

# PATIENT REGISTRATION (please print)

1. Chart Number \_\_\_\_\_

2. Patient's Full Name \_\_\_\_\_ 3. Sex:  M  F  
Last First Middle Name Preferred

4. Race: (Please Circle) American Indian, Asian, African American, Native Hawaiian or Pacific Islander, Caucasian, Other, Patient Declined  
Ethnicity: (Please Circle) Non-Hispanic, Hispanic, Patient Declined

5. Patient's Social Security # \_\_\_\_\_ 6. Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

7. Patient's Home Address \_\_\_\_\_  
Street or Route City State Zip  
Patient's Email Address \_\_\_\_\_

8. Primary Care Doctor \_\_\_\_\_ 9. Financial Responsibility:  Patient  Other

10. Referring Doctor \_\_\_\_\_

11. Patient's Home Phone (\_\_\_\_) \_\_\_\_\_ Patient's Work Phone (\_\_\_\_) \_\_\_\_\_ Patient's Cell Phone (\_\_\_\_) \_\_\_\_\_

12. Is the Patient Currently Employed?  Yes  No  
Patient's Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Street or Route City State Zip

13. Patient's Marital Status  S  M  D  W  Sep. Spouse Name \_\_\_\_\_

14. Person we may contact in case of an emergency: Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_  
Street or Route City State Zip

**INSURANCE INFORMATION** – We cannot file your insurance without complete information and a copy of your insurance cards. Please bring your insurance card with you to the front desk when you have completed this form.

## PRIMARY INSURANCE COVERAGE

15. Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

16. Subscriber's Name \_\_\_\_\_ 17. Subscriber's Sex:  M  F

18. Subscriber's Date of Birth \_\_\_\_\_ 19. Subscriber's Social Security # \_\_\_\_\_

20. Patient's Relationship to Subscriber  Self  Spouse  Child  Other

21. Subscriber's Employer \_\_\_\_\_

22. Subscriber's ID # \_\_\_\_\_ 23. Group # \_\_\_\_\_

## SECONDARY INSURANCE COVERAGE

24. Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

25. Subscriber's Name \_\_\_\_\_ 26. Subscriber's Sex:  M  F

27. Subscriber's Date of Birth \_\_\_\_\_ 28. Subscriber's Social Security # \_\_\_\_\_

29. Patient's Relationship to Subscriber  Self  Spouse  Child  Other

30. Subscriber's Employer \_\_\_\_\_

31. Subscriber's ID # \_\_\_\_\_ Group # \_\_\_\_\_

## OTHER INSURANCE Yes No

FINANCIAL AGREEMENTS AND AUTHORIZATION FOR TREATMENT: I hereby authorize Raleigh Medical Group, Cary Medical Group, Raleigh Adult Medicine and Wake Endoscopy Center, LLC ("RMG/CMG/RAM/WEC") and its physicians and such assistants as a physician may designate to furnish and perform on me or the patient stated above ("Patient") such medical care, examination and treatment as may be ordered by an RMG/CMG/RAM/WEC physician in his or her medical judgment and such medical care, examination or treatment as is reasonable incident thereto. I hereby authorize direct payment to RMG/CMG/RAM/WEC of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by RMG/CMG/RAM/WEC to the Patient. I understand that, to the extent permitted by applicable law, I am and I agree hereby to be, financially responsible to RMG/CMG/RAM/WEC for charges not covered by this agreement, and I hereby guarantee payment to RMG/CMG/RAM/WEC on demand for all such charges.

Signature \_\_\_\_\_ Please check one:  Patient  Authorized Representative  
Date \_\_\_\_\_  Parent or Guardian of Minor

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize RMG/CMG/RAM/WEC to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient's examination and/or treatment to any insurance company, government agencies and their agents, and professional review organizations with which the Patient may have insurance coverage or which may be assisting in payment of the medical care provided by RMG/CMG/RAM/WEC to the Patient. I also hereby authorize RMG/CMG/RAM/WEC to release any medical information to any licensed physician, health care provider, or medical facility to which the Patient may be referred, admitted, or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action has been taken.

Signature \_\_\_\_\_ Please check one:  Patient  Authorized Representative  
Date \_\_\_\_\_  Parent or Guardian of Minor



# Wake Endoscopy Center, LLC PATIENT HISTORY AND PHYSICAL FORM

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Present Problem \_\_\_\_\_

Address \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Allergies \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ Referred by \_\_\_\_\_

History (check if applicable)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Seizures             | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Stroke         |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Liver disease         | <input type="checkbox"/> Hepatitis      |
| <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Joint replacement     | <input type="checkbox"/> Bleeding       |
| <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Ulcers         |
| <input type="checkbox"/> Crohn's disease      | <input type="checkbox"/> Colitis               | <input type="checkbox"/> Other _____    |

Are you on blood thinners  No  Yes Last dose of Aspirin \_\_\_\_\_

Surgeries \_\_\_\_\_

Disabilities \_\_\_\_\_

Current Medications \_\_\_\_\_

Do you smoke  No  Yes # packs/day \_\_\_\_\_ Do you drink alcohol  No  Yes

Family History	Age now or at death	Living	Cause of Death
Spouse	_____	_____	_____
Mother	_____	_____	_____
Father	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____

Family history of colon cancer  No  Yes Relation \_\_\_\_\_ age at diagnosis \_\_\_\_\_

**Physical Exam (FOR WEC USE ONLY)**

Heart \_\_\_\_\_ Lungs \_\_\_\_\_

Abdomen \_\_\_\_\_ ASA I II III IV V

Other findings \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

## HIPAA AUTHORIZATION FORM

Chart #: \_\_\_\_\_ Date: \_\_\_\_\_

I give my permission for the providers of Raleigh Medical Group, P.A. (a division of Raleigh Medical Group) to release ANY information about my medical condition, prescriptions, and financial account to:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Below, I give my permission for the providers of Raleigh Medical Group, P.A. (a division of Raleigh Medical Group) to release prescriptions and samples **ONLY** to:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

The above mentioned person(s) **will be required to provide photo ID** when picking up requested items.

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Patient signature: \_\_\_\_\_

By signing on the line below, I acknowledge that I was provided access to the Notice of Privacy Practices of Raleigh Medical Group, P.A.

Print Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

### For Personal Representation of the Patient (if applicable)

Print Name of Personal Representative: \_\_\_\_\_

Representative's Relationship (i.e. parent/guardian/other, etc.): \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_

\_\_\_\_\_ I refuse to acknowledge I was provided access to the Notice of Privacy Practices of Raleigh Medical Group, P.A. (a division of Raleigh Medical Group).

\_\_\_\_\_  
Signature of Practice Employee

\_\_\_\_\_  
Date

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## SUMMARY OF NOTICE OF PRIVACY PRACTICES

### Effective Date: April 14, 2003

This notice is a description of how medical information about you may be used and disclosed and how you can get access to this information.

For additional information, please refer to the full version of this notice or contact our privacy officer.

Wake Endoscopy Center, LLC  
2601 Lake Drive,  
Suite 201,  
Raleigh, NC 27607

Phone: **919-783-4888**

Fax: **919-783-4887**

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## USES AND DISCLOSERS OF YOUR PROTECTED HEALTH INFORMATION

We may use or disclose your health information:

- To treat you
- To get paid for treating you
- To run the Practice
- To remind you of appointments
- As may be required or otherwise permitted by law

For more information of how we may use or disclose your health information, please refer to the full version of this notice or contact our Privacy Officer.

We will use or disclose your health information for other purposes only with your authorization. If you authorize us to use or disclose your protected health information for other purposes, you may revoke that authorization at any time by notifying us.

## YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

You have a right to:

- Ask us to limit the information that we have
- Receive confidential communications from us regarding your health information
- Look at and obtain a copy of your health information
- Amend mistakes in your health information
- Obtain a list of disclosures of your health information that we have made; and
- Obtain a copy of the full version of our Notice of Privacy Practices

For more information on how to exercise your rights and how such rights may be limited by law, please refer to the full version of the Notice or contact our Privacy Officer.

## OUR DUTIES WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties with respect to your protected health information and our privacy practices, and to abide by the terms of our Notice of Privacy Practices.

## REVISIONS TO NOTICE OF PRIVACY PRACTICES

We may revise our policies with respect to the privacy of patient health information from time to time. Any amendments to our Notice shall be posted in our offices, and copies of any amended Notice will also be available in our offices.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. For more information on how to file a complaint, please refer to the full version of this Notice or contact our Privacy Officer.

## PRIVACY OFFICER CONTACT INFORMATION

If you have any questions regarding your privacy rights, please refer to the full version of this Notice or contact our privacy officer at (919) 859-5955. You may also address questions of concerns to the privacy officer by writing to:

Privacy Officer  
530 New Waverly Place  
Suite 200  
Cary, NC 27518