# Med One Medical Group
## Patient Demographics (please print)

Name: ______________________________________________ Chart #__________
First Middle Last
Date of Birth ________________ Age _____ Sex _____ Marital Status ___________
Social Security # ________-_______-________ Race _____________

Ethnicity (please check one) ☐ Non-Hispanic ☐ Hispanic ☐ Declined/Unavailable
Preferred Language ______________________________

Address ______________________________________________ Apt _____
City ______________________________ State _________ Zip Code ________

E-mail Address ______________________________________________
Cell Phone ______________________ Home Phone __________________________

I authorize voice messages to be left on my Cell/Home phone: Yes or No

Employer ______________________ Occupation __________________________

Name of Healthcare Proxy/ Caregiver______________________________________

**Emergency Contact:**

Name & Relationship ______________________________ Phone________________

Whom do you authorize to pick up your Prescriptions: __________________________

**Insurance:**

Policy Holder's Name ________________________ Date of Birth _____________
Relationship to you _______________________ Social Security _____ - ____ - ________
Address ____________________________________________________ Apt _____
City __________________________ State _______ Zip Code _______________

***Whom may we thank for referring you?*** __________________________________

**Signature:** ________________________________ **Date:** _____________

**MED ONE**
**MEDICAL GROUP**

CARA DAVIS, MD
GARY GRUBER, DC

7019 HARPS MILL RD., STE. 200
RALEIGH, NC 27615

PHONE: 919-850-1300
FAX: 919-850-0012

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patients Name: ____________________ Date of Birth: ____________________

Previous Name: ____________________ Med One Chart #: ____________________

**A.** I request and authorize the ***release*** of my healthcare information of the patient named above ***to***
Practice Name: ____________________

Address: ____________________

City: ____________________

Phone: ____________________ Fax: ____________________

**B.** I request and authorize Med One Medical Group to ***obtain*** my healthcare information of the patient named above ***from***
Practice Name: ____________________

Address: ____________________

City: ____________________

Phone: ____________________ Fax: ____________________

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition, or dates:
- ☐ ____________________
- ☐ All healthcare information
- ☐ Other: ____________________

Patient Signature: ____________________ Date: ____________

**THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT'S SIGNED.**

*****Copying Fees: $0.75 per pg. (1-25), $.050 per pg (26-50), and $0.25 per pg (51+) *****

# POLICIES, ASSIGNMENT, AND AUTHORIZATION OF BENEFITS

Chart #_________

Pt. Name ___________________________ Date of Birth__________________

Insurance Company ________________

I certify all information I have supplied to this office is true and accurate to the best of my knowledge. I will notify Med One Medical Group of any changes in my insurance status or any other pertinent information.

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any services rendered by Med One Medical Group. If the bill remains unpaid, and no satisfactory arrangements have been made and executed then the account will be reported to the credit bureau and assigned for collections.

I understand and agree that I am personally responsible for any bills or fees incurred by failing to give 24 hours notice to cancel or reschedule an appointment.

I hereby admit that I do not have Medicare nor Medicaid as my primary nor secondary insurance. If I have Medicare/Medicaid, no claims from this office will be filed to my insurance. I will be seen by this office on a self-pay basis only.

I irrevocably assign to you, my insurance company, authorize, and direct you to pay Med One Medical Group the proceeds and such sums as may be due and owing to Med One Medical Group for professional services rendered to me for medical reasons. I understand that this in no way relieves me of my primary obligation to pay for such services and that the signing of this form does not prohibit customary billing by the doctor. All bills are expected to be paid promptly in the usual manner.

I hereby instruct and direct you, my insurance company, to pay by check made out and mailed to:

Med One Medical Group<br>
7019 Harps Mill Rd., Ste. 200<br>
Raleigh, NC 27615

This is a DIRECT assignment of my rights and benefits under this policy. Payment for such amounts to the above providers in whole or part shall constitute payment as if said payment were made directly to me.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to my insurance company, adjuster, or attorney involved in this case.

I authorize Med One Medical Group to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature: _________________________________ Date: ____________________

Witness: ___________________________________

# Med One Medical Group
# Medical History

Chart: ________

| Relation | Date of Birth | State of Health | Age at Death | Cause of Death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brother(s) | | | | |
| | | | | |
| | | | | |
| Sister (s) | | | | |
| | | | | |
| | | | | |
| | | | | |

Check if your blood relatives have any of the following:

| | Disease | Relationship |
|---|---|---|
| | Arthritis/Gout | |
| | Asthma/Hay Fever | |
| | Cancer (please specify) | |
| | Chemical Dependency | |
| | Diabetes | |
| | Heart Disease/Strokes | |
| | High Blood Pressure | |
| | Kidney Disease | |
| | Thyroid Disease | |
| | Other (please specify) | |

**Hospitalizations**

| Year | Hospital | Reason & Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Have you ever had a blood transfusion?

☐ Yes ☐ No

If yes, please give approximate dates: ____________________

| SERIOUS ILLNESS/INJURY | DATE | OUTCOME |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Pregnancy History**

| Year | Sex | Complications |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Health Habits**

Check which substance you use and describe how much you use.

| | Substance | |
|---|---|---|
| | Exercise | |
| | Tobacco | |
| | Drugs | |
| | Alcohol | |
| | Other | |

**Occupational Concerns**

Check if your work exposes you to the following:

| | Exposure |
|---|---|
| | Stress |
| | Hazardous Substances |
| | Heavy Lifting |
| | Other |
| | Your Occupation: |

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ Signature ________ Date

______________________________ Reviewed By ________ Date

# MED ONE MEDICAL GROUP

Patient Name: ______________________ Date of Birth: ___________ Date: ________ Chart:_________

Please check all that apply to you:

**ALLERGIES:**
- ☐ No problems
- ☐ Hives/skin rashes
- ☐ Runny nose
- ☐ Food allergies
- ☐ Other: _____________________
- ☐ Itchy eyes
- ☐ Hay Fever
- ☐ Sneezing
- ☐ Mold

**CARDIOVASCULAR:**
- ☐ Ankle swelling
- ☐ Chest pain
- ☐ Palpitations
- ☐ Hypertension
- ☐ Other: ___________________
- ☐ Irregular heartbeat
- ☐ Painful legs
- ☐ Shortness of breath
- ☐ Varicose veins

**GENERAL/CONSTITUTIONAL SYMPTOMS:**
- ☐ Appetite change
- ☐ Chills
- ☐ Dizziness
- ☐ Fever
- ☐ Fatigue
- ☐ Other: ______________
- ☐ Headache
- ☐ Hot flashes
- ☐ Nausea
- ☐ Vomiting
- ☐ Sleep problems
- ☐ Weight changes

**EARS, NOSE, MOUTH, and THROAT:**
- ☐ Blisters in mouth
- ☐ Cough
- ☐ Difficulty hearing
- ☐ Difficulty swallowing
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Jaw pain
- ☐ Nasal pain
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Ear pain
- ☐ Other: ____________

**ENDOCRINE:**
- ☐ Cold intolerance
- ☐ Dry skin
- ☐ Flushing
- ☐ Hair Loss
- ☐ Heat intolerance
- ☐ Other: ____________________________
- ☐ Diabetes
- ☐ Menopause
- ☐ Sluggish
- ☐ Height loss
- ☐ Thirst

**EYES:**
- ☐ Blurred vision
- ☐ Dry eyes
- ☐ Eye discharge
- ☐ Loss of vision
- ☐ Other: _______________________
- ☐ Eye pain
- ☐ Photosensitivity
- ☐ Visual changes
- ☐ Watering eyes

**GASTROINTESTINAL:**
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Blood in stool
- ☐ Constipation
- ☐ Rectal Bleeding
- ☐ Other: _____________________________
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ IBS

**GENITOURINARY:**
- ☐ Abnormal PAP
- ☐ Blood in urine
- ☐ Overactive bladder
- ☐ Decreased libido
- ☐ Urinary problems
- ☐ Other: ________________
- ☐ Vaginal discharge
- ☐ Painful testicles
- ☐ Erectile dysfunction
- ☐ Menstrual pain

Date of last PAP _______
Date of last period ______

**HEMATOLOOGIC/LYMPHATIC:**
- ☐ Bleeding problems
- ☐ Blood clotting problems
- ☐ Swollen lymph nodes
- ☐ Other: _____________________________
- ☐ Bruise easily
- ☐ Anemia

**PSYCHIATRIC:**
- ☐ Mood changes
- ☐ Anxious
- ☐ Suicidal thoughts
- ☐ Other:__________________
- ☐ Panic attacks
- ☐ Depression

**INTEGUMENTARY (SKIN)**
- ☐ Acne
- ☐ Blisters
- ☐ Boils
- ☐ Change in mole
- ☐ Other: ____________________________
- ☐ Breast lump
- ☐ Non-healing wound
- ☐ Eczema
- ☐ Dry skin

**MUSCULOSKELETAL:**
- ☐ Arthritis
- ☐ Back pain
- ☐ Joint pain
- ☐ Neck pain
- ☐ Other: ____________________
- ☐ Leg pain
- ☐ Muscle pain
- ☐ MVA injury
- ☐ Sciatica

**NEUROLOGICAL:**
- ☐ Migraine
- ☐ Confusion
- ☐ Vertigo
- ☐ Seizures
- ☐ Difficulty concentrating/speaking
- ☐ Syncope
- ☐ Tremors
- ☐ Paralysis
- ☐ Other: _________

**RESPIRATORY:**
- ☐ Asthma
- ☐ Breathing difficulty
- ☐ Pneumonia
- ☐ Coughing up sputum
- ☐ Other: __________________________
- ☐ Dyspnea
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Wheezing

**CURRENT MEDICATIONS (include dosage)**

**Pharmacy #** ____________________________

_______________________________________

_______________________________________

_______________________________________

**ALLERGIES:**

________________________________________

________________________________________

________________________________________

________________________________________

Chart:

# Med One Drug Testing Protocol

**Objective**: The staff of Med One Clinic is committed to providing effective treatment to patient's suffering from disorders requiring treatment with controlled substances. This treatment includes, but is not limited to, the use of opioid analgesics, narcotic pain medications, benzodiazepines, amphetamines and stimulants. Due to the epidemic of Americans abusing prescription medications, and in order to monitor and account for the patient's compliance in taking their medication as prescribed, all patient's will be subject to oral or urine drug screening.

**Circumstance for Drug Screening:**

**New Patients- Oral or Urine Drug Screening:** All prospective patients who, if accepted, will be prescribed any controlled substance medication must submit a saliva or urine sample for drug testing prior to receiving prescription

**Existing Patients- Oral or Urine Drug Screening:** All existing patients who are currently taking a controlled substance, needing refills, will be required to submit a saliva or urine sample for drug screening prior to next refill of medication. All existing patients who are requiring a new start of a controlled prescription will be required to submit a saliva or urine sample for drug testing prior to receiving prescription.

**Routine Screening**: After first initial saliva or urine drug screen, all patients on continually refilled controlled substances will be required to participate in drug screening intermittently, and up to twice yearly, at the practice. If a patient is unable to comply with routine drug screening, the prescription will not be refilled until screening occurs.

**Pregnancy Testing:** All women of childbearing age prescribed a controlled substance will be required to be screened with a urine pregnancy test. This includes a urine HCG in office prior to any new start of a controlled substance, as well as routine screening every 6 months with urine HCG if prescription is continually prescribed. If the results are positive, patient will be tapered off medication if harmful to pregnancy, and no longer will be prescribed medication by Med One while pregnant or breast feeding. To resume medication treatment with clinic after pregnancy, they will need clearance from OBGYN and/or Medically Certified Midwife stating they are no longer breastfeeding. At that time, she will also be required to re-submit an oral or urine drug screening test with Med One.

** Under all patient circumstances, it will be the provider's discretion that will determine whether oral, urine, or both will be required as samples for drug screening.

**Drug Testing based on Risk Assessment (For Cause)**

The provider reserves the right to obtain a random drug screen during an appointment if there is reason to suspect non-compliance with medication. Any patient will be called to come to the clinic to submit a drug screen if adequate cause exists. The following justifies adequate cause:

a) A call has been placed to the clinic from another prescribing office or pharmacist that patient is abusing or diverting his/hers controlled prescription

b) Any patient who displays behavior, signs or symptoms consistent with withdrawal.

c) Any patient who displays behavior indicating a loss of their normal mental or physical faculties

**Drug Testing based on Prescription Drug Monitoring Program (PDMP) Documentation** The clinic staff may query the name of any patient who is receiving a controlled substance, from a clinician at our clinic, through our state PDMP. If information is found indicating that one of our patients appears to be obtaining

controlled medications from another practitioner, during a period of time that would run concurrent with the prescription that the patient received from this clinic, our staff shall verify this information with the pharmacy and/or clinician identified on the PDMP report. If this report is found to be true, any controlled prescriptions that were prescribed from clinicians at Med One will no longer be refilled. Pt will reserve rights to continue medical care at the clinic, but will no longer have privileges to be prescribed controlled medications from Med One.

**Refusing or Cannot Provide Saliva or Urine Sample for Drug Testing:** Any patient who refuses to provide a saliva or urine sample for drug testing shall not receive a prescription for a controlled substance.

**Drug Screening Procedures:**

Employees are responsible for:

1. Requesting samples from patients
2. Receiving samples from patients
3. Complete and submit all documentation required by the clinic and drug testing laboratory
4. Place samples in a secured area
5. Maintain chain of custody in all saliva and urine samples
6. Package and distribute saliva and urine samples to laboratory
7. Receive all laboratory confirmations
8. Provide clinicians with laboratory results

** Results of oral drug screen can take up to 72 hours before clinic receives them. They are not known at the time of appointment. **

**Use of Saliva or Urine Drug Screening Results**

**New Patients:** All new patients requiring a prescription for a controlled substance at time of appointment will submit an oral or urine drug screen, as well as be screened by the PDMP. At that time, if deemed a candidate for therapy with a controlled substance, the patient will receive up to a 7 day prescription for controlled substance. After that time, if drug screen is consistent with patient's medication use history, the patient may be prescribed a longer length of medication therapy by provider. If the patient is positive for a controlled medication not prescribed to patient, or illegal substance at the time of drug screening, the patient will no longer receive controlled substances from Med One at that time. If a patient states that he/she is currently prescribed a daily controlled medication, and it does not appear positive in his/her drug screen, they will no longer be able to be prescribed controlled medications at Med One.

**Existing Patients**: All existing patients currently prescribed a controlled substance will be screened with oral or urine drug test intermittently, up to twice yearly after initial test. If a new start of a controlled medicine is required, the patient will also complete a drug screen prior to new medication prescribed. If a patient fails to show up for a screening at least twice in a Calendar year, the patient will not receive a refill of medication until drug screen is completed in office. If the patient is positive for a controlled medication not prescribed to patient, or illegal substance at the time of drug screening, the patient will no longer receive controlled substances from Med One at that time. If a patient is prescribed a daily controlled medication, and the prescribed medications do not show positive in drug screen, they will no longer be able to be prescribed controlled medications at Med One.

By signing this document, I ___________________________, have reviewed and agree to the drug screening protocol and standards set in place by Med One

Patient Signature: ___________________________________ Date:_____________

Provider Signature:__________________________________ Date:_____________

## The Patient Health Questionnaire (PHQ-9)

Patient Name ______________________________ Date of Visit ____________

| Over the past 2 weeks, how often have you been bothered by any of the following problems? | Not At all | Several Days | More Than Half the Days | Nearly Every Day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling asleep, staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

**Column Totals** _____ + _____ + _____

**Add Totals Together** ______________

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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**MED-ONE MEDICAL GROUP**
7019-200 Harps Mill Road
Raleigh, NC 27615
Phone: 919-850-1300 Fax: 919-850-0012

**PATIENTS NAME**______________________________ **MR #**____________________

## CPE Form / New Patients

1. When was your last complete physical? ________________________________________
2. When was your last Pap (females)? ________________________________________
3. When was your last mammogram (females)? ____________________________________
4. Have you had a bone density scan? ______ Date? ______________________________
5. Have you had a colonoscopy (patients over 50)? ______ Date? ____________________
6. Did you get a flu vaccine this year?______ If yes Date and where _________________
7. Have you had the pneumonia or shingles vaccines?______________________________
8. Have you had a Tetanus shot?________ When?_________________________________
9. Do you see any specialists?____________________________________________

    ________________________________________________________________________
10. If not USA, what is your country of origin and preferred language?_________________

    ________________________________________________________________________