Synergy Family Medicine Patient Registration

919–869-3188

First Name _____Last Name_____ Preferred name_____

SS# _____ Date of Birth _____ email (for sending reminders)_____

Street Address _____ City _____ State_____Zip _____

Telephone: Home _____ Office _____ Cell_____

Spouse, partner, or parent's name _____ Telephone _____

Emergency contact _____ Telephone _____ Relationship _____

Whom may we thank for referring you to us _____

Patient employer information

Employer name _____ Telephone _____

Address _____City _____ State _____ Zip _____

Occupation_____

Insurance information

Primary Insurance name_____ Group # _____

ID# _____Telephone_____

Secondary Insurance Name _____ Group # _____

ID# _____Telephone _____

INFORMATION and ASSIGNMENT of BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Synergy Family Medicine to apply benefits on my behalf for covered services rendered by doctor. I request that payment from my insurance company be made directly to Synergy Family Medicine. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing either by me or by my insurance company at any time. _____ (initials)

Pharmacy information and medication refills:

Your pharmacy name and number_____ at 30 day or 90 day supply each time

Your mail order pharmacy name _____your ID #_____ phone #_____ fax # _____

Notification of test results:

We would like to notify you promptly of your test results, but it is not always feasible to talk to you directly. Your preferred way to be notified of noncritical results is: clinic visit, email, phone message, or fax at _____

I have read and understand the NOTICE OF PRIVACY PRACTICES and agree to abide it. _____ (initials)

I have read and understand the payment policy and agree to abide by its guidelines. _____ (initials)

Signature _____ Print name_____ Date _____

Synergy Family Medicine 919-869-3188
New patient general health information intake form

Name _____ DOB_____ SS# _____

Date of your first visit_____ Reasons for the first visit_____

Current medications and dosages_____

Drug allergies _____ Other allergies_____

Other Physicians currently treating you_____

Previous medical problems_____

List any previous surgeries_____

Females only: Menstrual history**--**Age at onset _____ Regular___ Irregular ___ Birth control method _____
Pregnancies _____ # Live Births _____ # Miscarriages_____ Age of menopause_____

Do you Smoke: Yes___ No___ Cigarettes___ Cigars___ number of years smoked _____ Did you quit before?____
How much do you smoke a day _____ Are you interesting in quit smoking: Yes__ No__ quit date_____
Do you regularly drink alcohol? Yes ___ No____ How much _____
Do you regularly drink coffee/soda? Yes ___No___ How many cups/cans per day _____
How do you exercise?_____ How often? _____ Are you under stress at work /home Yes ___No___
How would you describe your diet? Moderate low fat__, low card___, very low fat, low card___ vegetarian__ organic__

Personal Medical History Have you ever had any of the following (check all that apply)
___acid reflex / stomach ulcers
___ ADHD
___anxiety
___allergies
___anemia
___arthritis
___asthma or short of breath
___blood in stool
___cancer
___chest pain/pressure
___COPD/emphysema
___constipation
___depression
___diabetes
___dizzy spells
___eczema/psoriasis
___edema
___ erectile dysfunction
___ fatigue
___ fibromyalgia
___ GERD
___ genital herpes
___heart attack
___heart failure
___heart irregular beats

___high blood pressure
___headaches (tension)
___headaches (migraine)
___headaches (menstrual)
___hemorrhoids
___hepatitis A, B, or C
___IBS
___Indigestion
___ infertility
___ insomnia
___ joint pain
___kidney disease
___low back pain
___memory loss
___menstral problem
___ PMS
___skin lesions/disorders
___stroke
___tendonitis
___TIA
___thyroid problem
___ weight gain (overweight)
___ weight loss (under weight)

Family medical history

Please check all that apply:	father	mother	grandparents	siblings	children	more detail description:
High Blood Pressure	_____	_____	_____	_____	_____	
Epilepsy	_____	_____	_____	_____	_____	
Cancer	_____	_____	_____	_____	_____	
Eczema/Psoriasis	_____	_____	_____	_____	_____	
Heart attack/Stroke	_____	_____	_____	_____	_____	
Diabetes	_____	_____	_____	_____	_____	
Asthma	_____	_____	_____	_____	_____	
Hay Fever	_____	_____	_____	_____	_____	
Thyroid problems	_____	_____	_____	_____	_____	
Depression/anxiety	_____	_____	_____	_____	_____	
Overweight	_____	_____	_____	_____	_____	

Other pertinent information you think we should know: