



1380 Eastchester Dr, High Point, NC 27265

Dr. Imran Haque - Robert George, NP - Mindy Parks NP - Emily Harless, NP

\* ALL OF THE INFORMATION ON THIS FORM MUST BE FILLED OUT , UNLESS MARKED OPTIONAL!

PATIENT REGISTRATION

TODAY'S DATE: / /

PATIENT NAME: (First, Middle, Last) DOB: / / AGE:

MAILING ADDRESS:

PHYSICAL ADDRESS:

HOME PHONE: CELL PHONE: SS#:

SEX: M F T RACE: BLACK WHITE ASIAN HISPANIC NATIVE AMERICAN BIRACIAL OTHER

STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPERATED

PREFERRED LANGUAGE: EMAIL ADDRESS: (OPTIONAL)

HOW DID YOU HEAR OF US:

EMERGENCY CONTACT: RELATIONSHIP: PHONE:

PHARMACY:

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: PHONE:

INSURANCE ADDRESS:

MEMBER/SUBSCRIBER ID #: PHONE:

SUBSCRIBER SS#: SUBSCRIBERS RELATIONSHIP:

EMPLOYMENT INFORMATION

EMPLOYER'S NAME: OCCUPATION: (Optional)

PHONE: EMPLOYER'S ADDRESS:

OFFICE NOTIFICATIONS

PREFERRED METHOD OF CONTACT FOR:

APPOINTMENT REMINDERS: PHONE TEXT EMAIL OTHER:

OTHER GENERAL NOTIFICATIONS: PHONE OK TO LEAVE MESSAGE? OTHER:



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## INSURANCE WAIVER

● **INDIVIDUALS RESPONSIBILITY FOR NON-COVERED SERVICES:**

In consideration of services rendered but Horizon Internal Medicine Asheboro, Horizon internal Medicine High Point or Horizon Med-Spa and Vein Center to the undersigned patient, the undersigned promise(s) to pay and Copayments, Deductibles, Coinsurance or other charges required to be paid by your health insurance coverage.

● **ASSIGNMENT OF BENEFITS PROCEEDS:**

I request that payment of authorized HMO/Third party Payer/Government Agencies (Medicare or Medicaid) benefits to be made either to me or on my behalf to Horizon Internal Medicine for services furnished to me by the provider.

● **AUTHORIZATION TO RELEASE MEDICAL RECORDS:**

I hereby authorize Horizon Internal Medicine to release to my Insurer/HMO/Third Party Payer/ Government Agencies, or to whomever is financially responsible for my medical care, ALL information needed to substantiate payment for such medical care and, if required, for precertification/prior approval purposes.

● **REFERRALS/CO-PAYMENTS:**

HMO plans: for plans requiring referrals from the primary care physician, AUTHORIZATION MUST BE OBTAINED PRIOR TO THE TIME OF THE VISIT. Unauthorized visits will be billed to you according to the regular fee schedule. CO-PAYMENTS ARE DUE AT THE TIME OF VISIT. If benefits are denied due to lapsed coverage, you will be billed according to the regular fee schedule.

● **PRIVATE INSURANCE or NO INSURANCE:**

Payments are do at the TIME of VISIT!

\_\_\_\_\_  
(Print Patient Name or Authorized Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Patient or Authorized Representative)

\_\_\_\_\_  
(Relationship if **NOT** patient)



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## APPOINTMENT CANCELLATION/NO-SHOW POLICY

Thank you for trusting medical care to Horizon Internal Medicine. When you schedule an appointment with Horizon Internal Medicine, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than **24 hours** prior to your scheduled appointment. This gives us time to schedule other patient's who may be waiting for an appointment.

- Effective **November 1st 2017**, any established patient who fails to show or cancel/reschedules an appointment and has not contacted our office with at least **24 hours** notice, will be considered a No Show and charged a **\$25.00 fee**.
- Any established patient who fails to show or cancel/reschedule an appointment with no **24 hour** notice a **second** time, will be charged a **\$50.00 fee**.
- If a **third** No Show or cancellation/reschedule with no **24 hours** notice should occur, the patient will be at risk of being dismissed from Horizon Internal Medicine. If you do call to reschedule, **please** document the time and the name of the person that you spoke with.
- Any **NEW** patient who fails to show for their initial visit, will not be rescheduled.
- The fee is charged to the patient, **NOT** the insurance company, and is due at the time of the patient's next office visit.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.
- If you, the patient has a previous no show fee, you cannot be worked in or have a tele-visit appointment with our providers until the fee(s) is paid in **FULL**.

\_\_\_\_\_  
(Print Patient Name or Authorized Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Patient or Authorized Representative)

\_\_\_\_\_  
(Relationship if **NOT** patient)



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## HEALTH & HISTORY FORM

**PLEASE READ THOROUGHLY - ALL SECTIONS ARE MANDATORY**

TODAY'S DATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ AGE \_\_\_\_\_

**List of Complaints:** \_\_\_\_\_  
(Reason for Establishing)

### PRESENT HEALTH

**List Current/Active Medical Conditions:** \_\_\_\_\_  
\_\_\_\_\_

**List Current Medication (Include over the counter):** \_\_\_\_\_  
\_\_\_\_\_

**List of Current & Past Medical Specialists:** \_\_\_\_\_

**List Allergies/Intolerance to Medications, Food or Environment:** \_\_\_\_\_  
\_\_\_\_\_

**Blood Type (if known):** \_\_\_\_\_

### PATIENT MEDICAL HISTORY

(Have you ever been treated or Diagnosed for the following)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Hepatitis          |
| <input type="checkbox"/> Back or Neck Pain       | <input type="checkbox"/> High or Low BP              | <input type="checkbox"/> Diabetes           |
| <input type="checkbox"/> Stroke or TIA           | <input type="checkbox"/> Tuberculosis                | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> Thyroid Disease             | <input type="checkbox"/> Hemorrhoids        |
| <input type="checkbox"/> HIV or AIDS             | <input type="checkbox"/> Mono                        | <input type="checkbox"/> Anemia             |
| <input type="checkbox"/> Clotting Disorder       | <input type="checkbox"/> Migraines                   | <input type="checkbox"/> Meningitis         |
| <input type="checkbox"/> Cataracts or Glaucoma   | <input type="checkbox"/> Substance Abuse             | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Heartburn or Reflux     | <input type="checkbox"/> Diverticulitis              | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Mental Disorder         | <input type="checkbox"/> Heart Valve Dysfunction     | <input type="checkbox"/> Cerebral Palsy     |
| <input type="checkbox"/> Asthma or COPD          | <input type="checkbox"/> Auto-Immune Disorder        | <input type="checkbox"/> Urinary Problems   |
| <input type="checkbox"/> Bronchitis or Pneumonia | <input type="checkbox"/> Gastrointestinal Bleeding   | <input type="checkbox"/> Irregular Bleeding |
| <input type="checkbox"/> Depression or Anxiety   | <input type="checkbox"/> Arthritis or Joint Disorder | <input type="checkbox"/> Other: _____       |

Date of Last Colonoscopy: \_\_\_\_\_ Date of Last Mammogram: \_\_\_\_\_

**COMPLETE SURGICAL HISTORY:** \_\_\_\_\_  
(List Type of surgery and Year)

**SOCIAL HISTORY**

MARITAL STATUS: SINGLE  MARRIED  WIDOWED  DIVORCED  SEPERATED  ALCOHOL USE: Never  Rarely  Moderate  Daily   
TOBACCO USE: Never  Previously  Currently  Chew/Snuff  ILLICIT DRUG USE: Never  Previously  Type/Frequency: \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Father:	ALIVE	DECEASED	Age: _____	Health Problems: _____
Mother:	ALIVE	DECEASED	Age: _____	Health Problems: _____
Siblings:	ALIVE	DECEASED	Age: _____	Health Problems: _____
Children:	ALIVE	DECEASED	Age(s): _____	Health Problems: _____

Other Known History: \_\_\_\_\_

**REVIEW OF SYSTEMS**

- CONSTITUTIONAL SYSTEMS:**  Good general health lately  Recent weight changes  Fever  Fatigue
- EYES:**  Eye disease or Injury  Wear glasses or Contacts  Blurred or Double vision
- EAR/NOSE/MOUTH/THROAT:**  Earaches or Discharge  Chronic sinus problems or Rhinitis  Nose bleeds  Mouth sores  
 Bleed gums  Bad breath or Bad taste  Sore throat or Voice changes  Swollen glands in neck
- CARDIOVASCLUAR:**  Heart trouble  Chest Pain or Angina  Palpitations  Swelling of extremities
- RESPIRATORY:**  Chronic or frequent coughing  Spitting up blood  Shortness of breath  Wheezing
- GASTROINTESTINAL:**  Loss of appetite  Change in bowel movements  Nausea or Vomiting  Frequent Diarrhea  
 Painful bowel movements  Constipation  Rectal bleeding/bloody stools  Abdominal pain
- GENITOURINARY:**  Frequent urination  Burning/painful urination  Changes in flow of urine  Incontinence or dribble  
 Kidney stones ) Sexual difficulty  Testicular pain  Menstrual pain  Irregular periods  
 Vaginal discharge # of Pregnancies \_\_\_\_\_ # or Miscarriages \_\_\_\_\_ Date of Last Pap Smear \_\_\_\_\_
- MUSCULOSKELETAL:**  Joint pain  Joint stiffness/swelling  Muscle/joint weakness  Back pain  Cold extremities  
 Difficulty walking  Amputee
- INTEEGUMENTARY:**  Rash or itching  Changes in skin color  Changes in hair or nails  Varicose veins  Breast Pain  
 Breast Lump  Breast discharge
- PSYCHATIC:**  Memory loss  Nervousness  Depression  Insomnia
- NEUROLOGICAL:**  Frequent headaches  Light headed/dizzy  Seizures  Tremors  Paralysis  Hearing loss/ringing
- ENDOCRINE:**  Glandular or Hormonal problem  Heat or Cold intolerance  Changes in Hat or Glove size
- HEMATOLOGIC/LYMPHATIC:**  Slow to heal after cuts  Anemia  Enlarged glands

*To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.*

\_\_\_\_\_  
(Signature of Patient or Authorized Representative)

\_\_\_\_\_  
(Date)



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## ACKNOWLEDGEMENT OF RECEIPT OR PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OR HEALTH INFORMATION

**Notice of Private Practices:** You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available **upon request**. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosure we make of your protected health information.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosures of your protected health information to carry out treatment, payment activities, and healthcare operations.

I have been shown a copy of this office's Notice of Private Practices and have full opportunity to read and consider its contents. I understand that signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

\_\_\_\_\_  
(Print Patient Name or Authorized Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Patient or Authorized Representative)

***If this content is signed by a personal representative on behalf of the patient, complete the following:***

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

Representative/Parent/Legal Guardian name: \_\_\_\_\_

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

Relationship to client: \_\_\_\_\_

### ***For Office Use Only***

We attempted to obtain written acknowledgement or receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- \_\_\_\_\_ Individual refused to sign
- \_\_\_\_\_ Communication barriers prohibited obtaining the acknowledgement
- \_\_\_\_\_ other (please specify): \_\_\_\_\_



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## CONSENT TO RELEASE MEDICAL INFORMATION

(This form is used to retrieve records)

**Please disclose the following:**

- Medical Records
- Treatment Records
- Lab/Diagnostic Records
- Other: \_\_\_\_\_

**To be used for the following purpose(s):**

- Per Patient Request
- Continuing Health
- Weight Management Program
- Other: \_\_\_\_\_

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during my care. These may or may not include treatment of substance abuse, other abuse, HIV, psychiatric disorders, sexually transmitted diseases, etc. unless herein excepted.

**Doctor, Facility or Person (s):** \_\_\_\_\_

**Horizon Internal Medicine Asheboro - High Point & Horizon Med-Spa and Vein Center**

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(336) 660-6338 (P) (336) 307-3226 (F)

\_\_\_\_\_  
(Print Patient Name or Authorized Representative)

\_\_\_\_\_  
(Date of Birth)

\_\_\_\_\_  
(Signature of Patient or Authorized Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Disclosures Expiration Date)