BEACHCARE Urgent & Family Medical Center, PLLC
5059 Hwy. 70 West • Morehead City, NC 28557
Phone: (252) 808-3696 Fax: (252) 808-2022
Tax I.D. #45-2776539

We participate with most Insurance Companies and bill as a PRIMARY CARE.
WE DO NOT ACCEPT OUT OF STATE MEDICAID

PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: ____/____/____
LAST FIRST MI

Social Security Number: _____ Sex: M / F

(Circle One) Married Single Divorced Widow

Home Phone: _____ Cell Phone: _____ Email _____

Mailing Address: _____
STREET CITY STATE ZIP

Employers Name: _____ Employers Phone: _____

Employers Address: _____ Occupation: _____

Primary Care Physician: _____ Phone: _____

SECTION FOR MINORS

Parent/Guarantor Name: _____ Date of Birth: ____/____/____

Social Security Number: _____ Relationship _____

Address: _____ Phone: _____

Employers Name: _____ Phone: _____

Employers Address: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____

Policy Holder _____ Date of Birth: _____

Social Security Number: _____ Relationship: _____

Second Insurance: _____ ID#: _____

Policy Holder: _____ Date of Birth: _____

Social Security Number: _____ Relationship: _____

Third Insurance: _____ ID#: _____

Policy Holder: _____ Date of Birth: _____

Social Security Number: _____ Relationship: _____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment benefits to **BeachCare**. I acknowledge that I am financially responsible for payment whether or not covered by insurance and any unpaid balances are subject to collections.

Signature: _____ Date: _____

PATIENT RECORD OF DISCLOSURES

In general, The HIPPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office rather than their home.

Preferred Method of Contact (check all that apply to you):

☐ **Home Telephone**
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Work Telephone**
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Written Communication**
- ☐ OK to mail to home address
- ☐ OK to mail my work address

☐ **Email**
- ☐ Opt out
- ☐ OK to receive information via email

Email: _____

_____ By my initials, I request that **BeachCare** provide a copy of my medical records to my family physician and physicians consulted by **BeachCare** Medical staff to participate in my care.

_____ By my initials, I acknowledge that I have been offered a copy of the **BeachCare** Privacy Policy.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly will constitute an adequate record.

NOTE : Uses and disclosures may be permitted without prior consent in an emergency.

You expressly consent and agree that, in order to discuss or service your account(s) (the "accounts") or to collect amounts you may owe, [BeachCare], and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any email address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts, regardless of whether you incur charges as a result.

Person's authorized to receive your information:

Name _____ Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

SIGNATURE : _____ TODAY'S DATE : _____

PRINT NAME : _____

BEACHCARE URGENT AND FAMILY MEDICAL CENTER, PLLC

* MUST HAVE A LIST OF CURRENT MEDICATIONS PRIOR TO BEING SEEN*

Name _____ **DOB** _____

Pharmacy and Location _____

PAST MEDICAL HISTORY:

☐ Heart Condition ☐ High Blood Pressure ☐ Diabetes

☐ High/Bad Cholesterol ☐ Anxiety Depression ☐ Lung Disease/Asthma ☐ Emphysema/COPD

☐ Stroke ☐ Seizures ☐ Thyroid Disorder

☐ Please list any other medical problems: _____

☐ LMP (Last Menstrual Period) _____ ☐ Hysterectomy ☐ Menopause

☐ Past Surgeries _____

☐ Allergies (Please list reaction) _____

_____

☐ ***MEDICATION/DOSAGE*** _____

_____

_____

FAMILY HISTORY: Please list any medical problems such as cancer, stroke, heart attack, diabetes, etc.

Mom _____ Aunt _____

Dad _____ Uncle _____

Grandparents _____ Children _____

Brother _____ Sister _____

Please select all that apply:

When was your last annual physical? _____ Would you like to schedule one today? ☐ No ☐ Yes

Smoke: ☐ No ☐ Yes If yes, how many packs per day? _____

Have you smoked in the past? ☐ No ☐ Yes If yes, how many packs per day? _____

What year did you start? _____ What year did you quit? _____

Exposed to Second Hand Smoke? ☐ No ☐ Yes

Drink Alcohol: ☐ No ☐ Yes If yes, how much/how often? _____

Have you in the past? ☐ No ☐ Yes If yes, how much/how often? _____

Use illegal street drugs: ☐ No ☐ Yes If yes, what drug? _____

Have you in the past? ☐ No ☐ Yes If yes, what drug? _____

Sexually active: ☐ No ☐ Yes If yes, how many partners? _____

☐ Men ☐ Women ☐ Both

Are you current on your:

Tetanus Vaccine	☐ Yes	☐ No	Year ____	Childhood Immunizations	☐ Yes	☐ No	Year ____
Pap Smear	☐ Yes	☐ No	Year ____	Mammogram	☐ Yes	☐ No	Year ____
PSA/Prostate Exam	☐ Yes	☐ No	Year ____	Breast Exam	☐ Yes	☐ No	Year ____
Colonscopy	☐ Yes	☐ No	Year ____	COVID Vaccine	☐ Yes	☐ No	Year ____

Sexually Transmitted Disease Screening ☐ Yes ☐ No Year ____