ID CARE®
INFECTIOUS DISEASES SPECIALTY PRACTICE
1319 AVON STREET
FAYETTEVILLE NC 28304
P 910.729.6552
F 910.500.1002

Patient Registration

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check Primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

Gender ☐ M ☐ F	SSN	E-mail Address	Driver's License

Marital Status	Preferred Contact	Ethnicity	Race
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	☐ Mail ☐ Home Phone ☐ Day Phone ☐ Cell Phone ☐ Patient Portal	☐ Cambodian ☐ Filipino ☐ Hispanic/Latino ☐ Non-Hispanic	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Primary Care Provider	Referring Provider

Responsible Party (Guarantor) ☐ Same as patient

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

SSN	Relationship to Patient	Preferred Language	Driver's License

Emergency Contact (for minor child, this section may be used for other parent)

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

I/We do hereby consent to and authorize the performance of all treatments, procedures and medical services deemed advisable by the physicians and staff of the ID Care® to me or to the above-named minor or person of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize my ID Care® to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing. I certify that I have received the Notice of Privacy Practices.

Signature of Patient/Responsible Party _____ Date _____

Name of Patient/Responsible Party (Please Print) _____ Relationship to Patient _____

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Insurance Information

Primary Insurance Plan		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		

For Medicare Patients Only		
Health Insurance Claim #	Part A Effective Date	Part B Effective Date

Secondary Insurance Coverage for Patient		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		

☐ I hereby authorize and request that payment of authorized Medicare/other insurance company benefits be made on my behalf, be paid directly to ID Care® for any medical services rendered to me or my family member. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. I will pay the portion of these bills that insurance payer determines as my responsibility. If services provided by ID Care® is not cover by my insurance payer, I will take full responsibility of the payment upon receipt of services.

_____ _____
Signature of Patient /Responsible Party Date

_____ _____
Name of Patient/Responsible Party (please print) Relationship to Patient

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Patient History Form

Pharmacy Information

Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

Medication Name	Dosage

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ No Known Allergies

Medical History

Please List Chronic Medical Conditions	Year	Please List Previous Surgeries	Year
☐ None		☐ None	
☐		☐	
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Patient History Form

Family History – Please List Medical Condition of Family Member

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
	☐	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐	☐	☐

Social History for Adult Patient

Occupation		Employer	
Do you have children? ☐ Yes ☐ No	How many?	Female(s)	Male(s)
Tobacco Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Smokeless Brand:	
Alcohol Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Beer ☐ Wine ☐ Liquor ☐ Other:	
Exercise Activity	☐ Moderate ☐ Vigorous ☐ Sedentary Days/Week:	Sleep Pattern: ☐ Changes ☐ No Changes	
Caffeine Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chocolate ☐ Coffee ☐ Soda ☐ Tea ☐ Tablets ☐ Other:	

For Pediatric Patient

Patient Reside with:	Primary	☐ Mother	☐ Father	☐ Both Parents	☐ Other:
	Secondary	☐ Mother	☐ Father	☐ Other:	

Mother's Occupation	Father's Occupation
Parents Relationship ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	Childcare ☐ Mother ☐ Grandparent ☐ Father ☐ Nanny ☐ Sibling ☐ Daycare
Tobacco Exposure: ☐ Yes ☐ No Smokers at home: ☐ Yes ☐ No	Patient is current smoker? ☐ Yes ☐ No

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone(H):_____ **Phone(W):** _____

Address:_____ **City/State/Zip:** _____

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____ **Facility Fax:** _____

Facility Address: _____ **City/State/Zip:** _____

Dates and Type of information to disclose:

☐ Medical Record (Past & Present)
☐ Dates Other: _____
☐ Specific Information Requested:
_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care
☐ Referral
☐ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand 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.

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

Release To: ID CARE - Infectious Diseases Specialty Practice

Address: 1319 Avon Street

City, State, Zip: Fayetteville NC 28304

Phone: 910.729.6552 **Fax: 910.500.1002**

☐ **Please mail records.**
☒ **Please fax records.**

I understand I may 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 information that has already been released in response to this authorization. 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: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing 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 obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative