SOUND MEDICAL FAMILY PRACTICE
Patient Information

Patient's Last Name: _____ **First:** _____ **Middle I:** _____

Social Security # _____-_____-_____

Marital Status S / M / D / W

Mailing Address: _____ **City** _____ **State** _____ **Zip** _____

Sex: ❑ M ❑ F **Age** _____ **Birth Date:** ___-___-___

May we leave a medical message about your healthcare on Your voice mail? ❑ Yes ❑ No

❑ **Home Phone** ( ) _____-_____

❑ **Cell Phone** ( ) _____-_____

Employment Information: ❑ Retired

Employer: _____

Occupation: _____

Work Phone: _____ **EXT** _____

Emergency Contact Information:

Name _____

Relationship _____

Phone # ( ) _____

Phone # ( ) _____

May this emergency contact have Access to your medical records?

❑ Yes ❑ No Initial_____

What is your preferred pharmacy?

_____

Email Address: (used for office communication)

_____

Would you like to have access to our patient portal? ❑ Yes ❑ No

Race:
- ❑ White/Caucasian
- ❑ Black
- ❑ African American
- ❑ Asian
- ❑ Native Hawaiian
- ❑ Other Pacific Islander
- ❑ American Indian
- ❑ Alaska Native
- ❑ Other Race
- ❑ Decline

Ethnicity:
- ❑ Not Hispanic or Latino
- ❑ Hispanic or Latino
- ❑ Decline

HIPAA Acknowledgements:

Please initial each line:

____ **I hereby acknowledge that I have been provided with a copy of the privacy policy**

____ **I elect the following people below to have access to my medical records:**

Name_____**Relationship**_____

Name_____**Relationship**_____

Name_____**Relationship**_____

Deemed Consent-Consent for treatment-Release of Medical Information-No Guarantee-Electronic Communications

I hereby authorize medical treatment by any Sound Medical Family Practice Physician, Physician Assistant, and or affiliated medical staff member. I further authorize release of any and all medical and/or billing information as is necessary for reimbursement from any insurance carrier. I accept responsibility for payment of all treatment that the insurance carrier determines does not constitute as covered services. I understand that no guarantee or assurance has been made as to the results which may be obtained from any exam, testing or treatment. I agree that Sound Medical may request and use my prescription
medication history from other healthcare providers or third-party pharmacy benefit organizations for treatment purposes. We will send you appointment reminders and other important electronic messages by text and email.

By providing your email address and cell phone number, you consent to receive electronic messages by such means. We will not share your information. You may opt out of electronic communication at any time.

If the patient is a minor or has a power of attorney, who is the responsible party for this patient:

Name: _____**Relationship to patient**_____**Birth Date**_____-_____-_____

Signature of Patient or Responsible Party X **Date**____-____-____

Financial Policy

Sound Medical

Family Practice

Thank you for choosing Sound Medical Family Practice as your medical home. Please read this policy carefully, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in many insurance plans, including Medicare and Medicaid. We are happy to file your insurance for your claims. If you are not insured by a plan we participate with, payment in full is required at each visit. Knowing your insurance plan is your responsibility, please contact your insurance company if you have questions about coverage and participation.

2. **Co-payments and deductibles.** All co-payments and deductibles will be collected at the time of service. This is a contractual agreement that you have with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

3. **Non-covered services.** Please be aware that some services you receive may not be covered or may not be considered reasonable or necessary by Medicare or other insurance companies. We will only perform or request services that we feel are medically necessary and appropriate in order to provide you with the best medical care we can. You will be asked to sign an Advanced Beneficiary Notice (ABN) if there is a likelihood that your insurance will not pay for services that your provider feels are medically necessary and appropriate. If your insurance does not pay for these services, you will be responsible for the payment.

4. **Proof of insurance.** We must obtain a copy of a valid insurance card as well as a valid photo ID. Failure to provide us with this information, you may be personally responsible for payment in full for your visit. If your insurance coverage changes, please notify us before your next appointment so we can make the appropriate changes to your account.

5. **Claims submission.** We will submit your claims to your insurance company and assist you in any way we reasonably can to help get your claim paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

Financial Policy

6. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. We encourage you to keep your regularly scheduled appointment.

7. **Special circumstances.** In the vent that you have a financial hardship situation and need to make special arrangements for payment of your bill, please speak to one of our billing specialist as soon as possible.

8. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments cannot be accepted unless specifically negotiated with Sound Medical's financial manager. Please be aware that if a balance remains unpaid we may refer your account to a collection agency and you and your immediate family members may be discharged from our practice. If a discharge occurs, you will be notified via certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

Thank you for taking the time to read and understand our financial policy. Please let us know if you have any questions or concerns.

PATIENT INSURANCE INFORMATION

Name of Primary Insurance______

Name of Secondary Insurance_____

I have read and understand the financial policy and agree to abide by its guidelines.

I agree to provide Sound Medical with a current copy of my insurance card (s) for scanning and claims submission at every office visit.

X_____Date_____-_____-_____

Sound Medical Family Practice

MEDICAL HISTORY

Date: _____-_____-_____

Patient Name:_____DOB:_____-____-_____

Sex: o Male oFemale

Prior Family Physician/Provider

Physician/Provider Name:_____ _____Phone ( ) _____-____

Address _____City_____ Zip_____ Fax ( )_____-_____

(Please obtain medical records from this provider. Please bring records on your first appointment)

Medication allergies and type of reaction:

Name of medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Medications and doses you are currently taking:

Please list over the counter meds/supplements also

Name of Medication	MG	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Pharmacy: _____City_____Phone ( )_____-_____

Past Medical History Please check all that apply to you

Cardiovascular ___High blood pressure ___Heart Arrhythmia what kind_____
___Congestive Heart Failure
___ High cholesterol Heart attack when?_____
____Peripheral vascular disease

Pulmonary ___Asthma ____Bronchitis ___COPD ___ Pneumonia
___Pulmonary embolism what year? _____age_____

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___Tuberculosis what year? _____ age_____

Gastrointestinal __GERD what year? ____ age___
__Crohn's Disease what year?____age___
__diverticulosis __Hepatitis (circle) A B C what year?_____age___
__Stomach ulcers __Heartburn

Renal ___Acute renal failure what year? ____age___ ___Kidney disease –Stage_____what year?___
___Kidney stone what year? _____age____ Current Creatinine level? _____

Musculosketal __Rheumatoid arthritis __Gout __Osteoporosis __Osteoarthritis

Endocrine __Prediabetes __Diabetes **I or II** what year?___ age___
__Thyroid disease what year? ____ __Osteoporosis

Neurological __ADD what year? _____age____ __Alzheimer's/Dementia what year?____age__
__Cerebral Palsy __Stroke what year_____ what age?_____
__Tension headaches __Migraine headaches
__Multiple Sclerosis __Restless leg syndrome __Seizure disorder

Hematologic __ Hemolytic anemia __Iron deficiency anemia __Pernicious (b12 deficiency) anemia
__Sickle cell anemia __Myelofibrosis

Allergy/Immunology _Seasonal allergies testing year_____ what triggers_____
__Eczema what year? _____age____ __Sinusitis

Cancers What part of the body_____what year?____Status?_____

Vision ___Cataract __Right __Left __Bilateral __Glaucoma

Hearing ___Loss of hearing __Right __Left __ Bilateral

Weight Current Weight # _____ as of what date?_____/_____/_____

Hospitalizations _____check here if you have never been hospitalized

Date____/___/___ For what?_____Name of hospital_____

Date___/___/____For what?_____ Name of hospital_____

List any other specialist you are currently seeing

Name_____Speciality_____
Name_____Speciality_____

Advanced Directives Do you have any of the following?
___Living Will ___Durable Power of Attorney ___Do Not Resuscitate

Sound Medical
Family Practice **Last Name_____, First_____**

Preventative Health Screening

Please provide the date you last had the following test or service

__Flu Shot ____/___/____ __Pneumonia 23 Shot ____/___/____ __Prevnar 13 ____/___/____

__Zostavax (shingles vaccine) ___/___/____ __Tetanus Shot ___/___/____

__Colonoscopy ___/___/____ __Bone Density ____/___/____ __Eye Exam____/____/____

Women: __Last Mammogram ____/____/____ (please circle) Normal Abnormal
__ Last Pap Smear ____/____/_____ (please circle) Normal Abnormal

Men: __ Last PSA ____/____/____

Surgical History

Check all that apply

- Appendix what year?_____
- Arthroscopy which joints_____what year?_____
- Biopsy –what part of body_____ what year?_____
- Coronary Bypass - What year?_____
- Cataract
- Hysterectomy __Total __Partial Year_____ Why?_____
- Gallbladder
- Joint Replacement Which joint (s)_____
- Other_____what year?_____

Family Medical History

Father

- Medical History Unknown
- Medical History Unremarkable
- Deceased Cause of death?_____what age?____

Check any that apply to your father's health

__Heart - What type of heart problems_____

__Stroke __Cancer - What kind of cancer_____

__Lungs __Alzheimer's/Dementia __Diabetes I or II

__Alcoholism __Drug abuse what drugs_____ __Depression __Bipolar __Mental Illness

Mother

- Medical History Unknown
- Medical History Unremarkable
- Deceased Cause of death?_____what age?_____

Check any that apply to your Mother's health

__Heart –What type of heart problems_____

__Stroke __Cancer - What kind of cancer_____

__Lungs __Alzheimer's/Dementia __Diabetes I or II

__Alcoholism __Drug abuse what drugs_____ __Depression __Bipolar __Mental Illness

Brother - How many brothers do you have?_____

- Medical History Unknown
- Medical History Unremarkable
- Deceased Cause of death?_____what age?____

Check any that apply to your brother's health

__Heart – What type of heart problems_____
__Stroke __Cancer - What kind of cancer_____

__Lungs ____Alzheimer's/Dementia __Diabetes I or II

__Alcoholism __Drug abuse-what drugs_____ __Depression __Bipolar __Mental Illness

Sister - How may sisters do you have?_____

- Medical History Unknown
- Medical History Unremarkable
- Deceased Cause of death?_____what age?____

Check any that apply to your sister's health

__Heart – What type of heart problems_____

__Stroke __ Cancer - What kind of cancer_____
__Lungs ___Alzheimer's/Dementia __Diabetes I or II

__Alcoholism __Drug abuse -what drugs_____ __Depression __Bipolar __Mental Illness

Social History

What's your occupation**:** _____o Current o Retired year? _____

Marital Status: oSingle o Married o Separated o Divorced o Widowed o Widowed/Remarried
Number of children _____Step Children_____Foster Children_____

What are your hobbies: _____
What kind of exercise do you do?_____How often?_____ day or week

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacist? (Please circle one below)

1. Never 2- Rarely 3- Sometimes 4- Often 5- Always

Tobacco/ Caffeine/Alcohol/ Supplements

Tobacco use o Never Smoked o Past Smoker Quit Date __/__/__ Smoked how many years?__

Type of tobacco

- Cigarettes –how many per day _____ cigarettes / packs (please circle)
- Cigars- how many per day _____
- Pipe-how many per day_____
- Smokeless Tobacco –how many per day_____
- Marijuana- how many times per day_____

Caffeine use

- Coffee – servings per day _____
- Tea- servings per day ____
- Soda- servings per day ____ o Chocolate – how many servings per day_____

Alcohol Consumption o Never o Social o Regular Use o Member of AA
o Former member of AA

Type of Alcohol

o Beer – servings per day_____ per week_____
o Malt Liquor – servings per day _____ per week_____
o Wine – servings per day _____ per week_____
o Liquor – servings per day _____ per week_____

Supplements o None o Appetite Suppressants o Multivitamins

Do you follow a specialized diet? o Yes o No o If yes, which one?_____

Substance use

Do you use recreational drugs? o Never o Regular Use o Past –what year?_____

o Narcotics o Marijuana o Cocaine o Heroin o Opium o Other _____

How often do you use _____times a **day or week** (circle one)
Method of use o Smoke o Injection o Snort o Huff

Mental Health History

Do you suffer from any of the following?

- **Anxiety** o Acute Stress Disorder o Panic Attacks o PTSD o Phobias
- **Cognitive Disorder** o Alzheimer's o Dementia
- **Eating Disorder** o Anorexia o Bulimia
- **Mood Disorder** o Depression o Bipolar o Manic Episode
- **Schizophrenia/Psychosis** o Paranoid o Disorganized o Residual
- **Sleep Disorder** o Insomnia o Narcolepsy

Have you ever had environmental/chemical exposures or communicable diseases?
o Yes o No
If yes, what were you exposed to or what communicable disease?_____

_____

To the best of my knowledge, I have provided you my medical history.

X_____ **Date** / /

Patient's Signature

Sound Medical
Family Practice

John Rickabaugh, M.D.
Frieda Menzer, M.D.
Meg Dolan, PA-C
Andrew Stern, PA-C
Jennifer Brown, AGNP

3608 Medical Park Court, Morehead City, NC 28557
Phone: 252-247-3476 • Fax: 252-240-0747

300-E Taylor Notion Road, Cape Carteret, NC 28584
Phone: 252-354-1970 • Fax: 252-354-1968

Medical Record Request

Authorization to Request or Release Protected Health Information

Patient Name:_____

Date of Birth:_____-_____-_____ Last 4 of SS # ____ ____ ____ ____

☐ I hereby consent and authorize Sound Medical to **CONSENT and REQUEST** copies of my medical records to the following:

☐ 3608 Medical Park Court Morehead City, NC 28557
Phone (252) 247-3476 Fax (252) 247-3478

☐ 300 E Taylor Notion Road Cape Carteret, NC 28584
Phone (252) 354-1970 Fax (252) 354-1968

Name of physician/provider/patient_____

Address _____City_____

State_____Zip_____ Phone ( ) _____-_____Fax( )_____-_____

☐ **I am requesting specific medical records: Last 2 years of progress notes and labs. All radiology and immunization reports.**

☐ **I am requesting:**_____

I understand I may revoke this authorization at any time. I understand this authorization form, and I authorize my records to be released. I understand this authorization may include sensitive information such as consent for release of alcohol, drug, psychiatric, psychological, and information related to HIV testing, AIDS, and communicable diseases. I agree that a copy of this release or fax of this release shall be as valid as the original release.

X_____Date____-____-____
Signature of patient or legal representative

Witness Signature _____Date____-____-____