TRIANGLE COMMUNITY PHYSICIANS

PATIENT INFORMATION

MR# _____ Physician: _____

NAME_____, _____ _____
LAST FIRST MIDDLE INITIAL

ADDRESS _____
CITY STATE ZIP

DATE OF BIRTH_____SEX M/F SOCIAL SECURITY #:_____

RACE_____ LANGUAGE _____ ETHNICITY_____

PRIMARY PHONE: _____SECONDARY PHONE:_____
(Home/Cell) (Home//Cell/Work/Other)

SINGLE/MARRIED/DIVORCED/WIDOWED RELATIONSHIP TO INSURANCE SUBSCRIBER
CIRCLE ONE SELF/SPOUSE/CHILD/OTHER

EMPLOYER _____EMPLOYER PHONE_____

EMPLOYER ADDRESS_____
CITY STATE ZIP

RESPONSIBLE PARTY_____PHONE_____

ADDRESS_____
CITY STATE ZIP

PRIMARY INSURANCE

INSURANCE NAME _____ID# _____

GROUP #_____SUBSCRIBER NAME_____

SUBSCRIBER DATE OF BIRTH_____SUBSCRIBER SSN _____

SECONDARY INSURANCE

INSURANCE NAME_____ID#_____

GROUP #_____ SUBSCRIBER # _____

SUBSCRIBER DATE OF BIRTH_____SUBSCRIBER SSN _____

EMERGENCY CONTACT_____PHONE #_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN, REALIZING I AM RESPONSIBLE TO PAY ANY CO-PAY, CO-INSURANCE AND NON-COVERED SERVICES AND I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE NECESSARY MEDICAL INFORMATION REQUIRED BY THE INSURANCE COMPANY NEEDED TO PROCESS CLAIMS.

_____
SIGNED (PATIENT OR PARENT IF MINOR) DATE

TRIANGLE COMMUNITY PHYSICIANS, P.A.
ADULT HEALTH HISTORY FORM

Name:_____ Today's Date:_____

Age: _____ Date of Birth:_____ Date of last Physical: _____

Reason for visit/health issues to discuss:

1._____ 3._____

2. _____ 4. _____

MEDICAL HISTORY		SURGICAL HISTORY	
Year	Medical problems/Illness/Hospitalization ❑ None	Year	Prior Surgeries/Operations ❑ None

CURRENT MEDICATIONS including over-the-counter medicines, herbs, vitamins, birth control pills	ALLERGIES medications/foods
❑ None	❑ None
Local Pharmacy:	
Mail in pharmacy:	

CHILDHOOD ILLNESSES	
Chicken pox ❑ had disease ❑ Never ❑ Received vaccine	Mumps ❑ Received vaccine ❑ had disease ❑ Never
Measles ❑ Received vaccine ❑ Never ❑ had disease	Rheumatic fever ❑ Never ❑ had disease

VACCINATIONS		
Tetanus vaccine: Date:	❑ Under 10 years ago	❑ Over 10 years ago
Hepatitis B vaccine	❑ Not received	❑ Completed series (3 shots)
HPV vaccine (cervical cancer):	❑ Not received	❑ Completed series (3 shots)
Pneumonia vaccine Date:	❑ Not received	
Zostavax (shingles vaccine) Date:	❑ Not received	

PLEASE COMPLETE BACK SIDE OF FORM ➔

HEALTH MAINTENANCE					
Stress Test	Date:	❑ Never	Mammogram	Date:	❑ Never
Colonoscopy	Date:	❑ Never	Bone Density testing	Date:	❑ Never

WOMEN'S HEALTH (if applicable)			
Pregnancies		**Birth control:** ❑none ❑pills ❑patch ❑IUD ❑tubal ligation ❑vasectomy ❑withdrawal ❑ Condoms ❑trying to get pregnant	**Pregnancy complications:** ❑ None ❑ Diabetes ❑ Blood pressure ❑ Other _____
Total number pregnancies			
Full term infants		**Menstrual periods:** Last period:_____ Age at 1st period: _____ Age at menopause_____	**Pap smears**: Date: _____ Abnormals? Have you ever had any STD's? ■ No ❑ Yes Specify:
Premature infants			
Abortions/Miscarriages			
Living children			

SOCIAL HISTORY	
Marital status: ❑single ❑married ❑divorced ❑widowed	**Caffeine:** Type, Amount and how often: ❑ None
Occupation:	**Exercise:** Type and how often: ❑ None
Education: highest level completed: ❑ Middle school ❑ GED ❑ High school grad ❑ 2yr college/technical school ❑ BS/BA College graduate ❑ Graduate School ❑ PhD/professional school	**Diet:** ❑ No specific ❑ Diabetic ❑ Vegetarian ❑Low fat/low cholesterol
Type Sex partners: ❑ Men ❑Women ❑Both Number of sex partners: Lifetime: Last 6 mo:	**Illicit drugs:** ❑never ❑current ❑quit ❑ Marijuana ❑ Cocaine ❑ IV drugs
Tobacco: ❑never ❑current ❑quit Average amount: How long?:	**Pets in home:** ❑ cat(s) ❑ dog(s)
Alcohol: ❑Never ❑occasional ❑regular ❑ former alcoholic Average amount:	**Living Will:** ❑ Do not have one ❑ have one ❑ would like to discuss Current status: ❑ full code ❑ Limit futile treatment ❑ DNR

FAMILY HISTORY			
	Age/Age of death	Illnesses	Cause of death
Father	❑Living ❑Deceased		
Mother	❑Living ❑Deceased		
Brothers	❑Living ❑Deceased		
	❑Living ❑Deceased		
	❑Living ❑Deceased		
	❑Living ❑Deceased		
Sisters	❑Living ❑Deceased		
	❑Living ❑Deceased		
	❑Living ❑Deceased		
	❑Living ❑Deceased		
Children	❑Living ❑Deceased		
	❑Living ❑Deceased		
	❑Living ❑Deceased		
	❑Living ❑Deceased		

TRIANGLE COMMUNITY PHYSICIANS, P.A.
4309 Medical Park Drive
Durham, NC 27704
(919) 471-4484

Robert C. Pennington, MD John A. Kallianos, MD Kombiz P. Klein, DO

Practice Information

Insurance

You must bring your insurance card(s) with you to each appointment. Our office will gladly file your insurance if we are given correct information. If you give us incorrect insurance information, there will be a $6 "refile" charge that is not payable by your health plan. In the event that your insurance company does not cover a service rendered, you understand you will be financially liable for the medical service and/or supplies. It is the patients' responsibility for knowing the details of your coverage, as it is a contract between you and the insurance company.

Patients who do not present an insurance card or have no insurance will be responsible for payment at the time of service unless other arrangements are made with our billing department prior to the visit. We accept Cash, Check, MasterCard, and Visa. Please note there is a $25 charge for a returned check.

No Shows

There may be a $35 charge for appointments not canceled within 24 hours of the appointment time or for a same day work-in appointment that is not kept. This $35 charge is not payable by your health plan. Repeated failures to keep scheduled appointments will result in dismissal from the practice.

Prescriptions

Medication Refills: All medication refill requests must come from your pharmacy. They will fax a request for the desired medication(s). Requests for refills left on our voice mail will not be accepted. Please allow 48 hours for routine prescription to be refilled.

NEW prescriptions

There will be a $20 charge for prescriptions that are not part of an office visit or part of a continuing medical problem for which we are treating. Your health plan does not cover this charge. This charge does NOT apply to refills on existing prescriptions or to new prescriptions started directly relating to a recent office visit.

Forms

Please allow 7 business days for any form(s) to be completed. At the discretion of the physician there may be a charge of $10 to $15 dependent on what information the form requires.

_____
Patient/Guardian Signature

_____
Date

Triangle Community Physicians, P.A
Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records.
We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____Signature: _____ Date: _____

Compliance assurance notification for our patients

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule."
We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

If it is your desire for our office to discuss your medical information with someone other than yourself, please indicate his or her name below.

Name: _____
Please Print

TRIANGLE COMMUNITY PHYSICIANS, PA
4309 MEDICAL PARK DR., SUITE 200. DURHAM, NC 27704
Phone: 919-471-4484 Fax: 919-477-6131

Robert C. Pennington, MD John A. Kallianos, MD Kombiz P. Klein, DO

CHECK OUT INSTRUCTIONS

A. Our phone system is constantly being improved to better serve the patients and while we wish we could answer every phone call with a person, this is simply not possible. These instructions will reduce the number of unnecessary calls to the office and will help allow us to better serve you.

B. Routine medical problems requiring medications are required to have a follow up appointment, which should be made at the time of check out.

C. Prescriptions will be provided for the time between scheduled appointments unless otherwise arranged by your physician. Therefore, routine refills should not be required between appointments**. If you do require a refill, please contact your pharmacy who will notify us for approval.**

D. You should receive a reminder call of your appointment made by our Housecalls computer program; however, it is still your responsibility to know when your appointment is scheduled and be there accordingly.

E. Special tests require a follow up appointment to go over results. Exceptions may be made by individual physicians. If there are any immediate problems, you will be contacted directly. This should eliminate your need to call our office for results.

F. **Laboratory results will be sent to you in a letter within two weeks.** Some tests like PAP smears, bone densitometries, and sleep studies may take a longer period of time. Please allow us this time to notify you before you contact the office.

G. Most form completion requests will require an appointment. Please allow two weeks for non-urgent and 72 hours for urgent forms to be completed. Some forms may have a completion charge.

H. Visits to see our primary nurses will be done on a scheduled basis. Coumadin checks, B12 shots, testosterone shots, and Depo-Provera shots are examples of nursing visits requiring an appointment. Special consults for blood pressure checks, diabetes teaching, insulin instruction and other services will be scheduled as an appointment. In many cases there will be a nursing visit charge.

I. Mail order prescriptions are generally filled out and returned to the patient to mail back to the company. We do not fax these forms unless an exception has been made by your physician.

J. Same day appointments, same day cancellations or nurse triage call extension 241, all other nurse questions call ext. 242.