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 and appt. Text reminders to be left on my Cell 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: _____
Whom do you authorize to Speak to a Provider on your behalf: _____
Whom do you authorize to have Access to your Medical Records: _____

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:

Practice Name: _____

Address: _____

City: _____

Phone: _____ Fax: _____

To Release my MEDICAL RECORDS TO: MED ONE MEDICAL GROUP, please mail the records to the above address

IF THE RECORD IS MORE THAN 25 PAGES PLEASE MAIL IT TO THE ABOVE ADDRESS.

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 than the account will be assigned for collections including collection and attorney fees, if applicable.

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
7019 Harps Mill Rd., Ste. 200
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

Chart: _____

Medical History

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

Pregnancy History

Year	Sex	Complications

Have you ever had a blood transfusion?

☐ Yes ☐ No

If yes, please give approximate dates: _____

SERIOUS ILLNESS/INJURY	DATE	OUTCOME

Health Habits

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

	Exercise	
	Tobacco	
	Drugs	
	Alcohol	
	Other	

Occupational Concerns

Check if your work exposes you to the following:

	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

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?_____

    _____