Clayton Medical Health & Vascular

101 Winding Wood Drive Clayton, NC 27520
919-553-1911

Patient Intake Form

Full Name:_____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #:_____ **Email:** _____

Occupation: _____

Emergency Contact#1: _____ **Phone #:** _____
Relationship: _____
Emergency Contact#2: _____ **Phone #:** _____
Relationship: _____

Medical History

Are you taking any medications? _____

Please indicate any of the following conditions that you currently have:

- ☐ headaches
- ☐ cancer
- ☐ heart/circulation problems
- ☐ major accident
- ☐ neck / back injuries
- ☐ numbness
- ☐ allergies
- ☐ TMJ
- ☐ joint surgery
- ☐ varicose veins
- ☐ diabetes
- ☐ sprains, strains
- ☐ arthritis, tendonitis
- ☐ abnormal skin condition
- ☐ high / low blood pressure
- ☐ blood clots
- ☐ fibromyalgia
- ☐ recent injuries

Explain Any Conditions You Have Marked Above:

_____

_____

Patient Signature:_____ **Date:** _____

Clayton Medical Health & Vascular

Patient History Form

Date:_____

Name:_____ D.O.B._____

Past Medical History: *(check all that apply)*

- ☐ Acid Reflux
- ☐ Alcohol or Drug Problem
- ☐ Allergy problems
- ☐ Anemia
- ☐ Artery/Vein problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ Cancer
- ☐ Cataracts
- ☐ Colitis/Crohns
- ☐ Chronic pain
- ☐ Depression, Anxiety
- ☐ Diabetes
- ☐ Esophagitis, ulcers
- ☐ Fractures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Heart disease
- ☐ Heart valve problems
- ☐ Hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ Irritable bowel
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease/Hepatitis
- ☐ Lung disease
- ☐ Migraines
- ☐ Mental Health Diagnosis
- ☐ MRSA
- ☐ Osteoporosis
- ☐ Recurrent skin infections
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sexually transmitted Infections
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ TB
- ☐ Thyroid diseases

Other diseases not listed above:_____

Hospitalizations/Significant injuries:_____

_____

Surgery/Procedures History: *(check all that apply)*

- ☐ Appendix
- ☐ Bladder Suspension
- ☐ Blood vessel surgery
  - ☐ Arteries
  - ☐ Veins
- ☐ Colon/Rectal surgery
- ☐ Dental surgery
- ☐ Eye surgery
- ☐ Gallbladder
- ☐ Heart Surgery
  - ☐ Bypass
  - ☐ Heart valve surgery
  - ☐ Angioplasty (balloon)
  - ☐ Stents
  - ☐ Pacemaker
- ☐ Hysterectomy
  - ☐ Complete ☐ Partial
- ☐ Hernia
- ☐ Joint replacement/Orthopedic surgery
- ☐ Kidney surgery
- ☐ Organ Transplant
- ☐ Prostate surgery
- ☐ Thyroidectomy
- ☐ Sinus surgery
- ☐ Tonsils and/or adenoids
- ☐ Tubal Ligation
- ☐ Vasectomy

Other surgery not listed above:_____

_____

Please list the names of other practitioners you have or are currently seeing:_____

Clayton Medical Health & Vascular

Family History:

Family Member	Age(s)	Living	Cause of Death
Father			
Mother			
Brother(s) #			
Sister(s) #			

Diseases in the family: *(check all that apply)*

- ☐ Arthritis
- ☐ Addiction problems
- ☐ Bleeding problems
- ☐ Cancer
  - ☐ Breast
  - ☐ Colon
  - ☐ Prostate
  - ☐ Other
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mental Illness

Social History:

Do you live: Alone ☐ with Spouse or Partner ☐ with Family ☐ Other ☐

Who do you rely on for support and help?_____

Do you smoke? ☐ Currently ☐ Past ☐ Never_____packs/day for_____years Date quit:_____

If you do smoke, are you interested in quitting? ☐ YES ☐ NO

Other nicotine use ☐ YES ☐ NO

Exposure to second hand smoke? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO ☐ Beer ☐ Wine ☐ Liquor How many drinks per week?_____

How many caffeinated beverages per day?_____☐ Coffee ☐ Tea ☐ Sodas ☐ Energy Supplements

Any recreational drug use? ☐ YES ☐ NO

Type:_____

Do you exercise regularly? ☐ YES ☐ NO If so how many times per week?_____Type of exercise:_____

Do you feel safe in your home? ☐ YES ☐ NO

How many hours of sleep do you get per night?_____ Do you wake feeling well rested? ☐ YES ☐ NO

Medication List

Medication Name (Prescribed and Over-the-counter)	Dose (How Much)	Frequency (How Often)

Allergies:_____

_____

_____

_____

Pharmacy:_____

_____

_____

Clayton Medical & Vascular Center
Alan Nadour, M.D.
Internal Medicine & Vascular Medicine

101 Winding Wood Drive
Clayton, NC 27520

Phone: (919) 553-1911
Fax: (919) 553-3993

Authorization to Release Information

Patient Name:----------DOB:----------

------ I hereby request a copy of my medical records as indicate below, be released to me.

------ I elect to have these records mailed to me; records will be ready in twenty one (21) business days.

------ I elect to pick these records up in person; records will be ready in twenty one (21) Business days.

------ I consent to and authorize: Name of physician/Facility----------

Address: ----------to release my medical records to as indicated below to Clayton Medical Health, NC

------ I consent to and authorize Clayton Medical Health, NC to release my medical records as

indicated below, to (physician/Facility's Name)----------Phone:----------

Address:----------City:----------State:----------Zip:---------

Treatment Dates Form:----------To:----------

------ History & Physical
------ Operative / Procedure
------ Consults/ Office/ Notes
------ Emergency Department Notes
------ Labs/ X-rays/ EKGs
------ Consults, Progress Notes (Hospital)
------ Other (Specify)----------

I Do------ I Do Not------ authorize the release of portions of the record relating to substance abuse, psychological/ psychiatric conditions and/or communicable diseases, including immunodeficiency virus (HIV), if present.

The information to be released will be used for the following purpose (check appropriate box):

------ Sharing with other health care providers as needed
------ Insurance Processing
------ Legal reasons
------ Personal Use
------ Other (specify)

I understand that I may revoke this consent at any time I writing except to the extent to the extent that the information has already been released pursuant to this consent and before I have revoked my consent. Otherwise, this consent shall continue to be valid only for as long as reasonable necessary to carry out the purposes enumerated above or unless it is with release to an insurance company for payment for medical and/or hospitalization benefits, it will automatically expire one year after date signed, whichever is the earliest date. I have been informed and understand that information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information. It is that once disclosed. The privacy of the information will no longer be protected under federal medical privacy law.

Note: Unless otherwise permitted by law, further release of this information is prohibited without prior written consent.

Signature of patient or legal representative ----------Date: ----------
Please Print Name:----------State relationship to patient:----------Phone Number: ----------
-Signature of Witness: ----------Date: ----------
Please Print Witness Name: ----------Authorization not valid beyond: ----------

HIPPA FORM FOR CLAYTON MEDICAL HEALTH & VASCULAR

Name: _____

Authorization to Contact Patient and Record of Disclosure (HIPPA):

The HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information(PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (CHECK ALL THAT APPLY):

____ OK to give detailed information via Voicemail, E-mail, or Text

____ Leave a message with office call back number only via Voicemail, E-mail, or Text

____ Other: _____

I authorize the release of protected health information to the individual(s) listed below:

Name: _____ Phone:_____ Relationship:_____

Name: _____ Phone:_____ Relationship:_____

I understand that I may revoke this authorization at any time by submitting a written request.

Patient/Guardian Signature:_____

Printed Name: _____ Date: _____

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Patient Responsibilities

- You are responsible to provide us at the time of service with the insurance information or any updates in your health insurance plan.
- You are responsible of providing our office team with any updates of your address or telephone number, as well as the updated information of the person who is financially responsible for your bills.
- You are responsible for the $25.00 fee charge for all No Show, Cancelation and Reschedules that are not reported at least **24 hours** prior to appointment time. We recognize that there are emergencies and compelling circumstances that will be taken into consideration.

Copays

- You are responsible to pay the required copayment at the time of each visit.
- If you do not have insurance, you will be expected to pay the amount at the time of the visit.
- If we cannot verify your insurance coverage at the time of your visit, you will be responsible for a minimum payment of $60.00.

Deductible

- It is your responsibility to know and understand your insurance plan and any deductible that may apply under your responsibility.
- Our billing staff will send you a statement that shows in detail the amount your insurance company has determined is applied to your deductible and is owed by you. You will be responsible for this payment.

Insurance information

- Our billing department can assist patient with any billing questions but cannot resolve any disagreement between patient and insurance.
- Our billing team will be available to help if you need to know any service codes for you to verify with your insurance if the service is covered under you plan or not. It is your responsibility to verify all the information.
- Medical insurance may not cover the entire cost of your medical services. If we believe that a service we are going to provide is not covered by your insurance we will notify you. However, we do not learn that a service is not covered until we submit the claim to your insurance. You will be responsible for any payments your insurance refuses to pay.

Signature:_____ **Date:**_____