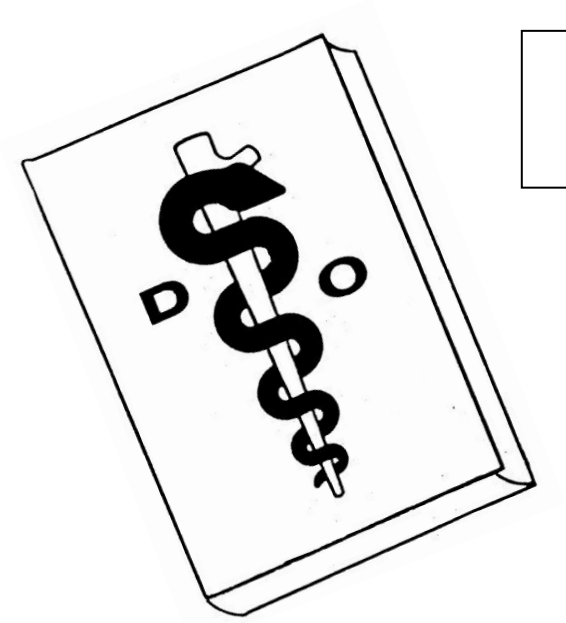

NEW PATIENT INFORMATION

GOLDSBORO WELLNESS CENTER

Disease Management, Health Education, Urgent Care.

2014

Establishing Care with (*Check One)*:

Dr. Shannon R. Jimenez D.O., FACOFP ____ Dr. Keith K. Carmack M.D. ____ Dr. Shelandra Bell D.O. ____

Dr. Bobby Lowery FNP ____ Jessica A. Heath P.A. ____ Ashley S. Barnes NP-C ____

PATIENT INFORMATION

Birth Date (DOB) _____ Social Security# _____

Last Name _____ First _____

MI _____ Maiden Name _____

Address _____ City_____ State_____ Zip_____

PH Home_____ Cell_____ Work_____

Gender: Male _____ Female _____ Other _____

Patient Marital Status:

Single_____ Married_____ Divorced_____ Widowed_____ Legally Separated_____ Partner____

Student Status Circle One: **F.** full time **P**. part time **N.** not a student

Patient e-mail Address: _____

May we leave a message at: **E-mail: Yes___ No_____ Home: Yes___ No_____ Work: Yes____ No____**

Ethnicity

_____ Hispanic

_____ Non-Hispanic

_____ Refuse to Report

Language (Circle one)

English

Spanish

Indian (Includes Hindi & Tamil)

Russian

Other

Translator Required: Y_____ N_____

Race (Check Applicable)

_____ American Indian or Alaska Native

_____ Asian

_____ Native Hawaiian

_____ African American or Black

_____ Caucasian or White

_____ Hispanic

_____ Other Race

_____ Other Pacific Islander

_____ Unreported/Refuse to Report

Your Birth order (1-7) _____

Preferred Pharmacy

Pharmacy_____

Address_____City_____State_____ Zip_____

Phone_____ Fax_____

Mail Order Pharmacy

Pharmacy_____

Address_____City_____State_____ Country_____ Zip_____

Phone_____ Ext_____ Fax_____

Emergency Contacts:

Last name_____ First Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Ph Home _____Work_____ Cell_____

Emergency Contacts Relation to Patient: _____

Release of Information Form

I, _____ give my permission to GWC to release all medical information to the enclosed list of people. I understand that I can change this list of people at any time by completing a new form and submitting it to GWC for my records

_____Spouse

_____Child

_____Parent(s)

_____Other(s)

Patient Signature_____Date_____

Guardian Signature_____ Date_____

EMPLOYMENT STATUS ***Circle*** applicable:

1. Full time **2.Part time** **3.Unemployed** **4. Self-Employed** **5. Retired** **6. Active-Military**

7. Reserved for National Assignment **8.Unknown**

Employer Information

Company Name _____

Address_____ City_____ State_____ Zip_____

Phone _____ Fax_____ Contact Person_____

E-mail_____

Billing & Insurance information

Statement will be addressed to the responsible party and all information is required if the policy holder or

Responsible party is not the patient. Please check one:

_____ Spouse/Guardian/Guarantor insured **(If the patient is less than 17yrs of age or your health insurance is provided by your spouse or someone other than yourself this box must be checked and that party's information must be provided on the following page)**

(If Spouse/Guardian/Guarantor Insured) Name the Type Below check one:

Guardian/Relative_____ Company_____ Legal_____ Workers Comp_____

IF THE RESPONSIBLE PARTY IS A RELATIVE WHAT IS THE RELATION WITH THE PATIENT: _____

_____Self Insured (**you are over the age of 17yrs and you are the primary insurance card holder. If you are under the age of 17 and you are the primary insured card holder you must still provide the legal guardians information and check this line**)

_____Self pay **(over the age of 17yrs, cash pay, you have no insurance or you will file your own insurance and we are not in your insurance network check this line)** note: If you are cash pay and want to discuss a cash billing rate please speak with your provider to determine details.

Insurance & Billing information

Primary Insurance: Provider Name: _____

Member Id #_____ Group #_____

If the patient is less than 17yrs of age or your health insurance is provided by your spouse or someone other than yourself that party's information must be provided below

Spouse/Guardian/Guarantor insured

Birth date_____ Social Security #_____ Gender: Male____ Female____ Other___

Last Name/Company_____ First_____ MI_____

Address _____ City_____State_____Zip_____

Phone_____ Fax_____ Work_____

E-mail_____

Secondary: Insurance: Provider Name: _____

Member Id #_____ Group #_____

Birth date_____ Social Security #_____ Gender: Male____ Female____ Other___

Last Name/Company_____ First_____ MI_____

Address _____ City_____State_____Zip_____

Phone_____ Fax_____ Work_____

E-mail_____

Tertiary Insurance: Provider Name: _____

Member Id #_____ Group #_____

Birth date_____ Social Security #_____ Gender: Male____ Female____ Other___

Last Name/Company_____ First_____ MI_____

Address _____ City_____State_____Zip_____

Phone_____ Fax_____ Work_____

E-mail_____

Disclosure and Acknowledgement Form

I have received and agree the Notice of Privacy Policies and Practices of GWC: Yes_____ No_____

Sign here_____Date_____

I have received the Financial Policy of GWC and agree that I am responsible for all charges and understand I could be dismissed for nonpayment.

PatientSignature_____Date_____DOB_____

Guarantors Signature_____ Date_____ DOB_____

Vaccines for Children Program (VFC) Eligibility

_____ Unknown

_____ Not VFC Eligible

_____ AHCCCSC Medicare/Medicaid

_____ American Indian/ Alaskan Native

_____ Uninsured

_____ Kids Care