Stephen R. McIntyre, M.D.

REGISTRATION FORM

Section I: Patient Information Date_____

Name:_____ I Prefer to be called: _____

Address:_____City:_____State:_____Zip:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____
The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_____ Social Security Number:_____ Race: _____ Sex: ____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School:_____ City/State:_____ ☐ FT ☐ PT
Your Employer:_____ Work Phone: (_____)_____
Email Address: _____ Preferred Language: _____

Whom may we thank for referring you? _____
Person to contact in case of emergency:_____ Phone:_____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Date of Birth: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer:_____ Work Phone: (____)_____ SSN#: _____

Section III Insurance Information

Name of Insured:_____ DOB:_____ Relationship to Patient:_____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City:_____State:_____Zip: _____
Insurance Company:_____ Grp #:_____ ID#: _____
Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured:_____ DOB:_____ Relationship to Patient:_____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City:_____State:_____Zip: _____
Insurance Company:_____ Grp #:_____ ID#: _____
Ins Co Address:_____ Ins Co. Phone:_____

Authorization To Release Information – Assignment of Insurance, Medicare, & Medicaid Benefits

I hereby authorize direct payment of surgical/medical benefits to Stephen R. McIntyre, MD, for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize Stephen R. McIntyre, MD to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

Signature
Patient/Guardian:_____ **Date:**_____

Patient Name: Date of Birth: Occupation:

Has any BLOOD RELATIVE ever had:	Circle Yes or No		Who/Which side of your family (Mother/Father)
Asthma	No	Yes	
Bleeding Disorder	No	Yes	
Cancer	No	Yes	What type of cancer?
Diabetes	No	Yes	What type? (Insulin Dependent, Type II, Other)
Epilepsy (Seizures)	No	Yes	
Heart Disease	No	Yes	
High Cholesterol	No	Yes	
High Triglycerides	No	Yes	
Hypertension	No	Yes	
Stroke	No	Yes	
Thyroid Disease	No	Yes	
Tuberculosis	No	Yes	

PERSONAL HISTORY

Please Answer No or Yes to All Items

Illnesses YOU Have Ever Had

Anemia	No	Yes
Asthma	No	Yes
Arthritis or Rheumatism	No	Yes
Bladder Disease	No	Yes
Cancer – Type	No	Yes
Colitis or Other Bowel Disease	No	Yes
Diabetes – Type	No	Yes
Epilepsy (Seizures)	No	Yes
Hay Fever	No	Yes
Heart Disease	No	Yes
Heart Murmur	No	Yes
Hemorrhoids or Any Rectal Disease	No	Yes
Hernia	No	Yes
High Blood Pressure	No	Yes
Hives or Eczema	No	Yes
Kidney Disease	No	Yes
Liver Disease	No	Yes
Meningitis	No	Yes
Migraine Headache	No	Yes
Nervous Breakdown	No	Yes
Peptic (Stomach) Ulcer	No	Yes
Rheumatic Fever	No	Yes
Thyroid Disease – **Hyper or Hypo** (circle one)	No	Yes
Venous Disease	No	Yes
Any Other Disease – List	No	Yes
ALLERGIES YOU Have		
Penicillin	No	Yes
Sulfa	No	Yes
Aspirin, Codeine, or Morphine (circle)	No	Yes
Mycins or other Antibiotics	No	Yes
Merthiolate or Mercurochrome	No	Yes
Any other Drugs	No	Yes
Any Foods	No	Yes
Adhesive Tape	No	Yes
Nail Polish or other Cosmetics	No	Yes
Tetanus Antitoxin or Serums	No	Yes
Latex	No	Yes
Other	No	Yes

Please Answer No or Yes to All Items

Injuries YOU Have Ever Had

Broken or Cracked Bones (which bones)	No	Yes
Concussions or Head Injury	No	Yes
Ever been Knocked Unconscious	No	Yes
If yes, When and How		

WEIGHT Now	WEIGHT 1 Yr Ago
Maximum Weight was when?	

TRANSFUSIONS		
Ever had a Blood or Plasma Transfusion?	No	Yes

SURGERY – Have you had?			
Appendectomy	No	Yes	Date
Cataract	No	Yes	Date
Coronary By-Pass	No	Yes	Date
Gall Bladder	No	Yes	Date
Hernia	No	Yes	Date
Hysterectomy	No	Yes	Date
Tonsillectomy	No	Yes	Date
Tubal Ligation	No	Yes	Date
Any Other Surgery			
What?			Date

Have you ever been advised to have any surgical Operation which has not been done?	No	Yes

Have you been hospitalized for any illness?	No	Yes

Do you smoke?	No	Yes
Ever Smoked? Type of Tobacco	No	Yes
How many years?		
When did you quit?		
Do you drink?	No	Yes
Alcoholic Beverage Type?		
Amount?		
Caffeine	No	Yes
What type?		
Amount per day?		

Stephen R. McIntyre, MD PLLC

Stephen R. McIntyre, MD **May Lee, FNP-C** **Kenneth Anderson, PA-C**
1940 Briarwood Drive - Suite B 828-294-1116 (P)
Hickory, NC 28602 828-294-0096 (F)

Triple Authorization Form

Assignment & Release:

I, the undersigned, have insurance with (name of carrier) _____ and assign directly to Stephen R. McIntyre, M.D. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I further authorize Stephen R. McIntyre, M.D. to disclose information in my medical records, including current and previous medical records, to other physicians and health care providers to whom Dr. McIntyre may refer me for treatment.

X_____ X_____
Date Signature

Minor/Child Consent

I, being the parent or guardian of _____ do hereby request and authorize Stephen R. McIntyre, M.D. and his staff to perform necessary services for my child, including but not limited to, x-rays, and administration of anesthetics which are deemed advisable by the physician, whether or not I am present at the actual appointment when the treatment is rendered.

X_____ X_____
Date Signature

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

X_____ X_____
Date Signature

PATIENT ACKNOWLEDGMENT AND CONSENT

For New Patients Only

I have been given a copy of Stephen R. McIntyre MD PLLC's Notice of Privacy Practices, version effective 09/23/2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

_____

_____

FOR Stephen R. McIntyre MD PLLC USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

_____

_____

Stephen R. McIntyre, MD PLLC

Stephen R. McIntyre, MD **May Lee, FNP-C**
Kenneth Anderson, PA-C **Dale P. Wicker, FNP-BC**
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HIPAA Form

Due to Federal Legislation concerning the privacy of patient information, it is necessary for you to let us know the best way to inform you of your (or your child's) private medical information.

Patient Date of Birth _____

I, _____ (adult patient's name) OR

I, _____, the parent or guardian of

_____ (minor child) desire to be notified of medical

as follows: (Check all that apply):

_____ MAIL the information.

_____ LEAVE A MESSAGE on my answering machine at home (#_____)

or on my cell phone (#_____).

_____ DISCUSS ONLY WITH ME on the telephone. My daytime phone numbers are:

Home #:_____ Work #:_____

_____ You may also discuss my medical information with:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Please sign and date below:

Signature:_____ Date:_____

Signature:_____ Date:_____

Signature:_____ Date:_____

IF ANY INFORMATION CHANGES, YOU ARE RESPONSIBLE FOR INFORMING OUR OFFICE. CHANGES REQUIRE COMPLETION OF A NEW HIPAA FORM.