_\_\_\_

Witness:

\_\_\_\_\_

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**RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT**

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I, \_\_\_\_\_, have received a copy of the Notice of Privacy  
Patient's Name

Practices from the medical office indicated above.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

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**FOR OFFICE USE ONLY**

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We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed and a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

\_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

Prepared by: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**White Lake Family Practice, PLLC**  
**Patient Consent Form**

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending care provider or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I, the undersigned, acknowledge that White Lake Family Practice, PLLC will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

**MEDICARE PATIENTS:** I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to White Lake Family Practice, PLLC.

I acknowledge that I have been given the White Lake Family Practice notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. **Patient Initials:** \_\_\_\_\_

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
**Patient (or Responsible Party) Signature**

\_\_\_\_\_  
**Date**