North Buncombe Family Medicine, PA

Personal Information:

Patient Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____ Cell Telephone: _____

Social Security: _____ Marital Status: (*circle one*) Married Single Divorced Widow

Are you (the patient) a minor? *Yes / No*

Email Address: _____

Emergency Contact: _____

Emergency Contact Telephone: _____

Preferred Notification Method: (*circle one*) Mail Telephone Web Message *Must provide email address*

Demographics:

Race: (*circle one*) 1. White/Caucasian 2. Hispanic 3. American Indian or Alaska Native 4. Asian
5. African American 6. More than one race 7. Native Hawaiian 8. Other Pacific Islander 9. Other: _____

Preferred Language: _____

Ethnicity: (*circle one*) Non-Hispanic/ Non-Latino Hispanic/Latino

**Race, Preferred Language and Ethnicity are used for reporting purposes only in order to comply with the American Recovery & Reinvestment Act of 2009. No personal information is released when reporting demographic information.*

Employer/Insurance Information:

Name of Employer: _____

Primary Insurance Carrier: _____

Subscriber Date of Birth: _____ *Must have the date of birth for the subscriber*

Guarantor Information:

Name of Guarantor: _____

Address: _____

Home Phone#: _____ Work Phone #: _____ Cell Phone#: _____

Guarantor Social Security #: _____

Guarantor Date of Birth: _____

Consent for Treatment:

I hereby consent to medical treatment(s) and diagnostic lab(s). I understand I have the right to ask questions about my treatment and/or procedures and I agree to notify my provider of my concerns.

Patient or Legal Guardian Signature: _____ Date: _____

Office Use Only: Identification on file: Yes/No Photo: Yes/No Verified by: _____

North Buncombe Family Medicine, PA

FollowMyHealth Patient Registration Form

By accepting the invitation to the Patient Portal, you will be able to:

- View your Health Summary
- Send and Receive Messages through your Inbox
- Review Lab Results
- Review Recent Visits
- Schedule an Appointment
- View Upcoming Appointments
- Print your Immunization Record
- Update your Information

Patient Name: _____

Last 4 digits of your social security #: _____ Date of Birth: _____

Email Address: _____

_____ **YES**, I would like to accept an invitation to the Patient Portal.

_____ **NO** – Reason: _____

By declining, I understand I will not have access to the information in the Patient Portal.

We want to thank you for your interest in the Patient Portal. You will receive an email with the invitation to activate your account. Please activate your account within 30 days.

For Office Use Only:

Registered by _____ Pt Portal Invite _____

Pt Portal Active _____ Pt Portal Refused _____ EHR Updated _____

Completed by _____

NORTH BUNCOMBE FAMILY MEDICINE, PA RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR NAME: _____

BY SIGNING BELOW, I AUTHORIZE North Buncombe Family Medicine, PA TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP			NAME OF DESIGNATED PERSON
SPOUSE	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____

OTHERS _____

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____

We ask if you have any change in this request that you please inform the receptionist.

North Buncombe Family Medicine, PA MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT SIGNATURE _____

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC....

RELATIONSHIP			
SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE _____

I UNDERSTAND THAT THE NORTH BUNCOMBE FAMILY MEDICINE, PA WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.