# Patient Registration and Health Questionnaire

Name: _____ Date of Birth:_____ Todays Date:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Phone #'s: (HOME)_____ (CELL)_____ (WORK)_____

Occupation/Employer:_____

Under 18 Parent/Guardian Name:_____ DOB:_____

Spouse Name:_____ DOB:_____

Emergency Contact Name and Relationship:_____
Emergency Contact #_____

Social Security #_____-_____-_____ Drivers License #_____

Referred By:_____ Email Address:_____

## Insurance And Billing Information

Billing Name if other than patient:_____
Relationship:_____

Billing Address:_____ City:_____
Sate:_____ Zip:_____
Phone #:_____

Insurance Company Name:_____ Address:_____
Name of Insured:_____ Relationship to
Pt._____
ID #_____ Group#_____ Effective
Date:_____

**Assignment of Insurance Benefits**

**I hereby authorize direct payment of surgical/ medical benefits to Dr. Anthony Njapa for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. I also give full consent to disclose my Health Information and or Records to my Insurance company if requested by them in order for my claims to be filed and paid.**

**MEDICARE/MEDICAID**

**I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT IS CORRECT. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF.**

**A photocopy of these assignments shall be as valid as the original.**

**PATIENT NAME (please print):**_____
**DATE:**_____
**PARENT/ GUARDIAN (please print):**_____
**SIGNATURE:**_____

# HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

| **Name** *(Last, First, M.I.):* ☐ M ☐ F | **DOB:** |
|---|---|
| **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | |
| **Previous or referring doctor:** | **Date of last physical exam:** |

## PERSONAL HEALTH HISTORY

**Childhood illness:** ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

**List any medical problems that other doctors have diagnosed**

**Surgeries**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

| Name the Drug | Strength | Frequency Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| **Pharmacy used most frequent:** | **Pharmacy Location :** | |

**Allergies to medications**

| Name the Drug | Reaction You Had |
|---|---|
| | |
| | |

| | | | | | |
|---|---|---|---|---|---|
| Alcohol | Do you drink alcohol? | | | ☐ Yes | ☐ No |
| | If yes, what kind? | | | | |
| | How many drinks per week? | | | | |
| Tobacco | Do you use tobacco? | | | ☐ Yes | ☐ No |
| | # OF PKS PER DAY: | ☐ Chew - #/day | ☐ Pipe - #/day | ☐ Cigars - #/day | |
| | ☐ # of years | ☐ Or year quit | | | |
| Drugs | Do you currently use recreational or street drugs? | | | ☐ Yes | ☐ No |
| | Have you ever given yourself street drugs with a needle? | | | ☐ Yes | ☐ No |

## FAMILY HEALTH HISTORY

| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
|---|---|---|---|---|---|
| **Father** | | | Children | ☐ M ☐ F | |
| **Mother** | | | | ☐ M ☐ F | |
| Sibling | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | **Grandmother** *Maternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Maternal* | | |
| | ☐ M ☐ F | | **Grandmother** *Paternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Paternal* | | |

## MENTAL HEALTH

| | | |
|---|---|---|
| Is stress a major problem for you? | ☐ Yes | ☐ No |
| Do you feel depressed? | ☐ Yes | ☐ No |
| Do you panic when stressed? | ☐ Yes | ☐ No |
| Do you have problems with eating or your appetite? | ☐ Yes | ☐ No |
| Do you cry frequently? | ☐ Yes | ☐ No |
| Have you ever attempted suicide? | ☐ Yes | ☐ No |
| Have you ever seriously thought about hurting yourself? | ☐ Yes | ☐ No |
| Do you have trouble sleeping? | ☐ Yes | ☐ No |
| Have you ever been to a counselor? | ☐ Yes | ☐ No |

## WOMEN ONLY

| | | |
|---|---|---|
| Heavy periods, irregularity, spotting, pain, or discharge? | ☐ Yes | ☐ No |
| Number of pregnancies _____ Number of live births _____ Number of abortions_____ | | |
| Have you had a D&C, hysterectomy, or Cesarean? | ☐ Yes | ☐ No |

Coastal Mds/ Anjan Medical

1098 Medical Center Drive Suite A

Wilmington, NC 28401

(910)793-4311

Purpose: This form is used to confirm the direction of an individual that we may use or disclose protected health information for a particular purpose.

I authorize the use and/ or disclosure of my protected health information as described below. I understand that this authorization is voluntary and made to confirm direction.

Name:_____

Address:_____

Telephone #:_____

Entities authorized to use or disclose Name or specify the persons and/ or organizations including us, who you are authorizing to make use of your protected health information:

Example: Spouse, Children, significant other, other physician, insurance company.

_____

_____

_____

* If we Contact you @ home or on your cell phone is it ok to leave a voice mail on your answering machine (Example: Appt. Reminders ETC.) Yes ☐ or No ☐

SIGNATURE- YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I, _____ have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you, I understand that by signing this form, I am confirming my authorization that you may use and/ or disclose to the persons and/or organizations named in this form.

Signature: _____ Date:_____

If this authorization is signed by a personal representative on behalf of the individual or minor complete the following:

Personal Representatives Name:_____

Relationship to Individual:_____

COASTAL MDS / ANJAN MEDICAL
1098 MEDICAL CENTER DRIVE SUITE A WILMINGTON, NC 28401
PHONE # :( 910)793-4311 Fax # :( 910)793-4322

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

**Purpose of this Disclosure:** **Is** To help with on going medical treatment .

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I Understand that any release of these protected documents is covered under The Federal Confidentiality Regulations (United States Code, Title 42 and the Federal regulations that implement it Title 42, Part 2 of the Code of Federal Regulations) as well as the Health insurance Portability and Accountability Act of 1996 (HIPPA).This Code guarantees the Strict Confidentiality of Information about all persons receiving substance abuse prevention and treatment services. This law and regulations protect any person and information about a patient if the patient has applied for or receives any alcohol or drug abuse related services including assessment, diagnosis, detoxification, counseling, group counseling, treatment or referral for treatment from a covered program. This rule applies from the moment an appointment for such treatment appointment is made. I understand that my Health information Specified above will be disclosed pursuit to this authorization, and that the Recipient of the information may redisclose the information and it may no longer be protected by the Hippa privacy law. The Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, noted above, however will continue to Protect the Confidentiality of Information that identifies me as a patient in an Alcohol and or other Drug program from redisclousure. I may revoke this consent at anytime except to the extent that action based on this consent has been taking in reliance on it. This consent will expire automatically after 365 days from the date in which it was signed. Violation of the Federal Law and Regulations by a Program is a crime and that suspected Violation may be reported to appropriate authorities in accordance with these regulations. However the regulations of this disclosure also permit disclosure without consent in several situations including communicating information to medical staff and or personnel during a medical emergency or reporting any form of child abuse or neglect to the authorities.

Patient Signature: _____ Date Signed: _____

Witness Signature: _____ Date: _____

**Authorization Expires:** One year (365 days) from date signed by patient above.

If we are requesting this authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

Please note we cannot condition our provision of services or treatment to you on the receipt of this signed authorization. You may inspect a copy of the protected health information to be used or disclosed; You may refuse to sign this authorization and we will provide you with a copy of this signed authorization; You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization. I have reviewed and understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the federal law except as stated so above. If you are receiving records from this office in reguards to drug and or alcohol treatment please note the Information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR part 2) prohibits you from making any further disclouseure of this information without the express written consent of the individual from which it pertains, except in emergency conditions specified by those regulations. A general release or generic release is NOT sufficient for this purpose.