Domenic Palagruto, DO ● Karen Wood, MD ● Amanda Carey, PA

3599 George II Highway, Southport, NC 28461
Phone: 910-845-3244 ● Fax: 910-845-3276
www.bslfamilymedicine.com

NEW PATIENT PACKET

Boiling Spring Lakes Family Medicine

Domenic Palagruto, DO ● Karen Wood, MD ● Amanda Carey, PA

Patient information

Patient name:

_____

(Suffix) First Middle/ Maiden Last

If the patient is a child: Mother's name: _____ Father's Name: _____

Marital Status: ❑ Single ❑ Married ❑ Seperated ❑ Divorced ❑ Widowed

Address: _____

City State Zip

Home Phone: _____ Cell: _____ Work: _____

Circle Prefered Number Above

Place of employment: _____ Job title: _____

Who is responsible for charges: _____ Date of birth: _____

This would be the person listed on the insurance card

Address of responsible party: _____

Name of spouse: _____ Date of birth: _____

Emergency contact/Relationship to patient: _____ Phone:_____

Please do NOT use a number listed above as an emergency contact number

INSURANCE INFORMATION

Please provide a copy of all insurance cards so that this office can submit claims

Do you have insurance? ❑ Yes ❑ No Which plan do you have?_____

Do you have Medicaid? ❑ Yes ❑ No You must have your (your child's) medicaid card up to date at each visit or you WILL be expected to PAY ON THE DAY of the visit.

Do you have Medicare? ❑ Yes ❑ No Which parts? _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize Boiling Spring Lakes Family Medicine (Dr. Domenic Palagruto, Dr. Karen Wood, Amanda Carey, PA, Dr. Donald Binz) of the surgical and/or medical benefit, if any, otherwise payable to me for services rendered.

Signature of insured or Parent/ Guardian:_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Boiling Spring Lakes Family Medicine (Dr. Domenic Palagruto, Dr. Karen Wood, Amanda Carey, PA, Dr. Donald Binz) to release any information acquired in the course of my examinations and/or treatment to my insurance carriers, third party payers, or others involved in processing and collection of any claims submitted on my behalf.

Signature of Patient or Parent/ Guardian:_____

We invite you to frankly discuss any questions you have regarding services provided by this office at any time. Good medical care is based on a mutual understanding and open communication between physician and patient.

Boiling Spring Lakes Family Medicine

Domenic Palagruto, DO ● Karen Wood, MD ● Amanda Carey, PA

Boiling Spring Lakes Family Medicine

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name:_____

Date of Birth:_____ Phone: _____

Address: _____

City:_____ State:_____ Zip: _____

1.) *I authorize the use or disclosure of the above named individual's health information as described below.*

2.) *The following individual or organization is authorized to make the disclosure*

Practice Name:_____ Phone: _____

Address: _____

City: _____ State:_____ Zip: _____

3. The type and amount of information to be disclosed is as follows (include dates where appropriate)

_____ Complete Health Records

_____ Lab results/ X-ray reports

_____ Physical exam

_____ Consultation reports

_____ Immunization records

_____ Other (please specify) _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

Boiling Spring Lakes Family Medicine , Dr. Domenic Palagruto, Dr. Karen Wood, Amanda Carey, PA, Dr. Donald Binz.
3599 George II HWY, Southport, NC 28461
Phone: 910-845- 3244

For the purpose of continuity of care.

6. I understand I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

7. If I fail to specify an expiration date, event , or condition, this authorization will expire in sixty days. I understand that authorization for the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be sued or disclosed, as provided in CFRI64524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules.
If i have questions about disclosure of my health information I can contact: _____

Privacy officer for: _____

_____

Signature of patient or legal representative

Signature of witness

_____

Date

Date

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC-3701.243 and federal law 42 CFR, part II.)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Boiling Spring Lakes Family Medicine Notice of Practices has been provided to me for review.

I understand that the purpose of this notice is to inform me of my rights in regard to my Protected Health information and also in the ways in which the practice may use my protected health information.

Patient of Representative Date

Boiling Spring Lakes Family Medicine

Domenic Palagruto, DO ● Karen Wood, MD ● Amanda Carey, PA

I, _____ ( ) do, ( ) do not, authorize the doctors and staff of Boiling Spring Lakes Family medicine to leave messages and/ or test results on my answering machine.

_____ _____

Date Patient/ Guardian signature

Emergency contact only (name & number): _____

I, _____, authorize the doctors and staff of Boiling Spring Lakes Family Medicine as defined above to discuss all aspects of my medical records with the people listed below:

Name (print)	Relationship to patient/ **Phone number**	
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____

Date Patient/ Guardian Signature Witness Signature

Email address: _____

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Name:_____ Today's Date:_____

Mother's Maiden Name:_____ Date of Birth:_____

Pharmacy of Choice (please include address):_____

Other current physicians or specialists: (include name, specialty, address, phone number)

_____

_____

_____

_____

Drug Allergies:

Drug:_____ Reaction:_____

_____ _____

_____ _____

_____ _____

_____ _____

Current Medications: (including over the counter medications & supplements.)

Name:_____ Dosage:_____ Frequency:_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have the following tests been performed elsewhere? (please list date)

_____Mammogram _____Pap Smear _____Colonoscopy _____Bone Density

_____Tetanus Vaccine _____Shingles Vaccine _____Pneumonia Vaccine

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Family History:

	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother
Living										
Deceased (age)										
Asthma										
Breast Cancer										
CAD (Heart Disease)										
Colon Cancer										
Diabetes										
Heart Attack										
High Cholesterol										
High Blood Pressure										
Lung cancer										
Melanoma										
Ovarian Cancer										
Prostate Cancer										
Rheumatoid Arthritis										
Stroke										
Sudden Cardiac Death (under 50)										
Thyroid, High										
Thyroid, Low										
Uterine Cancer										
Other:										

Any other family medical history:

_____

_____

_____

_____

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Social History Questionnaire:

Substance Use:

1.) Do you or have you ever smoked tobacco?

Never _____

Former: How long ago did you quit? _____

How much did you smoke? _____

How many years did you smoke?_____

Current: How much?_____

How many years have you smoked? _____

2.) Do you or have you ever used any other forms of tobacco or nicotine? No____ Yes__

Please Specify:

_____

3.) Do you drink alcohol? No____ Yes____

How much? None Rarely Socially Daily, how many? _____

4.) Do you use any illicit or recreational drugs? No_____ Yes_____ What?_____

5.) What is your level of caffeine consumption?

None_____ Occasional_____ Daily, how many?_____ per day or _____ per week.

Home and Environment:

6.) Have there been any changes to your family or social situation? No____ Yes____

Please specify what changes: _____

_____

7.) Do you live alone or with others? _____

8.) General stress level?

Low_____ Medium_____ High_____

Education and Occupation:

9.) What is the highest grade or level of school you have completed or the highest degree you have received?

_____

10.) Are you currently employed? No____ Yes_____

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11.)

What is your occupation? _____

Are there any occupational health risks where you work? No____ Yes_____

What? _____

Marriage and Sexuality:

12.) What is your relationship status?

____Single ____Married ____Divorced ____Seperated ____Widowed ____Domestic Partner

13.) Are you sexually active? No____ Yes_____

14.) How many children do you have? _____

Activities of Daily Living:

15.) Are you able to care for yourself? No_____ Yes_____

16.) Are you blind or do you have difficulty seeing? No_____ Yes_____

17.) Are you deaf or do you have serious difficulty hearing? No_____ Yes_____

18.) Do you have difficulty concentrating, remembering, or making decisions? No_____ Yes_____

19.) Do you have difficulty walking or climbing stairs? No_____ Yes_____

20.) Do you have difficulty dressing or bathing? No_____ Yes_____

21.) Do you have difficulty doing errands alone? No_____ Yes_____

22.) Are you able to walk without restrictions? No_____ Yes_____

If not please elaborate:

_____

23.) Do you have transportation difficulties? No_____ Yes____

Diet and Exercise:

24.) What is your exercise level?

_____None _____Occasional _____Moderate _____Heavy

25.) What kind of exercise activities do you participate in?

_____

Advance Directive:

26.) Do you have an advanced directive? No_____ Yes_____

Social Functioning:

27.) Do you interact with people outside of your house daily? No_____ Yes_____

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Surgical History:

28.) Please list any previous surgeries:

Surgery: _____ Date: _____ Surgeon: _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Past Medical History:

Weight:

- ☐ Loss_____
- ☐ Gain_____
- ☐ How much?_____

Eyes:

- ☐ Vision Changes _____
- ☐ Cataracts _____
- ☐ Glaucoma _____
- ☐ Last eye exam _____

Ears, Nose, Throat:

- ☐ Hearing loss_____
- ☐ Frequent ear infections _____
- ☐ Frequent sinus infections _____
- ☐ Allergy symptoms_____

Dental:

- ☐ Last dental visit_____
  Name of doctor_____

Cancer:

Type, Treatment, year:

_____

_____

_____

Respiratory:

- ☐ Chronic cough_____
- ☐ Asthma_____
- ☐ Pneumonia _____
- ☐ Bronchitis _____
- ☐ Shortness of Breath_____
- ☐ Emphysema/COPD_____
- ☐ Sleep Apnea_____

Cardiac:

- ☐ Chest pains_____
- ☐ Palpitations_____
- ☐ Irregular pulse_____
- ☐ Heart Disease_____
- ☐ Heart Attack_____
  History:_____
- ☐ Heart Murmur_____
- ☐ Atrial Fibrillation_____
- ☐ Congestive heart failure_____
- ☐ High blood pressure_____
- ☐ High cholesterol_____
- ☐ Swollen ankles_____
- ☐ Leg pain when walking_____
- ☐ Varicose veins_____

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Gynecologic:

- ☐ Irregular periods _____
- ☐ Painful periods _____
- ☐ Very heavy periods _____
- ☐ Endometriosis _____
- ☐ Infertility _____
- ☐ Frequent vaginal infections _____
- ☐ Abnormal pap smear _____
- ☐ Abnormal vaginal bleeding _____
- ☐ First day of last period _____ (month, day, year)
- ☐ Birth control method

Pregnancies:

- ☐ Number _____
- ☐ Miscarriages _____
- ☐ Abortions _____
- ☐ Number of live births _____

Menopause:

- ☐ Hot flashes _____
- ☐ Night sweats _____
- ☐ Sleeplessness _____
- ☐ Moodiness _____

Breasts:

- ☐ Abnormal mammogram _____
- ☐ Breast mass _____
- ☐ Tenderness _____

Blood:

- ☐ Anemia _____
- ☐ Bleeding problem _____
- ☐ Blood clots _____
- ☐ Pulmonary embolism _____
- ☐ Blood transfusion _____

Gastrointestinal:

- ☐ Difficulty swallowing _____
- ☐ Persistent nausea & vomiting _____
- ☐ Persistent diarrhea _____
- ☐ Constipation _____
- ☐ Rectal bleeding _____
- ☐ Dark/tarry stools _____
- ☐ Change in bowel habits _____
- ☐ Heartburn _____
- ☐ Stomach ulcers _____
- ☐ Colon polyps _____
- ☐ Irritable bowel disease _____
- ☐ Ulcerative Colitis _____
- ☐ Crohn's disease _____
- ☐ Hepatitis _____
- ☐ Diverticulosis _____
- ☐ Chronic abdominal pain _____
- ☐ Hiatal hernia _____
- ☐ Hemorrhoids _____
- ☐ Food allergy/ intolerance _____

Genitourinary:

- ☐ Painful urination _____
- ☐ Urgency to urinate _____
- ☐ Waking up at night to urinate _____ (more than twice a night) _____
- ☐ Enlarged prostate _____
- ☐ Kidney stones _____
- ☐ Frequent urinary tract infections _____
- ☐ Urine leakage _____
- ☐ History of sexually transmitted disease _____
- ☐ Herpes _____
- ☐ Sexual problem _____
  Describe:
  _____

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Musculoskeletal:

- ☐ Arthritis _____
  Where _____
- ☐ Rheumatoid arthritis _____
- ☐ Painful swollen joints _____
- ☐ Osteoporosis _____
- ☐ Osteopenia _____
- ☐ Spinal stenosis _____
- ☐ Broken bones _____
  Where _____
- ☐ Gout _____
- ☐ Recurrent back pain _____
- ☐ Foot pain _____
- ☐ Carpal tunnel syndrome _____

Endocrine:

- ☐ Diabetes
- ☐ Pre-diabetes
- ☐ High thyroid
- ☐ Low thyroid
- ☐ Thyroid nodule

Nervous System:

- ☐ Epilepsy/ Seizure disorder _____
- ☐ Numbness/ tingling sensation _____
- ☐ Migraines _____
- ☐ Frequent headaches _____
- ☐ Concussion _____
- ☐ History of stroke or TIA _____
- ☐ Tremors _____
- ☐ Lack of balance _____
- ☐ Meniere's disease _____
- ☐ Vertigo _____

Psychiatric:

- ☐ Autism Spectrum Disease (ASD) ____
- ☐ ADD/ ADHD _____
- ☐ Developmental/behavioral issues __
- ☐ Anxiety _____
- ☐ Depression _____
- ☐ Suicidal thoughts _____
- ☐ Difficulty sleeping _____
- ☐ Eating disorder _____
- ☐ Other mental disorder/illness _____
- ☐ Alcoholism _____
- ☐ Drug abuse _____

Skin:

- ☐ Eczema _____
- ☐ Rashes _____
- ☐ Hair loss _____
- ☐ Hives _____
- ☐ Shingles _____
- ☐ Chicken pox _____
- ☐ Mole changes _____
- ☐ History of skin cancer _____
  Where: _____