Hampstead Family Medicine
25 N. Hampstead Village Dr.
Hampstead, NC 28443
P: 910.803.0340

Fax: 910.259.3013
www.hampsteadfamilymedicine.com

Primary Care in Burgaw
306 S. Campbell St.
Burgaw, NC 28425
P: 910.259.3377

Patient Intake Form

PATIENT DETAILS

Last Name:____

First Name: ______________________ Middle Name:______________

Suffix: __________ Date of Birth: __________ Gender: Male Female Other

Street Address: ____

City: ______________________ State: ______ Zip Code: ______________

Home Phone: __________________ Mobile Phone: ______________

Email: ______________________________ SSN: ______________

Ethnicity/ Race: __________________ Primary Language: ______________

Marital Status: SINGLE MARRIED DIVORCED SEPARATED WIDOWED

Spouses Name: ____________________ Spouses Phone: ______________

INSURANCE DETAILS

Primary Insurance Company: ____________________________________

Group Number: ________________ Policy ID Number: ________________

Primary Insurance Type: HMO PPO Medicare Medicaid Other

Policy Holder: SELF SPOUSE OTHER

Policy Holder Name: __________________ Date of Birth: ______________

Policy SSN: ______________________

Secondary Insurance Company: __________________________________

Group Number: ________________ Policy ID Number: ________________

Secondary Insurance Type: HMO PPO Medicare Medicaid Other

Policy Holder: SELF SPOUSE OTHER

Policy Holder Name: __________________ Date of Birth: ______________

Policy SSN: ______________________

Patient Name: ______________________________ DOB: ______________

TREATING PHYSICIANS

Previous Primary Care Physician: ______________________________
Phone: ______________

Specialist Providers:
1. ______________________ Phone: ______________
2. ______________________ Phone: ______________
3. ______________________ Phone: ______________
4. ______________________ Phone: ______________
5. ______________________ Phone: ______________

ALLERGIES

Allergy: ______________________ Reaction: ______________________
Allergy: ______________________ Reaction: ______________________
Allergy: ______________________ Reaction: ______________________
Allergy: ______________________ Reaction: ______________________
Allergy: ______________________ Reaction: ______________________

CURRENT MEDICATIONS

Medication Name: ______________________________
Strength: ____________ Frequency: ____________ Prescriber: ____________
Medication Name: ______________________________
Strength: ____________ Frequency: ____________ Prescriber: ____________
Medication Name: ______________________________
Strength: ____________ Frequency: ____________ Prescriber: ____________
Medication Name: ______________________________
Strength: ____________ Frequency: ____________ Prescriber: ____________
Medication Name: ______________________________
Strength: ____________ Frequency: ____________ Prescriber: ____________
Medication Name: ______________________________
Strength: ____________ Frequency: ____________ Prescriber: ____________
Medication Name: ______________________________
Strength: ____________ Frequency: ____________ Prescriber: ____________
Medication Name: ______________________________
Strength: ____________ Frequency: ____________ Prescriber: ____________
Medication Name: ______________________________
Strength: ____________ Frequency: ____________ Prescriber: ____________
Medication Name: ______________________________
Strength: ____________ Frequency: ____________ Prescriber: ____________

Patient Name: ______________________ DOB: ______________

FAMILY HEALTH HISTORY

Relative:	Condition:	Living/Deceased:	If deceased, at what age?
		☐ ☐	
		☐ ☐	
		☐ ☐	
		☐ ☐	
		☐ ☐	
		☐ ☐	
		☐ ☐	
		☐ ☐	
		☐ ☐	

SURGICAL HISTORY

Description: ______________________ Doctor: ______________________
Location: ______________________ Year: ______________________

Description: ______________________ Doctor: ______________________
Location: ______________________ Year: ______________________

Description: ______________________ Doctor: ______________________
Location: ______________________ Year: ______________________

Description: ______________________ Doctor: ______________________
Location: ______________________ Year: ______________________

Description: ______________________ Doctor: ______________________
Location: ______________________ Year: ______________________

SOCIAL HISTORY

Do you currently consume alcohol? YES/NO ☐ ☐

If yes, how many drinks per week? ______________________

Do you currently smoke? YES/NO ☐ ☐

What do you smoke? TOBACCO MARIJUANA OTHER

If yes, how many cigarettes daily? ______________________

Do you or have you ever used illicit/recreational drugs? YES/NO ☐ ☐

If yes, what types? ____

____

Patient Name: ______________________ DOB: ______________

	YES/NO
Do you consume caffeine?	☐☐

If yes, how frequently? ______________________

	YES/NO
Do you exercise regularly?	☐☐

If yes, what types? ______________________

____

	YES/NO
Do you follow a specific diet?	☐☐

If yes, what diet? ______________________

	YES/NO
Are you currently sexually active?	☐☐

Only Continue if you answered yes above:

	YES/NO
Do you use protection?	☐☐

If yes, what type(s)? ______________________

	YES/NO
Are you currently pregnant?	☐☐
Are you planning to become pregnant?	☐☐
Would you like to be tested for STIs?	☐☐
Do you have any children?	☐☐

If yes, how many? ______________________

When was the first day of your last menstrual cycle? ______________________

PREFERRED PHARMACY

Pharmacy Name: ______________________ Phone: ______________

Address: ______________________ City: ______________

State: ______________ ZIP: ______________

Patient Name: ______________________ DOB: ______________

PERSONAL HEALTH HISTORY

Do you have a history of any of the following?

	YES / NO		YES / NO
Acne	☐ ☐	Hypertension	☐ ☐
Anemia	☐ ☐	Male Hypogonadism	☐ ☐
Arthritis Conditions	☐ ☐	Hypothyroidism	☐ ☐
Asthma	☐ ☐	Chronic Infection	☐ ☐
Atrial Fibrillation	☐ ☐	Insomnia	☐ ☐
Bleeding Disorders	☐ ☐	Irritable Bowel Syndrome	☐ ☐
Benign Prostatic Hyperplasia	☐ ☐	Kidney Disease	☐ ☐
Coronary Artery Disease	☐ ☐	Menopause	☐ ☐
Cancer	☐ ☐	Migraines/Headaches	☐ ☐
Cardiac Arrest	☐ ☐	Neuropathy	☐ ☐
Celiac Disease	☐ ☐	Onychomycosis	☐ ☐
Chest Pain	☐ ☐	Organ Injury	☐ ☐
Congestive Heart Failure	☐ ☐	Osteoporosis	☐ ☐
Chronic Fatigue Syndrome	☐ ☐	Pulmonary Embolism	☐ ☐
Depression	☐ ☐	Seizure Disorder	☐ ☐
Drug/Alcohol Abuse	☐ ☐	Skin Conditions	☐ ☐
Erectile Dysfunction	☐ ☐	Shortness of Breath	☐ ☐
Fibromyalgia	☐ ☐	Sinus Conditions	☐ ☐
GERD	☐ ☐	Stroke	☐ ☐
Heart Disease	☐ ☐	Tremors	☐ ☐
Hyperlipidemia	☐ ☐	Other	☐ ☐

SKIN HEALTH QUESTIONAIRRE

Do you have any conditions that could be stimulated or adversely affected by heat? YES/NO ☐☐

Explain here:

____

____

Do you have any specific concerns about your skin? YES/NO ☐☐

Explain here:

____

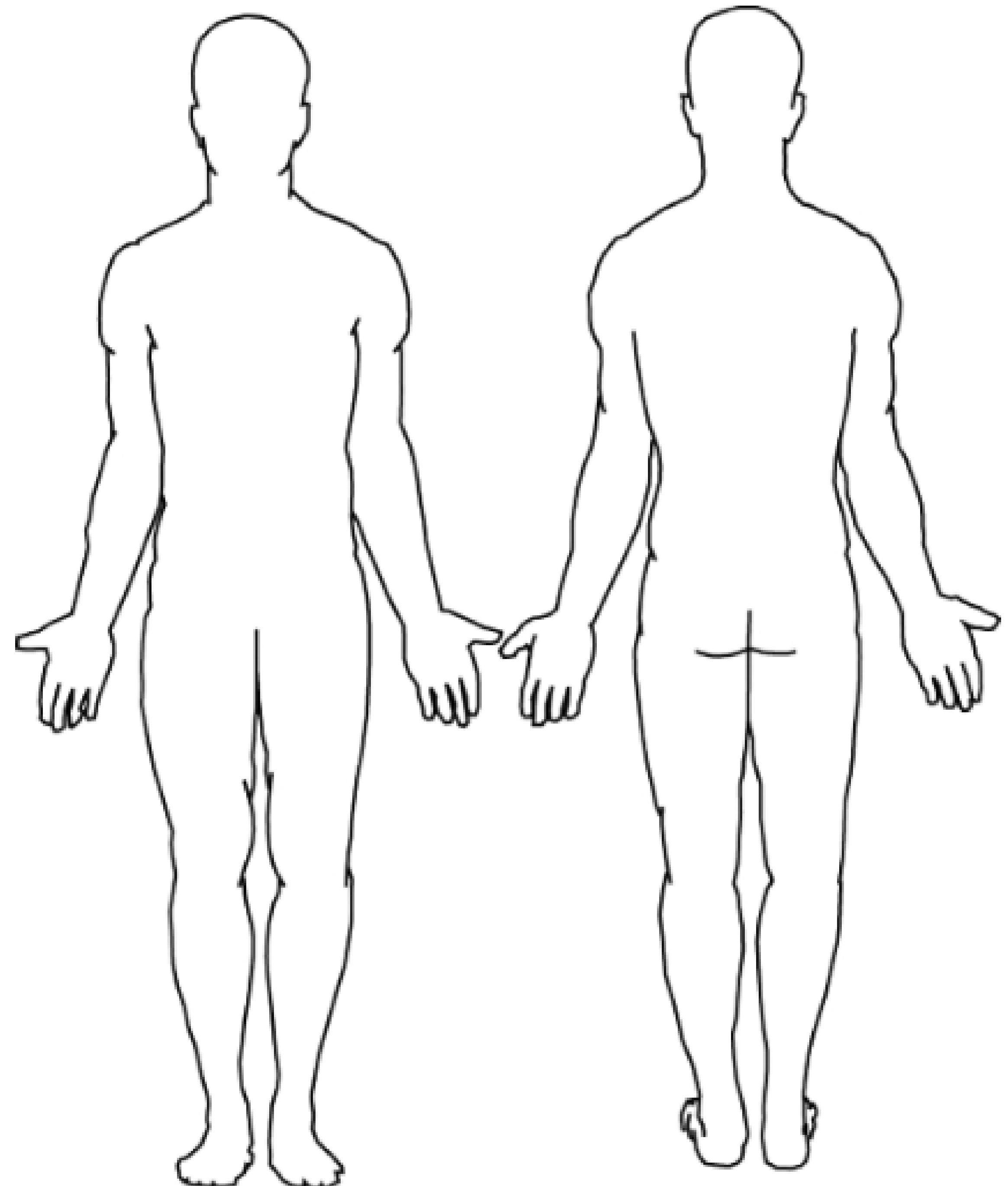
____

Patient Name: ____________________ DOB: ____________________

Do you feel that your skin is affected by any of the following?

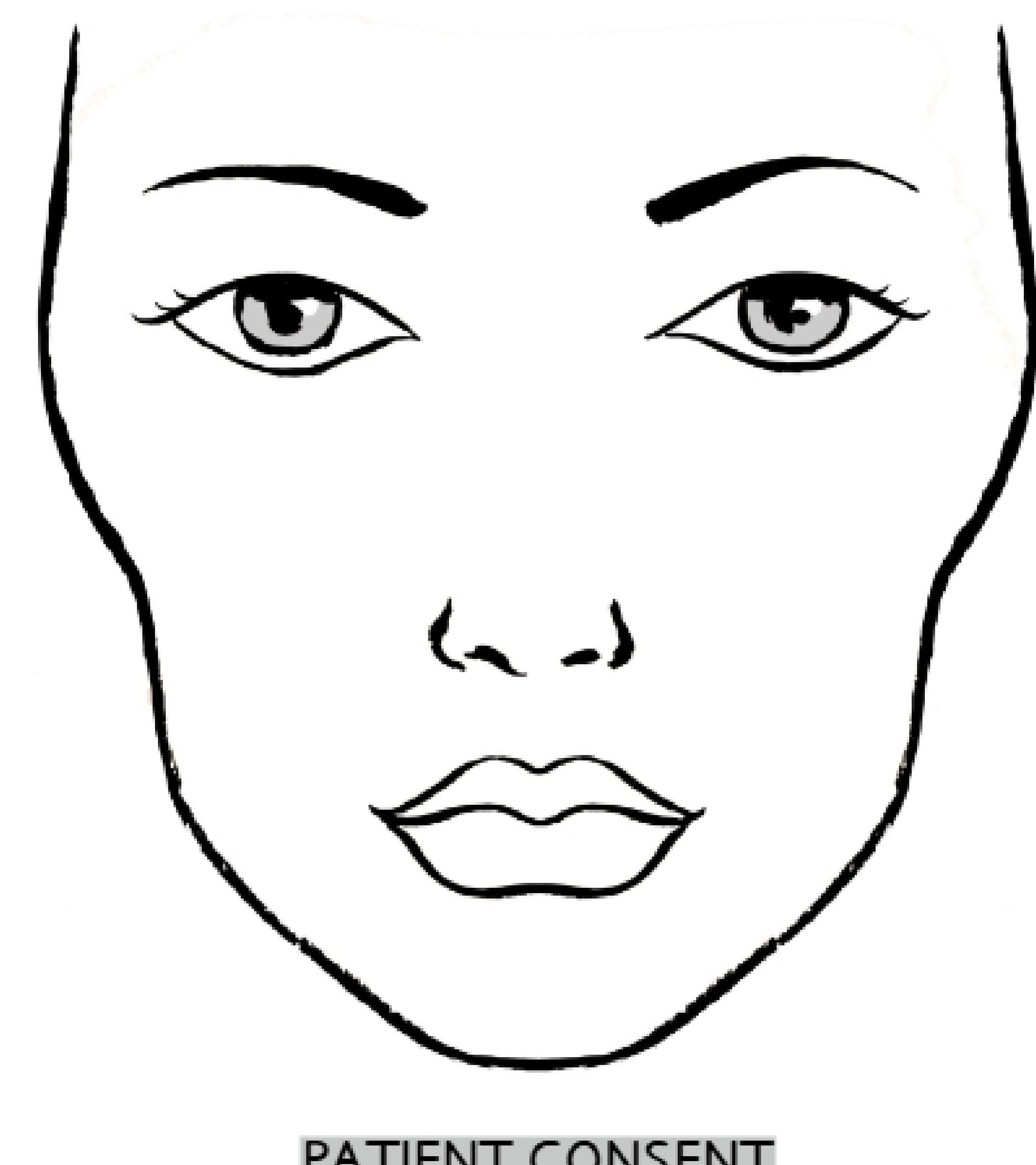
	YES / NO
Acne Scars	☐ ☐
Fine Lines	☐ ☐
Cellulite	☐ ☐
Crepey Skin	☐ ☐
Excessive Sweating	☐ ☐
Oversize Pores	☐ ☐
Photoaging (Sun Damage)	☐ ☐
Sagging Skin	☐ ☐
Scarring	☐ ☐
Skin Texture Issues	☐ ☐
Skin Laxity (Looseness)	☐ ☐
Stretch Marks	☐ ☐
Wrinkles	☐ ☐
Other: ____________________	☐ ☐

Which areas of the body do you feel are affected by the issues listed above?



Patient Name: ______________________________ DOB: ______________________

Which areas of your face do you feel are affected by the conditions that are listed on the previous page?



PATIENT CONSENT

By signing below, I hereby acknowledge, agree, and authorize the following:

A.) Accurate Information: I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.
B.) Patient Rights & Responsibilities: I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have a right to view this facility's Notice of Privacy Practices prior to signing this form.
C.) Release of Medical Information: I authorize that the release of my health information to the healthcare facility in accordance with this healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing information to my referring physician, primary care physician, and any physicians I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.
D.) Consent to Treat: I grant the healthcare facility, including its affiliated providers, physicians, other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.

Patient Name: ______________________________ DOB: ______________

E.) Consent for Communication: I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email or channels.
F.) Acknowledgement: By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient Signature: ______________________________

Print Name: ______________________ Date: ______________________

PATIENT PORTAL

Hampstead Family Medicine has made your healthcare information easily accessible by providing patients the opportunity to create a Patient Portal. The Patient Portal allows you to view test results, request appointments and prescription refills, update your personal information, pay balances on your account, and send messages to your provider. To enroll in the patient portal, scan the QR code provided to be directed to the website to create your account.

Sign In to Your Portal

Log in with athenahealth

Create an Account

Enrolling for multiple family members?
Ask one of our staff members how you can manage your entire family from one email address.

Follow us on our social media platforms for updates about the office and be sure to give us a review!

@hampsteadfamilymedicine

Hampstead Family Medicine

Patient Name: ______________________________ DOB: ______________

Office Policy Agreement

Thank you for choosing Hampstead Family Medicine for your healthcare needs. We strive to provide the best possible service to our patients. To make your visit as pleasant as possible and prevent future misunderstandings regarding appointments and billing, please read and familiarize yourself with the following policies and procedures.

1. Office hours are Monday-Thursday 8am-12:30pm and 1:30pm-5pm and Friday 8am-12:30pm. For after hour emergencies, do not wait for care. Please visit your nearest emergency department if needed.
2. We ask that all patients complete their new patient paperwork prior to their scheduled appointment. If you are unable to obtain the paperwork before your appointment, plan to arrive 15-20 minutes early to complete the necessary forms and ensure you are seen at your scheduled appointment time.
3. Please bring all medication bottles of each medication you are currently taking to each visit.
4. Patient demographics are updated continuously. Please be mindful when checking in for your appointment that our Front Office staff will verify all demographic information.
5. Please notify our staff if you are unable to keep your appointment within 24 hours of your appointment date and time. Failure to provide adequate notice will result in a NO SHOW fee. Please review the NO SHOW policy on the following page.
6. If you are more than 15 minutes late for your appointment, we reserve the right to reschedule your appointment for a later date.
7. Please be considerate if the office is running behind. Emergencies occur, and each patient will be treated with the time and care that is requires to address their concerns.
8. Children under the age of 18 will be required to have a parent present in office during the time of their visit. Children ages 16 and over will not require the parent to be in the room during their visit.
9. Prescription refills will be provided at the time of your appointment in quantities sufficient enough to last until your next visit. If refills are needed before your appointment, please utilize the patient portal to initiate a refill request or contact your pharmacy. Please allow 72 hours for your request to be processed.
10. Refill requests for controlled medications will noy be processed without an appointment. NO EXCEPTIONS.
11. Termination of the Physician-Patient relationship can occur at the request of either party at any time when the relationship is no longer proceeding in a mutually productive manner. If you are dismissed from the practice by your provider, emergency care will continue for an additional 30 days following your dismissal allowing you appropriate time to find another provider. Circumstances that may result in dismissal from the practice include but are not limited to:

Noncompliance with treatment
Failure to keep scheduled appointments
Threatening, demanding or abusive behavior directed toward our staff, physicians, other healthcare providers or fellow patients
Deceptive behavior
Medication abuse
Failure to pay consistent with payment policy listed
Patient choice to terminate relationship
Medical records will be faxed to ONE provider as a one time courtesy by our office. Should you require additional copies of medical records, there is a charge for this service.
*0-25 pages/0.75 per page
*26-75 pages/0.25 per page
*75 or more pages $75.

12. If you require a hospitalization, please list Hampstead Family Medicine as your primary care provider so that we receive discharge summaries related to your admission.
13. We participate with most major insurance plans. If you are unsure whether your insurance is in network with our practice, please call the member services number on the back of your card to inquire.
14. Please be aware that you will be responsible for any portion of your bill that is not paid by your insurance company.
15. We are obligated by contract to collect all co-payments at the time of srvices rendered. If you do not have your co-pay at the time of visit, we reserve the right to reschedule your appointment.
16. Insurance claims and appeals are filed in a reasonable timeframe and followed up on by our billing department. If you are experiencing difficulties ot delays with your insurance company in the payment of claims, it is your responsibility to ensure your insurer abides by your plan.
17. Patients are responsible for any unpaid balance and will be notified of the balance monthly. Following 90 days of notice, the balance will be turned over to a collection agency and the patient will be responsible for the additional fees of said agency. Failure to remit payment on a past due account can result in dismissal from the practice. Patients with balances of over $75.00 will not be seen until the balance is paid by at least 50% at the time of service. NO EXCEPTIONS.
18. All returned checks will be charged a $35 returned check fee.
19. If you are unisured, payment will be due at the time of services rendered. This includes payment for any point of care testing, injections, labwork, etc that may be needed. An initial office visit fee of $40 will be collected at check-in and any additional fees will be applied at the concusion of your visit.

Patient Name (PRINTED):____

Patient Signature: ______________________________________ Date: ____________

Office Witness: ______________________________________ Date: ____________