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S. Keith Smith, M.D., FAAFP
Deborah H. Davis, M.D., FAAFP
Tim M. Robinson, M.D.
Laurie C. Robinson, M.D.
Ellen C. Collett, M.D.
Martin Gessner, M.D.
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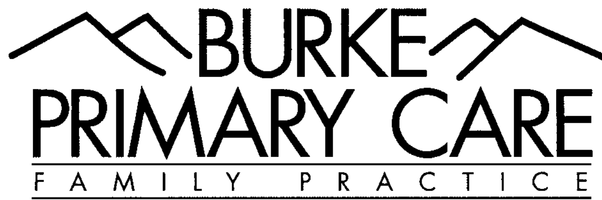



John F. Sallstrom, PA-C
R. Bruce Edwards, PA-C
W. Burton Moncrief, PA-C
Bill G. Vaassen, PA-C
David Lange, PA-C
Deborah F. Crawford, GNP

**OFFICE USE ONLY: Patient Number:** ________________

**Patient Name:** ________________________________ **Home Phone:** ____________________

**Mailing Address:** ________________________________ **City:** ____________________

**State:** _____ **Zip:** __________ **Social Security #:** ____________________ **Birthdate:** ________________

**Email Address:** ________________________________ **Cell Phone:** ____________________

**Sex:** ☐ Male ☐Female **Race:** ☐ White ☐ Black ☐ Indian ☐ Hispanic ☐ Other

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widow

**Employer/School:** ________________________________ **Work Phone:** ____________________

**Occupation:** ________________________________

**Emergency Contact:** ________________________________

**Phone:** ________________________ **Cell Phone:** ________________________

**Spouse or Guarantor:** ________________________________ **Date of Birth:** ________________

**Relationship:** ____________________ **Employer:** ________________________________

**Mailing Address:** ________________________________ **City:** ____________________

**State:** _____ **Zip:** __________ **Social Security #:** ____________________

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Burke Primary Care's Notice of Privacy Practices has been provided to me for my review. I understand the purpose of this notice is to inform me of my rights regarding my Protected Health Information and also the way in which the practice may use my Protected Health Information.

**Patient/Representative Signature:** ________________________________ **Date:** ________________

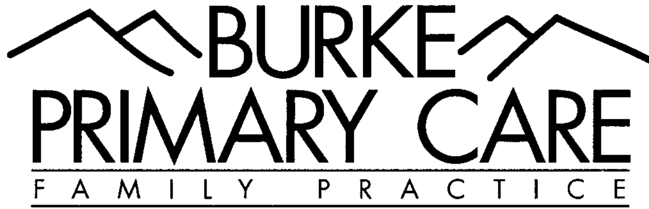
**INSURANCE ASSIGNMENT OF BENEFITS**

I understand that payment is due at the time of service and that Burke Primary Care files insurance as a courtesy to our patients. I further understand that any outstanding balance will be my responsibility to pay, and failure to remit may result in termination of services and possible collection procedures.

I hereby authorize direct payment to Burke Primary Care of medical benefits otherwise payable to me, including major medical insurance, payment of surgical and medical benefits, including major medical directly to the attending physician. I understand that I am financially responsible to Burke Primary care and my physician for charges not covered by this assignment.

Furthermore, Burke Primary Care and attending physicians are authorized to release copies of my medical records and any medical information required in the processing of applications/claims for financial coverage or for payment of services rendered during the patient physician relationship.

**Patient/Representative Signature:** ________________________________ **Date:** ________________

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103 Medical Heights Drive
Morganton, NC 28655
Voice: (828) 437-4211

**PLEASE RETURN THIS FORM WITH RECORDS TO:**

**FAX: (828) 438-4109**

Name:____________________________

Address:____________________________

Address:____________________________

Birthdate:____________________________

Telephone:____________________________

## CONSENT TO RELEASE OR RECEIVE MEDICAL INFORMATION

I, hereby authorize and request that you release copies of my medical record:

| | |
|---|---|
| **TO: Burke Primary Care** | **FROM: Burke Primary Care** |
| **FROM:**____________________ | **TO:**____________________ |
| Phone:____________________ | Phone:____________________ |
| Fax:____________________ | Fax:____________________ |

## MEDICAL INFORMATION REQUESTED:

☐ Complete Record ☐ Limit to Specific Information/Reports____________________

Please Note: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes.

## AUTHORIZATION:

This authorization will automatically expire 90 days from the date of signature. At that time, no express revocation shall be needed to terminate my consent, but I understand that I may revoke this consent at any time prior, except to the extent that action has been taken in reliance on this authorization.

Signed:____________________________ Date:____________________
Parent/Guardian

OFFICE USE ONLY:

Chart #:____________ Provider:______ Appt Date:____________ Directive:____________

# ADULT'S PATIENT HISTORY FORM

Please fill out the following on your family history. Use ( ) to indicate deceased.

| Relatives | Age or (Age at Death) | Health Problem or (Cause of Death) |
|---|---|---|
| Father | | |
| Mother | | |
| Sister(s) | | |
| Brother(s) | | |
| Grandparents | | |
| Son(s) | | |
| Daughter(s) | | |
| Other Family History: | | |

Marital status: ______________________

Education: ______________________

Occupation: ______________________

Are your vaccines up to date? ....... Yes ........ No ......... Unknown
(Tetanus, Hepatitis, Pneumonia shots)

Who do you live with: ______________________

Do you have a living will? ........ Yes ........... No

Are you an organ donor? ......... Yes ........... No

Blood transfusion prior to 1992? ......... Yes .......... No

Do you?

Drink coffee, tea or caffeinated beverages ......... Yes ........... No

If yes, how much per day: ______________________

Do you eat a special diet .................................... Yes ........... No

If yes, what kind: ______________________

Do you have firearms in the home ...................... Yes ........... No

If yes, stored how: ______________________

Use smokeless tobacco/snuff .............................. Yes ........... No

If yes, how much per day: ______________________

Smoke .............. Yes ....... No ........... How much: __________

Drink alcohol .. Yes ....... No ........... How much: __________

Exercise ........... Yes ....... No ........... How much: __________

Use recreational drugs ........ Yes ..........No

Wear a seatbelt ...................... Yes ..........No

Are you sexually active ...... Yes ..........No

What are your hobbies? ______________________

Please list past medical information below including diagnosis, hospitalizations, surgeries, and procedures (diabetes, hypertension, stress test, heart cath., colonoscopy)

| Date | Reason |
|---|---|
| | |
| | |
| | |

List all medications currently taking (including vitamins & herbs): ______________________

______________________

Any known allergies? ______________________

List any current symptoms or concerns you would like to discuss with with doctor: ______________________

______________________

______________________
Signature of Patient/Guardian

______________________
Date

Patient Name: ______________________

Patient ID: ______________________