Clingman Medical Center

An Affiliate of Hugh Chatham Memorial Hospital

3369 Clingman Road
Ronda, NC
Telephone: (336) 984-3003
Fax: (336) 984-2700

L. Howard Nabors, MD
Alexander Snyder, MD

Name: ________________________________
Phone Number: __(_____)________________
DOB: __________________________________

Patient Packet

Please note that we do access the North Carolina Controlled Substances Reporting System (CSRS) on a regular basis:

This statewide reporting system was established by North Carolina law to improve the state's ability to identify people who abuse and misuse prescription drugs classified as Schedule II-V controlled substances. It is also meant to assist clinicians in identifying and referring for treatment patients misusing controlled substances. The NC Commission for, and the Division of, Mental Health, Developmental Disabilities and Substance Abuse Services make rules and manage the program.

We use the controlled substances reporting system when prescribing controlled substances

Office use only

____Yes--Next available appointment
____Yes--Needs to be seen ASAP
____No--The individual would be better served staying with their current physician or finding another doctor
____No--Other:____

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Thank you for considering Clingman Medical Center as your primary care provider. **This is NOT an application**, but is a packet of information that must be completed in order for the physician to determine the most appropriate care for you.

Once your information is received by us, we will review the information and will respond to you within 5-7 business days. At that time we will let you know if our practice can provide services to you as a patient.

This form is for preliminary screening purposes ONLY and is for routine care or non-urgent problems. If you are currently experiencing an urgent problem, you should contact your current personal or primary care doctor or go to your nearest emergency room.

Providing your medical information on this form does NOT create a physician-patient relationship and is not a guarantee of an appointment or of any specific service.

<u>If you are accepted as a patient, you must see the doctor for an initial new patient visit in order to be established as a patient. If you have not seen the doctor within 3 months of our reply of acceptance, you will have to repeat this process and complete a new packet.</u>

Please select the doctor you would like to see:

___ **L. Howard Nabors, MD:** sees adult patients (16 years and older) Monday through Thursday

___ **Alexander Snyder, MD:** sees patients 2 years and older Tuesday, Thursday, and Friday

_____ **Mary Oberembt, ANP:** sees adult patients (16 years and older) Monday, Wednesday and Friday

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Please give a detailed description of your current and long term health condition

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Patient Information

Name ____

Date of Birth ____/____/____ Social Security # ________________

Address ____

____

Home Phone ________________ Work Phone ________________

Cell Phone ________________ Other Phone ________________

Employer ____

Occupation ________________ Employer Phone ________________

Employer Address ______________________________________

Marital Status: Single Married Divorced Widowed Separated

Spouse's Name ________________ Spouse's Phone ________________

Spouse's Employer ______________________________________

Spouse's Employer Phone # ______________________________

Insurance (BRING CARD) ________________________________

Who is your current primary care doctor? ____________________

Address ____

Phone ________________ Fax ________________

How did you hear about our office? Doctor Friend Family Other

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Allergies: (Circle all that apply)

Codeine Bee Sting Sulfa Penicillin Latex Other: ______________

Current Medications

Name of Medicine	Dose (mg)	How many times daily?

Do you use any of these products?

Tobacco __Yes __No
If yes, please describe how much is used daily:
Cigarettes______________________
Snuff______________________
Chewing Tobacco ______________

Caffeine __Yes__No
If yes, please describe how much is consumed daily:
Coffee______________________
Tea______________________
Soft Drinks______________________
Other______________________

Illicit or Street Drugs __Yes __No
If yes, please describe:
Type:______________________
Amount: ______________________
Frequency: ______________________
Have you ever overdosed? __Yes __No

Alcohol __Yes __No
If yes, lease describe how much is consumed daily:
Beer______________________
Wine______________________
Other______________________

Have you ever been hospitalized? ____**Yes**____**No**

When	Where	Why

Have you had any surgical procedures? (Circle) Yes No

When	Where	Type of procedure

Do you have children?

Name	**Date of Birth**	**Health Problems**

Please use the code in the box below to mark any conditions that you or your family members have been diagnosed with in the past.

______Appendicitis
______Prostate Problems
______Hysterectomy
______Gallbladder disease
______Heart Surgery
______Heart Attack
______Seizure/Epilepsy
______Colon Cancer

______High Blood Pressure
______Elevated Cholesterol

______Diabetes Mellitus
______Stomach Ulcers
______Stroke
______Asthma
______Emphysema
______Tuberculosis
______Lung Cancer
______Breast Cancer
______Arthritis

______Other

Y= Yourself
M= Mother
F= Father
S=Sister
B=Brother
S1= Son
D=Daughter
MGM= Maternal Grandmother
MGF= Maternal Grandfather
PGM= Paternal Grandmother
PGF= Paternal Grandfather

Mother: Living Deceased Cause of Death____________________
Age at Death____________________

Father: Living Deceased Cause of Death____________________
Age at Death____________________

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Emergency Contact Information

1. ____

Name of person not living with you   Relationship

____

Address (street, city, state, zip code)   Home/work phone number

2. ____

Name of person not living with you   Relationship

____

Address (street, city, state, zip code)   Home/work phone number

Authorized Recipient of Information

I hereby authorize Clingman Medical Center to discuss my (or my dependent child's) medical information, including lab and x-ray results, appointments, referrals, and medication information with:

____

Name   Relationship

______________________   ______________________

Signature of responsible party   Date

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Assignment of Benefits

I hereby assign payment directly to Clingman Medical Center of the medical and/or major medical benefits, if any, otherwise payable to me pursuant to the terms of any insurance policy for services rendered.

Release of Information

I hereby authorize Clingman Medical Center to release such medical and billing information as may be required by any insurance company concerned with payment of benefits for me (or my dependent child). I further authorize Clingman Medical Center to release medical information to any facility or physician to whom I (or my dependent child) am/are referred. These authorizations shall remain in effect until I provide written notice revoking them. If I (or my dependent) is referred to another physician whose practice is owned or operated by Hugh Chatham Memorial Hospital, I hereby authorize the release of this patient information packet in its entirety.

Privacy Notice

I acknowledge that I have received the Clingman Medical Center Privacy Notice as required by the Health Portability and Accountability Act (HIPPA).

Insurance Coverage Spouse or Parent

If your insurance coverage is through the employer of your spouse or parent, we must have the policy holder's birth date as well as their social security number in order to file a claim to your insurance company. We apologize for any inconvenience this may cause and appreciate your understanding and compliance with this matter.

Policy Holder's Name: ______________________________

Policy Holder's Social Security Number: ________________

Policy Holder's Date of Birth: ________________________

_________________________________   ________________

Signature of patient or responsible party   Date

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L. Howard Nabors, MD
Alexander Snyder, MD

Authorization for Release of Medical Records

I, ______________________________, do hereby consent and authorize

____

to release to Clingman Medical Center all medical records relating to my (or my dependent child's) identity, diagnosis, prognosis and treatment, psychiatric treatment, diagnosis and/or treatment of HIV related illness, sickle cell disease, or hepatitis. I understand the extent or nature of the medical information to be disclosed includes:

____

Furthermore, I understand that this authorization is revocable by me at any time should I provide a written, signed notice of revocation to Clingman Medical Center , except to the extent that any action has already been taken on this release. Otherwise consent will remain in force for 90 days.

Special Limitation or restrictions (if any): ______________________________________

____

______________________________________ ______________________________________
Signature of Patient Date Signature of Witness Date

____
Signature of Parent/Legal Guardian Date

Patient's Date of Birth: _____/_____/_____
Patient's Chart Number: ______________
Patient's ID ______________________

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AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Under the HIPAA regulations we are not allowed to give any medical or billing information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must complete this form. Signing this form will only give consent to release this information to the family members indicated below.

You have the right to revoke this consent in writing.

I authorize/allow Clingman Medical Center to release my medical and/or billing information to the following individual(s):

1. ______________________ Relation to patient: ______________________
2. ______________________ Relation to patient: ______________________
3. ______________________ Relation to patient: ______________________
4. ______________________ Relation to patient: ______________________

Patient Name: ______________________________ Date of Birth: ______________

Patient Signature: ____________________________ Date: ____________________

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS/ANSWERING MACHINE;

Occasionally it is necessary to leave messages for patients to remind them of an appointment, to notify the patient that the staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of this office discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient Name: ______________________________ Date of Birth: ______________

Patient Signature: ____________________________ Date: ____________________