NORTH CAROLINA SURGERY

PATIENT IDENTIFICATION

Patient's Legal Name _____
(LAST) (FIRST) (MIDDLE)

Rex Healthcare will compare your Legal Name to your name as it appears on your insurance card.

Gender ____ Last 4 numbers Social Security# (some insurances require full SS) _____

Birth Date _____

PATIENT INFORMATION: Race_____Hispanic_____Non-Hispanic_____Language_____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

Home Phone # _____Mobile Phone #_____Email Address_____

Referring Physician _____

Primary Care Physician_____

Other Physicians to Whom You Want Communication Sent _____ _____

PATIENT EMPLOYMENT INFORMATION

Status: Full-time ___ Part-time ____ Retired ____ Retirement Date _____ Full Time Student? Y/N Other_____

Employer's Name _____ Phone # _____

GUARANTOR INFORMATION (Person Financially Responsible if different than patient)

Name of Guarantor _____ Relationship to Patient _____

Last 4 Digits of Social Security # _____ Gender _____ Birth Date _____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

Home Phone # _____ Employer's Name _____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact _____ Relation to Patient _____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

Home Phone # _____Work Phone # _____Cell Phone # _____

PRIMARY INSURANCE

Name of Insurance Company _____

Policyholder's Name **(if other than patient)**_____ Relationship_____

Birth Date _____ Gender _____

SECONDARY INSURANCE

Name of Insurance Company _____

Policyholder's Name **(if other than patient)**_____ Relationship_____

Birth Date _____ Gender _____

ACCIDENT INFORMATION (Complete this section ONLY if your condition is accident related)

Type of Accident (Auto, Work, Other) _____ Description_____

Accident Date and Time _____Place of Accident (City,County,State)_____

Patient/Authorized Representative Signature _____Date_____

NORTH CAROLINA SURGERY

NAME _____ **DOB** _____

Decision Maker in the Event of Emergency_____Phone#_____

ALLERGIES:

_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS: Please list all prescriptions and over the counter medications, herbs and vitamins

Name_____Dose_____ Name_____Dose_____

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PHARMACY:

Name: _____ Address: _____

MEDICAL HISTORY:

Breast Cancer---------	☐	Colon polyps--------	☐	Pancreatitis----------	☐
Gallstones----------	☐	Diverticulitis---------	☐	Rectal bleeding---------	☐
Colon cancer----------	☐	Fibrocystic breast---	☐	Thyroid nodule---------	☐

Abnormal EKG-------	☐	Heart disease-------	☐	Heart attack----------	☐
Alcoholism----------	☐	Diabetes----------	☐	Seizures ----------	☐
Anemia----------	☐	Hepatitis----------	☐	Stroke----------	☐
Asthma----------	☐	HIV/AIDS----------	☐		
CHF----------	☐	High blood pressure	☐		
Cirrhosis----------	☐	Kidney disease-----	☐		
Clotting disorder------	☐				
COPD----------	☐				

Name: _____ DOB: _____

SURGICAL HISTORY: *Please list procedure and approximate date*

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

FAMILY HISTORY:

Relation	Cancer (Y/N, site)	Clotting Disorder	Heart Disease	Other
Mother				
Father				
Sister				
Brother				
Grandmother				
Aunt				
Other (specify)				

SOCIAL HISTORY

Tobacco Use No ___ Yes ___ Former ____
Alcohol Use No ___ Yes ___ Former ____
Drug Use No ___ Yes ___ Former ____

DOMESTIC ABUSE

Is abuse, violence, or sexual assault a problem for you in any way? No ____ Yes ____
Does your partner/caregiver threaten you in anyway? No ____ Yes ___

Please indicate if you have had the following symptoms *recently*:

Y	N	Rash
Y	N	Visual disturbance
Y	N	Shortness of breath
Y	N	Wheezing
Y	N	Palpitations
Y	N	Joint aches
Y	N	Seizures
Y	N	Abdominal pain
Y	N	Other (Please list below)

Y	N	Sinus Pressure
Y	N	Unexpected weight change
Y	N	Easy bruising/bleeding
Y	N	Sleep apnea
Y	N	Chest pain
Y	N	Vaginal bleeding
Y	N	Headaches
Y	N	Nervous/anxious

REX BREAST CARE SPECIALISTS

THE FOLLOWING INFORMATION IS IMPORTANT TO YOUR BREAST EXAM

PLEASE ANSWER ALL QUESTIONS

YES **NO**

___ ___ Do you have a breast lump?
Which breast?_____
Who discovered the lump? Doctor Myself Spouse

___ ___ Do you have nipple discharge?
If yes, circle one: Bloody Clear Milky Other_____

___ ___ Do you have skin dimpling (puckering)?

___ ___ Have you ever had a mammogram or breast ultrasound?
If yes, where? _____
Date of most recent:_____

___ ___ Do you have an abnormal mammogram?

___ ___ Have you been pregnant?
How many times have you been pregnant? _____
How many live births have you had? _____
How old were you when your first child was born? _____
Did you breast feed your children? _____

___ ___ Have you had any previous breast surgery?
If yes, which breast? _____
What kind of surgery was performed? _____
When was the surgery? _____
Circle the reason for the breast surgery:
Cancer Cysts Fibrocystic Solid tumor (not cancer) Other_____

___ ___ Have you had a hysterectomy?
If yes, when?_____
Circle the reason for hysterectomy: Bleeding Tumors Cancer Other_____

___ ___ Have your ovaries been removed?

___ ___ Have you ever taken hormone replacement therapy?
If yes, please list: _____
When and for how long? _____

___ ___ Have you ever taken birth control pills?
If yes, please list:_____
When and for how long?_____

___ ___ Has any female in your family had breast or ovarian cancer?
If yes, who?_____
Is the person above from your mother's or father's family? _____

___ ___ Has any male in your family had prostate cancer?
If yes, who?_____

How old were you when you started having your period?_____

When was your last period?_____

UNC HEALTH CARE

Patient Name_____
Date of Birth_____

Limited Release of Information to Family/Friends for Physician Clinics
HIM# 1315s

I give my permission to my physician practice that is part of the UNC Health Care System to share certain personal health information about me with the individuals listed below. These individuals will only be given information about me that is related to their involvement in my care or payment for my care.[1] I understand that I am not required to complete this form in order to obtain health care.

Name: _____ Phone Number: _____
Relationship: _____ Talk to this person about (*check each box that applies*):

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

Name: _____ Phone Number: _____
Relationship: _____ Talk to this person about (*check each box that applies*):

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes.

_____DATE: _____ TIME:_____
PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME & RELATIONSHIP (if not patient): _____

[1] This form is not a substitute for a health care power of attorney or other formal designation of an individual authorized to make health care decisions for you if you are not able. If an individual listed above is your guardian or agent (under a power of attorney), or is otherwise authorized by law to act on your behalf, your health care provider may share as much of your personal health information with that person as the law permits.

This form is not a substitute for a valid HIPAA compliant written authorization when it is required to release copies of medical and billing records or information.

[2] Non-sensitive information excludes mental health, alcohol and substance abuse, HIV and other communicable diseases, and genetic testing. **This form is not considered sufficient authorization to release sensitive information.**

Chart Location: Consents

UNC HEALTH®

Patient Label Here

GENERAL CONSENT FOR TREATMENT (PAGE 1 of 2)
HIM #129s

I understand that the University of North Carolina Health Care System (UNC Health) is an integrated health system made up of various entities as reflected at www.unchealthcare.org/documentapplicability (each referred to in this form as a "UNC Health affiliate" or collectively as "UNC Health affiliates"). **This consent will be effective for 1 year after the date I sign it at any UNC Health affiliate of which I am a patient; however, this consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect.**

Consent for Treatment/Care

I consent to treatment and care by UNC Health affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through electronic communications/telemedicine. I also consent to treatment and care by physicians and health care providers who are not employees or agents of UNC Health affiliates (including but not limited to physicians and providers in the specialties of emergency medicine, anesthesia, surgery, pathology, psychiatry, obstetrics and gynecology, radiology, oncology, cardiology, neurology, pediatrics and internal medicine) but are authorized by UNC Health affiliates to provide treatment and care to me as a patient of the UNC Health affiliate. and who provide services to the UNC Health affiliates' patients in accordance with their professional judgment. I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care that I have received from UNC Health affiliates. I understand that my care team at UNC Health affiliates may include resident physicians and students or other trainees. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

Consent for Use and Release of Information

I give permission to UNC Health affiliates – including their treating and referring providers and other staff members – to release any information about me, my health, the health services provided to me, or payment for my health services as permitted by law. For more detailed information about the way my information may be used or released, I can read UNC Health's *Notice of Privacy Practices*.

I give permission to UNC Health affiliates and their employees, agents, and contractors to take photographs or make videos of me for permissible treatment, payment, health care operations, education and for research purposes where either I have given consent or an Institutional Review Board has approved as long as such recordings are consistent with policies and laws that protect my rights.

Consent for Use Within UNC Health

I further give permission to UNC Health affiliates and their treating providers and other staff members to disclose to each other any of my sensitive information necessary for my treatment, including information related to behavioral and/or mental health (including records of my treatment by a facility whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, developmentally disabled, or substance abusers, as defined by N.C.G.S. Chapter 122C, Articles 1 and 3), drugs and alcohol (including records of a provider that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

Financial Responsibility

I understand and agree that physician charges for medical and related professional services performed or supervised by a physician will be billed separately from hospital charges. I understand that my actual charges may be different from charge estimates given to me. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, guardian, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges. If I have overpaid any of my accounts with a particular UNC Health affiliate, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with other UNC Health affiliates. I designate UNC Health as my authorized representative with respect to any health or liability insurance policy or any group health plan, fund or program applicable to me, and I authorize UNC Health to exercise on my behalf any grievance, claim or appeal rights, including external review rights, I may have under any such health or liability insurance policy or group health plan, fund or program.

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for

payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to the appropriate UNC Health affiliate on my behalf. I authorize UNC Health affiliates to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the appropriate UNC Health affiliate.

Social Security Number

I have given my social security number voluntarily. UNC Health affiliates may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

Wireless Telephone Number and Electronic Mail

UNC Health affiliates, or their agents or representatives, may contact me by electronic mail or telephone (including phone calls or text messages) at any electronic mail address or number contained in my UNC Health affiliate's records, including wireless telephone numbers, for the purposes of communicating with me about my health care, servicing my account and collecting amounts due. I also understand that UNC physician researchers or members of their research team may also contact me via phone, or electronic mail to determine my interest in participating in human subject research. Methods of contact may include pre-recorded or artificial voice messages and text messages, and the use of automatic dialing services. I understand that I may revoke consent to receive communications via phone calls, text messages or electronic mail at any time by following the instructions in the communication or calling UNC Health Customer Service at (888) 996-2767.

Personal Property

Unless I am a resident of a skilled nursing facility, I understand that UNC Health affiliates do not assume responsibility for my personal belongings that I keep in my possession, and I release UNC Health affiliates from all liability for the loss or theft of, or damage to, such belongings.

I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY ANY UNC HEALTH CARE AFFILIATE, OR IN PROGRESS.

I AUTHORIZE UNC HEALTH CARE AFFILIATES TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I HAVE READ AND UNDERSTAND THIS FORM, BEEN OFFERED A COPY, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.

_____ DATE: _____ TIME: _____

PATIENT SIGNATURE (or Authorized Representative)

_____

PRINTED NAME

RELATIONSHIP, if not patient: _____

GUARANTOR OF PAYMENT: This line may be signed by someone who wishes to agree to be responsible for payment *other than*: 1) the patient, 2) the patient's spouse, or 3) a minor patient's parent.

By signing as guarantor below, I agree to pay all charges of any UNC Health Care affiliate not paid, **even if I am otherwise not legally obligated to pay**.

_____ DATE: _____ TIME: _____

GUARANTOR OF PAYMENT SIGNATURE

_____

PRINTED NAME