580 New Waverly Place, Ste. 120, Cary, NC 27511 (919) 858-8360*(919) 858-8408(f)

PATIENT INFORMATION

Patient's Social Sec No.	Patient's Name (First, MI, Last)	Date of Birth	Age	Sex

Address	City	State	Zip

Home Phone Number	Work Phone Number	Cell Phone #	E-mail Address (optional)	
Name of Spouse or next of Kin	Relationship	Home Phone #	Work Phone #	Cell Phone #

PAYMENT INFORMATION AND AUTHORIZATION

Your insurance company will be billed for covered services within 3 days after your visit. Non-covered services that you receive will be billed to the patient and/or responsible party listed above. Parents or guardians are responsible for payment with regards to a minor. The balance of your account will be due and payable if your insurance company has not paid within 30 days.

I hereby authorize **MacGregor Family Physicians, PA** to release information compliant with all of the Hipaa regulations. By my signature and copies thereof, I authorize payment directly to **MacGregor Family Physicians, PA** of payments otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. If my account is turned over to an attorney for collections, I will be responsible for all attorney fees, which are usually 35% of the unpaid balance and all court costs incurred.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT

SIGNATURE_____ **DATE:**_____

MEDICAL INFORMATION

Family Members Names	Date of Birth /	Relationship

List all current medication, Prescription, over the counter, vitamins, herbs and dosage

Medication	Dosage	Frequency

List any allergies, drug sensitivities and reactions you have had in the past

1. Do you use tobacco products?_____What kind do you use?_____

2. How many per day?_____If you smoked the past when did you quit?_____

3. Do you drink alcoholic beverges?_____If so, how much?_____

4. When was your last Physical Exam?_____Women: Mammogram_____

5. Date of Last: Chest X-ray_____TB Skin test_____Results_____

   Eye exam_____Tetanus Shot_____

6. Past Hospitalizations/Surgeries (List dates and Reason):

_____: _____

_____: _____

_____: _____

_____: _____

_____: _____

7. Family History: Please check if a blood related member of your family has had any of the following:

_____TB _____Heart Disease _____Bleeding Tendency _____Rheumatic Fever_____
_____Diabetes _____Anemia _____High blood pressure _____Mental Disease_____
_____Arthritis _____Lung Disease _____Cancer _____Glaucoma _____Kidney Disease
_____Thyroid Disease _____Strokes _____Other Diseases:_____

8. Other areas of concern that you wish to discuss with your physician?_____

9. List any chronic diseases you may have:_____

IMPORTANT INFORMATION ABOUT YOUR HEALTH MAINTENANCE EXAMINATION

Our primary concern at MacGregor Family Physicians, PA is to provide you with quality healthcare. To this End, your health maintenance exam will include those procedures and diagnostic studies that aid in the prevention and detection of disease based on your age, sex and past medical history. At the time you are seen in our office, we do not know what is a covered benefit. The organization that you work for has determined what type of coverage you will receive. We are more than willing to provide health care within your insurance contract guidelines if you inform us at the time services are to be rendered. Otherwise any non-covered charges are your responsibility and payable upon receipt of your first bill. With your cooperation, we can provide you with quality healthcare and enable you to receive the insurance benefits to which you are entitled.

I have read and understand the policy stated above and accept financial responsibility as described

_____ _____

Patient Signature/Guardian signature Today's date