CONE HEALTH

Cone Health Primary Care at MedCenter Kernersville
1635 NC 66 South, Suite 210
Kernersville, NC 27284
(336) 992-1770 • Fax (336) 992-1776

Name: _____ Age _____
Last Name First Name Middle Initial

Date of Birth: ____/____/____ SSN: _____

Gender: ☐ Male ☐ Female Gender Identity: _____

Home Address: _____
Street Address Apt # City/State/Zip

Mailing Address: (If different from above) _____
Street Address or PO Box City/State/Zip

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Language: ☐ English ☐ Spanish ☐ Other _____ Needs interpreter: ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Race: ☐ Asian ☐ African American ☐ American Indian ☐ White ☐ Other ☐ Unknown

Primary Care Provider: _____ Preferred Pharmacy: _____

Emergency Contact Information

Name: _____
Last Name First Name Middle Initial

Home Address: _____
Street Address Apt # City/State/Zip

Relationship to Patient: _____ Home Phone: (_____) _____

Cell Phone: (_____) _____ Work Phone: (_____) _____

Patient Employment Information

Employer: _____ Occupation: _____

Check One: ☐ Full-Time ☐ Part-Time Work Phone: (_____) _____

Work Address: _____
Street Address City/State/Zip

Primary Insurance Information	Secondary Insurance Information
Insurance Company: _____	Insurance Company: _____
SSN# of Policy Holder _____	SSN# of Policy Holder _____
DOB of Policy Holder _____	DOB of Policy Holder _____
Policy No: _____	Policy No: _____
Group No: _____	Group No: _____

The undersigned hereby authorizes said Provider(s) to release all information pertaining to patients' treatment to his/her insurance company or companies and to any other physician or health care provider to whom the undersigned may be referred. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including medical, private insurance, and other health plans to: Cone Health Primary Care at MedCenter Kernersville.

_____ _____
Patient/Guardian Signature Date

Cone Health Primary Care at MedCenter Kernersville – New Patient Intake From

Name: _____ Date of Birth: _____

Nickname/Preferred Name: _____; Preferred Pronouns: she/her; he/him; they/them; other_____

Occupation: _____(employed/job, stay-at-home parent/caregiver, student, unemployed, etc)

Primary reason for today's visit: _____

Other concerns for a future visit: _____

Have any of the following symptoms been bothering you recently? (please circle any that apply)

General:	**Head/Neck:**	**Cardiovascular**:	**Respiratory**:	**Gastrointestinal**:	**Musculoskeletal**:
fever up to _____degrees	headache	chest pain	trouble breathing	abdominal pain	muscle pain
chills	vision change	chest pressure	dry cough	nausea	joint pain
unintended weight loss	hearing change	heart racing	cough w/ mucus	vomiting	back pain
fatigue	sore throat	leg/foot swelling	bloody cough	blood in stool	neck pain
night sweat	voice change		wheeze	diarrhea	recent injury
	sinus pressure			constipation	old injury w/ pain now
				heartburn	
Skin:	**Genital/Urinary**:	**Blood/Lymph**:	**Hormonal**:	**Neurological**:	**Mental Health**:
rash	blood in urine	easy bruising	feeling too cold	weakness arm/leg	depression
itching	leaking urine	easy bleeding	feeling too hot	drooping face	anxiety
concerning mole	difficulty urinating	large lymph node	increased thirst	speech problem	sleep problems
new lumps /bumps	genital bleeding		increased eating	passing out	mood swings
hair/nail problem	genital discharge		abnormal periods	dizzy/vertigo	drug use
	genital rash		weight gain	numbness/tingling	alcohol overuse

Other symptoms or problems not listed above:

Medical History:

Have you ever been diagnosed with any of the following? (please circle any that apply)

Heart Attack	Blood clot in leg	Low Thyroid	Colon Polyps	Depression
High Blood Pressure	Blood clot in lung	High Thyroid	Abnormal Pap smear	Anxiety
High Cholesterol	Stroke	Asthma	Abnormal Mammogram	Other mental illness
Heart Failure	Diabetes	COPD	Cancer – type:	Drug use/addiction
Atrial Fibrillation	Kidney Disease			Alcohol use/addiction

Have you been hospitalized 24+ hours/overnight in the past year? Yes / No

If yes, what was the problem?

Other illness or illnesses not noted above:

Medications: please include prescriptions, over-the-counter drugs, herbs, alternative treatments, etc. *You may attach a list.*

Medication Name / Dose / Time of day you take it	Medication Name / Dose / Time of day you take it

Allergies & Side Effects: please list any medication you've had a bad reaction to, and please specify that reaction

Please complete back of form →

Substance Use History:	
Tobacco: Never/Current/Former tobacco use If cigarettes, #packs per day (average) _____ for _____ years If current smoker, would you like to quit? Yes/No	Type: Cigarette/Cigar/Pipe/Chew? If former smoker, when did you quit? _____ **Other**: ever used vape/e-cigarette? Yes/No
Alcohol: Never/Rarely/Sometimes/Often/Daily/Former If you drink, #drinks on average per week? _____ Do you or your loved ones think you drink too much? Yes/No	**Drugs:** Never/Rarely/Sometimes/Often/Daily/Former If drugs used, which ones have you used/do you use?

Sexually active?	**Partner(s) are or have been:**	**Sexually Transmitted Infection (STI):**	**Your Gender Identity:**	**Your Sexual Orientation:**
never not currently yes in past year: one partner 2+ partners	male female transgender other	**Any history of STI?** Yes/No If yes, specify:_____ **How are you preventing an STI?** Abstinence/ Condom/ Other_____ **Are you interested in being screened for an STI today?** Yes/No **Last time tested for STI:** _____	Female Male Trans Female Trans Male Non-Binary Other: _____ Choose not to say	Heterosexual Lesbian/Gay Bisexual Other:_____ Don't know/unsure Choose not to say

Family Planning:	**If applicable**:
Are you pregnant/breastfeeding now? Yes/No **Are you or your partner planning to become pregnant?** Yes/No **If no, how are you or your partner preventing pregnancy?** Abstinence/ condom/ pill/ patch/ ring/ IUD/ Nexplanon/ tubes tied/ vasectomy/ same-sex partner/ postmenopausal/ hysterectomy/ other: _____	Last Period: _____ #Pregnancies: _____ #Children: _____ #Miscarriages: _____ #Abortions: _____

Safety:	**Have you ever been physically/emotionally abused by a partner or someone important to you?** Yes/No If yes, when did this most recently happen? _____ Do you have help? _____

What surgeries have you had? (please circle any that apply)				
C-section(s) Hysterectomy	Tubes tied Vasectomy	Gallbladder removal Appendix removal	Joint replacement Broken Bone repair	Other:

Do any family members have the following illnesses, that you know of? Other: family history unknown If yes, please circle - specify (mother, brother, maternal grandfather, etc.)				
High Blood Pressure Heart Attack	Diabetes Stroke	Skin Cancer Colon Cancer	Breast Cancer Ovarian Cancer	Prostate Cancer Other Cancer
Other family illness or illnesses not noted above:				

Routine Cancer Screening: please tell us when you had the test, and where you had it so we can request records		
Colonoscopy, Cologuard or stool test to screen for colon cancer? _____ If you are 50 or older, and never had this test, please tell us the reason.	**Mammogram** to screen for breast cancer? _____ If you are 40 or older, and never had this test, please tell us the reason.	**Pap smear** to screen for cervical cancer? _____ If you are 21 or older, and never had this test, please tell us the reason.

Adult Immunizations: When was your last... (if uncertain, a guess or the approximate year is fine)			
Flu shot? _____ (Recommended every year)	**Tetanus shot?** _____ (Td/Tdap booster every 10 years)	**Shingles shot(s)?** _____ (Old vaccine was Zostavax, newer one is Shingrix)	**Pneumonia shot(s)?** _____ (Prevnar and Pneumovax if 65 or older, Pneumovax earlier if certain illnesses)

Thanks for taking this time to share this information! Welcome to Cone Health Primary Care! ☺

CONE HEALTH Cone Health Medical Group
Partnering for exceptional care.

Cone Health Primary Care at Med Center Kernersville
1635 NC Hwy 66 South Suite 210
Kernersville, NC 27284
336-992-1770 (o)
336-992-1776 (f)

ADVANCED DIRECTIVES

Do you have Advanced Directives?

☐ Yes

☐ No

If yes, please mark the appropriate box:

☐ DNR ☐ Living Will ☐ Healthcare Power of Attorney

Would you like additional information?

☐ Yes

☐ No

Name: _____ DOB: _____

CONE HEALTH

Falls

1. Have you had any falls in the past year? ☐ Yes ☐ No ☐ Non-ambulatory
2. How many falls in the last year? ☐ 1 ☐ 2 or More
3. Was there injury with the fall? ☐ Yes ☐ No

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless?	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
4. Feeling tired or having little energy?	0	1	2	3
5. Poor appetite or overeating?	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead, or thoughts of hurting yourself in some way?	0	1	2	3

Scores _____ + _____ + _____ + _____

= Total score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge?	0	1	2	3
2. Not being able to stop or control worrying?	0	1	2	3
3. Worrying too much about different things?	0	1	2	3
4. Trouble relaxing?	0	1	2	3
5. Being so restless that it is hard to sit still?	0	1	2	3
6. Becoming easily annoyed or irritable?	0	1	2	3
7. Feeling afraid as if something awful might happen?	0	1	2	3

Scores _____ + _____ + _____ + _____

= Total score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Cone Health Medical Group

DESIGNATED PARTY RELEASE

We request that you complete this form when consenting for us to leave detailed verbal information (results of labs, x-rays, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, or with another party that you choose to designate.

This form does not allow copies of your medical records to be released. To release copies of your medical records, you must complete a Request & Authorization for Use/Disclosure of Protected Health Information form.

Note: The "Health Care Providers Guide-Communicating with a Patient's Family, Friends, or Others Involved in the Patient's Care," the U.S. Dept. of Health and Human Services, Office for Civil Rights, provides the following information: Even though HIPAA requires health care providers to protect patient privacy, providers are permitted, in most circumstances, to communicate with the patient's family, friends, or others involved in their care or payment for care, without obtaining written authorization from the patient. You can find more information about HIPAA at this website: http://www.hhs.gov/ocr/hipaa.

Patient name *(PRINT)* _____ Date of Birth _____

Todays' Date _____

At my request, I authorize ___ *All* Cone Health Medical Group Practices, or ___ *Only* PCK-PRIMARY CARE MKV to verbally disclose my protected health information, as needed, to *(enter name of person(s)/entity who may be allowed to receive your protected health information):*

Name: _____ Name: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Phone Number: _____ Phone Number: _____

Relationship to Patient: _____ Relationship to Patient: _____

At my request, I authorize ___ *All* Cone Health Medical Group Practices, or ___ *Only* PCK-PRIMARY CARE MKV to communicate my protected health information to me via the following methods:

☐ Leave detailed message on my home answering machine (phone #: _____)

☐ Leave detailed message on my voice mail at work (phone #: _____, ext: _____)

☐ Leave detailed message on my cell phone voice mail (phone #: _____, ext: _____)

Patient Signature: _____ **Date:** _____

*****IMPORTANT NOTICE BELOW*****

PROCEDURE TO CANCEL THIS AUTHORIZATION:
I understand that I may revoke this authorization at any time in writing. However, if I revoke this authorization, I also understand that the cancellation will *not* affect any action taken in reliance on this authorization before receipt of the written notice of cancellation.

CONE HEALTH
Primary Care
MEDCENTER KERNERSVILLE
1635 NC 66 South
Suite 210
Kernersville, NC 27284
Phone: 336-992-1770 Fax: 336-992-4899

Medical Records Release Form
(from another practice to ours)

Patient Name_____ Date of Birth_____
Telephone_____ Social Security # _____
Address_____

I hereby authorize the use or disclosure of my individual identifiable health information as described below. This includes information pertinent to mental health, drug/alcohol abuse and HIV/AIDS diagnosis. I understand that this authorization is voluntary. The information released may not be released by the recipient without my authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy regulations.

I authorize Cone Health Primary Care at MedCenter Kernersville to request progress notes, labs, xrays, procedure notes and immunizations from the last 1 year.

Please indicate if you would like your records once we receive them. Yes / No

Please request records from:

Dr. _____ Phone:_____

Address:_____ Fax:_____

The patient or the patient's representative must read and initial the following statements:

a. I understand that unless revoked earlier, this authorization will expire on____/____/____.
Initials:_____
b. I understand that I may revoke this authorization at any time by notifying Cone Health in writing, but if I do, it won't have any effect on any actions Cone Health took before it received the revocation.
Initials:_____
c. I understand that Cone Health cannot make me sign this authorization as a condition to receive treatment from Hospital except:
    1. When Cone Health provides me with research-related treatment, or
    2. When Cone Health provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.

Initials:_____
d. **I understand there may be a charge for reproduction of medical records/films/tapes.**
Initials:_____

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

(Form MUST be completed before signing)

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian/Auth. Repres Date

_____ _____
Witness Signature Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

CONE HEALTH.
Primary Care
MEDCENTER KERNERSVILLE

Dear Patient,

We are delighted that you have selected us to be your health care provider. To ensure that we provide you with exceptional service with your healthcare and billing needs, please take a few moments to read and sign the following information.

Registration

Cone Health Primary Care works on appointment/same day work in basis. Please call ahead for same day work in availability time. Office hours are 8:00 am - 5:00 pm Monday through Friday. The office is closed for business between the hours of noon - 1:00 pm and closed on the weekends. Please make note that there is a fee of $50.00 if you do not show for your scheduled appointment and for cancelled appointments if not notified 24 hours prior to your original appointment. **If you have 3 no shows you will be discharged from our practice.**

New patients should arrive 30 minutes prior to actual appointment time to fill out paperwork. If you are more than 10 minutes late for your appointment, we may ask that you reschedule your appointment. If you wait more than 10 minutes in the waiting room, please ask the receptionist if there is a delay in the physician's schedule.

Billing/Insurance

Please be advised that the billing and insurance filing of the services provided in our office is managed by the Billing and Profees Department. If you have any questions with regards to your account/balance please call 844-566-1324 (Toll Free).

Your insurance will be filed for all Office visits including Nurse Visits and a co pay will be collected at the time of service. All in house labs are referred to Solstas Laboratory Network located on the lower level of our MedCenter building.

As a courtesy, we will file a claim to your insurance company, and it is your responsibility to provide proof of insurance coverage. If you cannot provide proof of insurance, you will be responsible for payment of the bill at the time of your visit.

Please make note that it is the patient's responsibility to notify our office if your visit is related to a Worker's Compensation Case and if you have notified your present employer of the injury. We will file with your insurance until you advise us that your employer will cover your visit as a Worker's Compensation incident.

Visit with your Doctor

Please bring all medications, vitamins, mineral pills, etc., you take to each visit. If you need your medicine refilled, please call your pharmacy/drug store first. Please allow 24 hours for all refill requests called in to our office.

If you need to reschedule a referral visit please call the Specialist Office directly that will be provided to you by the referral coordinator. To obtain your results from a referred Specialist Office please call their office directly for results. We will contact you with all STAT labs and abnormal results.

Emergency Contact/After Hours

Please call 911 or go to the nearest Emergency Room if you have a life-threatening emergency. Otherwise, dial 336-992-1770 to reach the on call physician. Please make note that no prescriptions will be filled after regular business hours.

Customer Service

Your feedback is important to us as our team strives to be the leading choice as your Primary Care Provider.

Thank you for your patronage,

Conc Health Primary Care Kernersville Team

_____ _____

Patient Signature Date

_____ _____

Guardian/Power of Attorney Signature Date

CONE HEALTH.

CONTROLLED MEDICATIONS PRESCRIPTION POLICY

Since the inception of **North Carolina's STOP ACT in July 2017,** Cone Health Primary Care Kernersville no longer uses narcotic pain medication or other controlled substances when treating new patients with chronic pain or chronic medical issues. We do treat new patients with chronic pain using non-narcotic medicines, physical therapy and other modalities, depending on the condition.

We reserve narcotic pain medication as an occasional tool for pain management to improve function while a patient is recovering from an **acute** injury or condition. Cone Health Primary Care may prescribe a narcotic pain medication for temporary relief of acute pain (5 days or less) or for an injury that will require surgical intervention.

We have created this policy because there is growing concern among medical providers regarding the safety of these medicines with risk for overdose and addiction.

We will not replace a stolen or lost prescription for narcotic pain medicine or other controlled substance.

The following medications are not prescribed at this clinic: Suboxone, Nucynta (Tapentadol), Demerol, Methadone, and MS Contin. This list is not comprehensive.

This clinic reserves the right to restrict all controlled substance medications based on safe and appropriate medical care for our patients.

Cone Health Primary Care Kernersville utilizes the North Carolina Controlled Substance Reporting Database.

I acknowledge that I have read, understand and will abide by the Cone Health Primary Care Kernersville Controlled Medications Prescription Policy.

Signed by:_____

Print Name:_____ Date:_____