Cone Health Medical Group
Partnering for exceptional care.

Cone Health Primary Care at MedCenter Greensboro at Drawbridge
3518 Drawbridge Parkway, Suite 330
Greensboro, NC 27410
336-890-3140 • Fax 336-890-2937

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 Greensboro at Drawbridge.

______________________________ ____________________
Patient/Guardian Signature Date

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CONTROLLED MEDICATIONS PRESCRIPTION POLICY

Since the inception of **North Carolina's STOP ACT in July 2017**, Cone Health Primary Care MedCenter Greensboro at Drawbridge 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 MedCenter Greensboro at Drawbridge utilizes the North Carolina Controlled Substance Reporting Database.

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

Signed by: ____

Print Name: ____ Date: ________________________

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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* PCD-PRIMARY CARE DRAWBRIDGE to verbally disclose my protected health information, as needed, to *(enter name of person(s)/ entlty 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* PCD-PRIMARY CARE DRAWBRIDGE to communcate 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 of Birth ______________

*******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.