
BRIAN FORBUS, PA - C

Last Name: _____ First Name: _____ Middle Initial: _____

Sex: Male Female DOB: _____SSN: _____

Address: _____

Home phone: _____ Cell phone: _____

May we contact you to remind you of your appointments via home/cell phone, or both? _____

Patient Email: May we contact you via email? Yes No

If yes, please provide email address_____@_____

Race/Ethnicity: ____Caucasian ____ African American ____Latino/Hispanic _____non-Hispanic ____Other

Marital Status: _____Married _____Single _____Divorced _____Separated _____ Widowed

Occupation: _____ Work Number: _____

Pharmacy name and phone: _____

Referring Provider: _____ Phone Number: _____

Primary Care Provider: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____

Contact Number for emergency person: _____

**2767 CULTRA ROAD CONWAY, SC 29526**
**PHONE (843) 365-0421 * FAX (843) 365-0584**
**WWW.ATLANTICCOASTPAIN.COM**

## Insurance

Primary Insurance: _____ ID#: _____

Are you the policy holder? _____If no, policy holder name: _____

DOB: _____ SSN: _____ Phone Number: _____

Secondary Insurance: _____ ID#: _____

Are you the policy holder? _____If no, policy holder name: _____

DOB: _____ SSN: _____ Phone Number: _____

The above information is true to the best of my knowledge. I authorize Atlantic Coast Adult Medicine to forward information to insurance carriers required to process my claims. I authorize my insurance benefits to be paid directly to the physicians. I understand that I am responsible for any amount not covered by insurance, any collection fees or interest acquired.

Signature: _____Date: _____

## Worker's Compensation

Type of accident (circle one) Worker's Comp Motor Vehicle Other

Adjustor / Case Manager Name: _____

Phone Number:_____ Fax#: _____

Claim#: _____ Case#: _____

Do you have an attorney representing you in this matter? Yes No

Name: _____

Address: _____

Phone#: _____ Fax#: _____

Date of injury: _____

The above information is true to the best of my knowledge. I authorize Atlantic Coast Adult Medicine to forward information to insurance carriers required to process my claims. I authorize my insurance benefits to be paid directly to the physicians. I understand that I am responsible for any amount not covered by insurance, any collection fees or interest acquired.

Signature: _____Date: _____

Atlantic Coast Adult Medicine

2767 Cultra Road * Conway, SC 29526

Phone: 843-365-0421 * Fax: 843-365-0584

# Past Medical History

Please list the names of other physicians you are seeing:

_____

_____

_____

Please mark the following conditions /diseases you have been treated for in the past:

**General Medical**

_____Cancer – type _____

_____Diabetes – type _____

**Cardiovascular / Hematological**

_____Anemia

_____Heart Attack

_____Coronary Artery Disease

_____High Blood Pressure

_____Peripheral Vascular Disease

**Gastrointestinal**

_____ GERD (acid reflux)

_____ Gastrointestinal Bleeding

_____ Stomach Ulcers

_____ Constipation

**Urology**

_____ Chronic Kidney Disease

_____ Kidney Stones

_____ Urinary Incontinence

_____ Dialysis

**Respiratory**

_____Asthma

_____Bronchitis / Pneumonia

____ Emphysema / COPD

**Neuropsychological**

_____ Multiple Sclerosis

_____ Peripheral Neuropathy

_____Seizures

_____ Depression

_____ Anxiety

_____Schizophrenia

_____ Bipolar Disorder

**Head / Ears / Eyes / Nose / Throat**

_____ Headaches

_____ Migraines

_____ Head injury

_____ Hyperthyroidism

_____ Hypothyroidism

_____ Glaucoma

**Musculoskeletal / Rheumatologic**

_____ Bursitis

_____ Carpal Tunnel Syndrome

_____ Fibromyalgia

_____ Osteoarthritis

_____ Osteoporosis

_____ Rheumatoid Arthritis

_____ Chronic Joint Pain

**Other**: _____

_____

## Past Surgical History

Please list any surgical procedures you have had performed including the date:

1) _____ Date: _____
2) _____ Date: _____
3) _____ Date: _____
4) _____ Date: _____
5) _____ Date: _____

_____ I have never had any surgical procedures performed

## Current Medications

Please list all medications you are currently taking including vitamins and over the counter.

| Medication Name | Dose | Frequency |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## Allergies

Do you have any drug / medication allergies? Yes No

If so, please list them

| Medication | Allergic Reaction |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## Family History

Please check all the appropriate diagnosis as they pertain to your first-degree relatives

_____ Arthritis _____ Cancer _____ Diabetes _____ Headaches / Migraines

_____ High Blood Pressure _____ Kidney _____ Liver _____ Osteoporosis

_____ Seizures _____ Rheumatoid Arthritis _____ Stroke

_____ Other_____

_____ Other_____

## Social History

Occupation: _____ When was the last time worked? _____

Who is currently in your household? _____

Are there any stairs in your home? Yes No If so, how many? _____

Are you currently under Workman's Compensation? Yes No

Is there an ongoing lawsuit related to your visit? Yes No

Alcohol Use: _____Social _____ History of alcoholism _____ Daily _____ Never

Tobacco Use: _____ Current User _____ Former User _____ Never _____ Vape

_____ Packs per day _____ Former User Quit Date_____

Illegal Drug Use: _____ Denies any illegal drug use _____ Currently uses illegal drugs

_____ Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medication? Yes No

# Review of Symptoms

Check the symptoms from which you currently suffer

Constitutional: _____ Chills _____ Difficulty sleeping _____ Night sweats _____ Fatigue

_____ Insomnia _____ Low sex drive _____ Fevers _____ Tremors

_____ Weakness _____ Unexplained weight loss _____ Unexplained weight gain

_____ Easy bruising

Eyes: _____ Recent visual changes

Ears/ Nose / Throat / Neck: _____ Dental problems _____ Earaches _____Hearing problems

_____ Nose bleeds _____ Sinus problems

Cardiovascular: _____ Chest pain _____ Fainting _____ Shortness of breath during sleep

_____ Bleeding disorder _____ Palpitations _____ Blood clots

_____ Swelling in feet

Respiratory: _____ Cough _____ Wheezing _____ Shortness of breath

Gastrointestinal: _____ Constipation _____ Diarrhea _____Acid reflux _____ Abdominal cramps

_____ Nausea / vomiting _____ Hernia

Musculoskeletal: _____ Back pain _____ Joint swelling _____Joint pains _____Neck pain

_____ Muscle spasms _____ Joint stiffness

Genitourinary / Nephrology: _____ Flank pain _____ Blood in urine _____Painful urination

_____ Decreased urine flow / frequency / volume

Neurological: _____ Dizziness _____ Numbness _____ Headaches _____ Tremors

_____ Seizures _____ Tingling

Psychiatric: _____ Depressed mood _____Feeling anxious _____ Stress problems

_____ Suicidal thoughts _____ Suicide planning _____ Thoughts of harming others

_____All other review of symptoms negative

Reviewer: _____

**Atlantic Coast Adult Medicine**

**Notice of Privacy Practices**

**Acknowledgement of Receipt**

Date: _____

I acknowledge that I was provided with a copy of the Atlantic Coast Adult Medicine Notice of Privacy Practices

Patient Name (print): _____

Patient Signature: _____

If completed by a patient's personal representative, please print and sign your name in the space below:

_____ _____ _____

Personal Representative (print) Personal Representative (sign) Relationship

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For Atlantic Coast Adult Medicine use

Complete this section if this form is not signed and dated by the patient or the patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Atlantic Coast Adult Medicine Notice of Privacy Practices but was unable to for the following reason:

_____ Patient refused to sign

_____ Patient unable to sign

_____ _____

Employee Name Date

Atlantic Coast Adult Medicine

2767 Cultra Road * Conway, SC 29526

Phone: 843-365-0421 * Fax: 843-365-0584

# HIPAA Privacy Rule of Patient Authorization Agreement

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as the following:

- A basis for planning my care and treatment
- A means of communication among health professionals who may contribute to my healthcare
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

- I have the right to review this Practice's Notice on Information practices prior to signing this consent
- This Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I have provided, if requested
- I have the right to object to the use of my health information for directory purposes
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to conduct treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested.

I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

I authorize the Practice to disclose or provide Protected Health Information about me to the individual(s) listed below. (List each family member, friend or other individual to receive PHI):

Name: _____ Phone: _____

Relationship: _____ ____All information ____Only Appointments ____Financial _____ Health

Name: _____ Phone: _____

Relationship: _____ ____All information ____Only Appointments ____Financial _____ Health

Signature: _____ Date: _____


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Request for Protected Health Information

Date: _____ Patient: _____ DOB: _____

I authorize Atlantic Coast Adult Medicine to receive my medical information from your

office _____ for the purpose of

continuity of care.

This signed PHI Form authorizes ACAM to receive the following medical information:

- 6 months progress notes
- Radiology studies (Mammogram, Dexa Scan, Colonoscopy…)
- 6 months Labs

This authorization is valid for 12 months from the date of signature unless otherwise specified

_____ _____

Name of Patient or personal representative /relationship to patient (print) DOB

_____ _____

Signature Date


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Request for Protected Health Information

Date: _____ Patient: _____ DOB: _____

I authorize Atlantic Coast Adult Medicine to release my medical information to your office _____ for the purpose of continuity of care.

This signed PHI Form authorizes ACAM to release the following medical information:

- Progress notes
- Radiology studies
- Labs

This authorization is valid for 12 months from the date of signature unless otherwise specified

_____ _____

Name of Patient or personal representative /relationship to patient (print) DOB

_____ _____

Signature Date