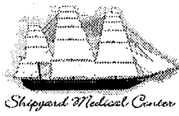
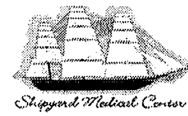


Shipyard Medical Center



Patient Name ______________________________________ Date of Birth ____/____/______
(First) (Middle) (Last)

Address ______________________________ ________ City ______________ State____ Zip________

Home Ph: ______-______-________ Cell Ph: ______-______-________ Work Ph: ______-______-________

Social Security ______-______-________ Sex: M F Email address______________________________

Place of Employment ____

Emergency Contact ____________________ ____________________________Ph: _____-______-_______

Preferred Pharmacy/Location and Phone Number____

Policy Holder's Name______________________________DOB___________SSN_____-______-_________

HIPAA Privacy Practices Acknowledgment

I have received a copy of Shipyard Medical Center's HIPAA privacy notice that explains how my Protected Health Information (PHI) may be used. Additional copies of the Notice of Privacy Practices are available at the front desk. Questions about our Notice of Privacy Practices may be directed to: Attn: Privacy Officer Shipyard Medical Center, 2632-3 Carolina Beach Road, Wilmington, NC 28412.

I acknowledge receipt of Shipyard Medical Center's privacy practices. In addition, my medical information **may be** shared with the individuals listed **below**. (Please exclude any doctors)

1) ________________/____________ ________________
Name / Relationship Phone

3) ________________/____________ ____________
Name / Relationship Phone

2) ________________/____________ ________________
Name / Relationship Phone

4) ________________/____________ ____________
Name / Relationship Phone

- ○ **Please check this box if it is OK to leave a message on your answering machine that contains Private Heath Info**
- ○ **Please check this box if you *do not* want us to disclose your Private Health Information to anyone**
- ○ **See Section C1 for Explanation: If you pay cash you reserve the right to withhold records release for this visit.**

X____ ____________________
Guarantor or Patient Signature Date

Consent for Treatment: I hereby authorize the performance of medical treatment that may be advised or recommended by S M C, including necessary and/or beneficial services and use of equipment in the performance of the treatment.
Financial Agreement: I understand that Shipyard Medical Center files insurance as a courtesy and that I am ultimately responsible for payment for the services provided. I authorize Shipyard Medical Center to furnish any necessary information to insurance carriers concerning my illness/treatment and request payment be made directly to Shipyard Medical Center.

X____ ____________________
Guarantor or Patient Signature Date

2632-3 Carolina Beach Road Wilmington, NC 28412-1806
Phone 910-794-3939 Fax 910-794-3938

Shipyard Medical Center and Urgent Care

2632-3 Carolina Beach, Wilmington, NC 28412
Phone: 910-794-3939 Fax 910-794-3938

CONFIDENTIAL

NEW PATIENT HISTORY

Patient Name ____________________ Today's Date ____________

Age __________ DOB __________ Your Primary Care MD ____________

What is your reason for this visit? ____________________

Is it the result of an accident? ______ If yes, explain ____________________

❑ Male ❑ Female If female, date of last menstrual period ____________

SYMPTOMS (Check conditions you are currently having) (Check here if no symptoms) ☐

General
- ❑ Fever
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Weakness

Eyes
- ❑ Redness
- ❑ Pain
- ❑ Discharge
- ❑ Decreased Vision

Ears, Nose, Mouth & Throat
- ❑ Ear Ache
- ❑ Sneezing
- ❑ Running Nose
- ❑ Toothache
- ❑ Sore Throat
- ❑ Facial Pain

Respiratory
- ❑ Cough
- ❑ Shortness of Breath
- ❑ Wheezing

Cardiovascular
- ❑ Chest Pain
- ❑ Rapid Heart Beat
- ❑ Swelling of Both Ankles

Skin and/or Breast
- ❑ Breast Lump
- ❑ Tenderness of Breast
- ❑ Rash
- ❑ Itching
- ❑ Sunburn

Muscleoskeletal
- ❑ Back Pain
- ❑ Pain, Injury or Swelling
- ❑ Joints, Muscles or Bones

Gastrointestinal
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Nausea
- ❑ Abdominal Pain

Genitourinary
- ❑ Urinary Frequency
- ❑ Discomfort when Urinating
- ❑ Pain in Testicle
- ❑ Vaginal Discharge
- ❑ Abnormal Vaginal Bleeding

Neurological
- ❑ Seizure
- ❑ Numbness
- ❑ Headache

Endocrine
- ❑ Extreme Thirst
- ❑ Extreme Urinary Frequency
- ❑ Unexpected Weight Loss

Hemstalogic & Lymphatic
- ❑ Bruise Easily
- ❑ Sickle Cell Pain Crisis
- ❑ Swollen Glands

Allergic/Immunologic
- ❑ Reaction to Insects
- ❑ Reation to Food
- ❑ Hives

Other

____

CONDITIONS (Check conditions you have ever had) (Check here if no conditions) ☐ (Check here if no surgeries) ☐

- ❑ Attention Deficit Disorder
- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anxiety Disorder
- ❑ Appendicitis
- ❑ Arthritis

Problems
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump, Benign
- ❑ Blood Transfusions
- ❑ Cancer, Type __________
- ❑ Cataracts
- ❑ Congestive Heart Failure
- ❑ Depression
- ❑ Diabetes
- ❑ Drug Abuse
- ❑ Emphysema, COPD
- ❑ Gallstone, Surgery
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart Disease
- ❑ Heart Surgery
- ❑ Hepatitis, Type ______
- ❑ Hernia Surgery
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Stones
- ❑ Liver Disease
- ❑ Migraine Headaches
- ❑ Myocardial Infraction (Heart Attack)
- ❑ Prostrate Problem
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid
- ❑ Ulcers
- ❑ Others, including surgeries or pregnancies ____________________

MEDICATIONS (List medications you are currently taking) (Check here if no conditions) ☐

____

DRUG OR FOOD ALLERGIES (Check if none) ☐

____

PHARMACY

____

FAMILY HISTORY (Fill in information about immediate family – father, mother, brothers, sisters, children) (Check here if no family history) ☐

Medical Condition	Relative with condition, and some details	Medical Condition	Relative with condition, and some details
Asthma		Heart Attack, Angina	
Cancer		High Blood Pressure	
Depression		Migraine Headache	
Diabetes		Strokes	
Other			

HEALTH HABITS

Alcohol	
Tobacco	
Illegal Drugs	
Caffeine	

HOSPITALIZATIONS

____

OCCUPATION

____

PREVENTIVE HEALTH (Indicate if you have had any of the following, and if so probide the approximate date last done) (Check here if none) ☐

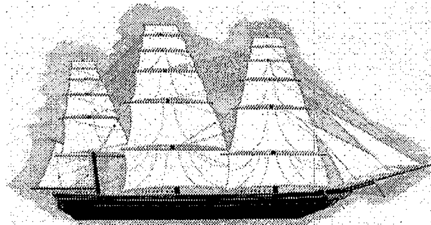
Cholesterol test	❑ no	❑ yes ______	Osteoporosis test	❑ no	❑ yes ______	Tetanus shot	❑ no	❑ yes ______
Complete physical	❑ no	❑ yes ______	Colonoscopy	❑ no	❑ yes ______	Pneumonia shot	❑ no	❑ yes ______
Pap smear	❑ no	❑ yes ______	Mammography	❑ no	❑ yes ______	Spirometry	❑ no	❑ yes ______
Flu shot	❑ no	❑ yes ______						

ACTIVITIES (List what you do for fun)

____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Print Name ____________________ Signature ____________________ Date ____________



2632-3 Carolina Beach Road
Wilmington, NC 28412

910-794-3939 Phone 910-794-3938 Fax

Patient name: ______________________________________

We need the most accurate month/day/year of your last screening for:

Mammogram (females) when: ______________________________

Colorectal Cancer Screening
- colonoscopy when: ______________________________

Glaucoma Screening - eye exam when: ______________________________

Bone Density Test when: ______________________________

Spirometry – tests how much air you inhale when: ______________________

Flu shot when: ______________________________

Pap Smear (females) when: ______________________________

Dentist Visit when: ______________________________

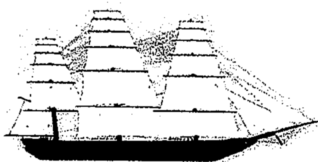
Herpes Zoster Vaccine when: ______________________________

Pneumonia shot when: ______________________________

Do you smoke: _________ yes _____ packs per day

__________ no _______ former smoker

____
Patient Signature



Shipyard Medical Center
2632-3 Carolina Beach Road
Wilmington, NC 28412
910-794-3939 Phone 910-794-3938 Fax

Authorization for Use or Disclosure of Protected Health Information

Name of Patient ____________________
Date of Birth ____________________ Medical Record# ____________
Daytime Phone# ____________________ Evening Phone# ____________
Address ____________________
City ____________________ State ____________ Zip Code ____________

I hereby authorize Shipyard Medical Center to use or disclose my protected health information as indicated below ~~to~~ from:

Name ____________________
Daytime Phone# ____________________ Fax# ____________
Address ____________________
City ____________________ State ____________ Zip Code ____________

Information to be released:
From & To Dates ____________
- ☐ History and physical exam ____________
- ☐ Lab report ____________
- ☐ X-ray report ____________
- ☐ Consultation report ____________
- ☐ Other ____________

Purpose of Disclosure:
- ☐ Changing Physicians
- ☐ Second Opinion
- ☐ Continuing Care
- ☐ Legal
- ☐ At my (patients) request
- ☐ Insurance
- ☐ Workers' Compensation
- ☐ School
- ☐ Other ____________

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

- ☐ Substance Abuse (including alcohol/drug abuse
- ☐ Mental Health
- ☐ Psychotherapy Notes
- ☐ HIV related information (including AIDS related testing.

The confidentiality of this record is required under Chapter 899 of the North Carolina General Statutes, as well as, Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

X____________________ ____________
Signature of Patient or Legal Guardian Date

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying SMC Privacy Officer at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, Federal law prohibits the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information. FCR 42CFR Part 2.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

____________________ ____________ OR ____________________ ____________
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

____
Relationship to Patient

____________________ ____________
Records Received By Date

For Office Use Only

Date Request Filled ____________ By ____________
Identification Presented ____________ Account # ____________