

**MUSC**  
**CAROLINA FAMILY CARE**  
**INTERNAL MEDICINE**

Physician: \_\_\_\_\_

Date: \_\_\_\_\_

**Patient Information:**

Last Name	First	M.I.	Birth Date	Age	Gender
			( )		
Address	City	State	Zip	Home Phone	
			( )		
Soc. Sec. #	Employer	Address		Work Phone	
			( )		
Birthplace	Marital Status			Cell Phone	
Emergency Contact		Relation	Home Phone	Work Phone	Cell Phone

I, \_\_\_\_\_, do hereby authorize a representative from Carolina Family to speak with the following person(s) regarding my health care. Please note that without your authorization, we are not allowed by law, in most circumstances, to discuss any information about your healthcare.

Name	Phone number	Medical Care	Appointments	Financial
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you give the above representative authorized access to information regarding the following information?

*I do* *I do **not*** (circle one) authorize release of information to the above named individual(s) related to AIDS (acquired immunodeficiency syndrome), HIV (Human Immunodeficiency syndrome), sexually transmitted disease, psychiatric care/assessment and treatment for alcohol or drug abuse. Cross out any topics which you do not want information released.

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Witness

\_\_\_\_\_  
 Date

**MUSC**  
**Carolina Family Care-Internal Medicine**  
**Health History Form**

Your answers will help us understand your medical concerns and conditions. If you don't remember specific details, please give us your best guess. Thank you.

Age \_\_\_\_\_ How would you rate your overall health?  Excellent  Good  Fair  Poor

Main reason for today's visit: \_\_\_\_\_

Allergies to medications or foods: \_\_\_\_\_

**Your medical history.** Please check any that apply, including in the distant past. We will go over details during your visit.

	Yes	No		Yes	No		Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Any Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	COPD (emphysema)	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Reflux (heartburn)	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Colon disease	<input type="checkbox"/>	<input type="checkbox"/>	Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>

Other (including any surgeries and hospitalizations): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Health screening:** Please give the dates of your last test for the following.

Lipid (cholesterol)	Date _____	Abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Colonoscopy	Date _____	Abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any polyps? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mammogram	Date _____	Abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pap smear	Date _____	Abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PSA (prostate)	Date _____	Abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dexa scan (bone density)	Date _____	Abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Immunizations:** Please give the dates of your last immunizations for the following.

Tetanus _____	Pneumovax (pneumonia) _____
Tdap (tetanus & pertussis) _____	Zostivax (shingles) _____

**PLEASE TURN OVER**

Are you married?  Yes  No

Kids  Yes  No

Occupation \_\_\_\_\_

**Tobacco use:**

I have never smoked

I am a former smoker. Year you quit: \_\_\_\_\_ Average packs/day \_\_\_\_\_ Number of years \_\_\_\_\_

Current smoker: Average packs/day \_\_\_\_\_ Number of years \_\_\_\_\_

Other tobacco use: \_\_\_\_\_

**Alcohol use:**

Do you drink alcohol?  Yes  No

How many drinks per week: \_\_\_\_\_

**Exercise:** Do you exercise regularly?  Yes  No

What kind of exercise? \_\_\_\_\_

How long? (minutes) \_\_\_\_\_ How often? \_\_\_\_\_

If you don't exercise, why? \_\_\_\_\_

**Family History:** Please indicate whether any relatives (parent, sibling, child, grandparent) have had any of the following conditions. If yes, please indicate which relative.

	Yes	No		Yes	No
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/ clotting	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Eye disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>

Is your mother living?  Yes  No Age now or age she died \_\_\_\_\_

Is your father living?  Yes  No Age now or age he died \_\_\_\_\_

How many brothers? \_\_\_\_\_

How many sisters? \_\_\_\_\_

Other: \_\_\_\_\_

Have you completed a Living Will and/or Durable Power of Attorney for Health Care?  Yes  No

What other health concerns do you have? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature**

**Carolina Family Care  
East Cooper Internal Medicine  
1208 Two Island Court  
Mt. Pleasant, SC 29466**

I, \_\_\_\_\_, do hereby authorize a representative from CFC-East Cooper Internal Medicine to speak with the following person(s) regarding my: **Please check all that apply.**

Name	Relationship	Phone Number	Medical Care	Appointments
_____	_____	_____	*	*
_____	_____	_____	*	*
_____	_____	_____	*	*

Do you give the above representative authorization to the following information?

\*I do \* I do **NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV ( Human Immunodeficiency) Infection, sexually transmitted diseases, psychiatric care, psychological assessment and treatment for alcohol and/or drug abuse.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**This form will be part of your permanent medical record. Should any changes need to be made, please notify us immediately.**

# MUSC ORGANIZED HEALTHCARE ARRANGEMENT CAROLINA FAMILY CARE

## Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Carolina Family Care and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations. I/we have read or have had read to me this consent and understand and agree to its contents.

\_\_\_\_\_  
Initials

## Authorization for Release of Information and Assignment of Insurance Benefits

My physician is authorized to release any medical information required in the processing of applications or submission of information for financial coverage, including information referring to psychiatric care, drug and alcohol abuse, sexual assault, or tests for infectious diseases including AIDS/HIV for services provided during this admission. I/we also agree to the release of medical or other information about me to government regulatory agencies (federal or state) as required by law. For Medicare/Medicaid beneficiaries – I/we have provided all necessary information for proper assignment of Medicare/Medicaid benefits.

\_\_\_\_\_  
Initials

## Agreement of Financial Responsibility

I/we guarantee payment of all charges associated with services received from Carolina Family Care (CFC) or other related medical organizations, including University Medical Associates (UMA), Medical University Hospital Authority (MUHA), or any other related organization on behalf of the named patient. I/we agree to assign any insurance benefits or other funding to Carolina Family Care. I understand it is my responsibility to verify participation status of the physician with my health plan prior to the patient's visit and to obtain all authorization as required by my health plan prior to the patient's visit.

\_\_\_\_\_  
Initials

## H.I.P.A.A. (Health Insurance Portability and Accountability Act) Notification:

I acknowledge my receipt of a copy of the MUSC Organized Health Care Arrangements Notice of Privacy Practices.

\_\_\_\_\_  
Initials

## Agreement of Financial Responsibility for Non-Covered Services (Not applicable for all patients)

By signing and dating this form, I am indicating that I have been informed by Carolina Family Care or other related organization that the services the patient will receive today may not be covered because of the reason indicated below.

(Patient to Initial the appropriate section if applicable.)

- \_\_\_\_\_ CFC/the rendering physician is not a contracted/credentialed provider for your health plan. You will be responsible for any amounts not covered by your insurance plan.
- \_\_\_\_\_ Your insurance carrier/primary care physician has not provided a referral/authorization for today's service. You will be responsible for any amounts not covered by your insurance plan.
- \_\_\_\_\_ Your condition may be considered pre-existing based on the length of your coverage under your insurance plan. You may be responsible for the entire cost of the service.
- \_\_\_\_\_ Your service may not be considered medically necessary by your insurance plan. You may be responsible for the entire cost of the service.
- \_\_\_\_\_ Other reason: \_\_\_\_\_

I understand that the consent for medical treatment, authorization for release of information, assignment of insurance benefits, and agreement of financial responsibility will be valid for one year from the date of signature and can only be revoked upon written notice. By signing below, I/we acknowledge that this consent form has been read in full and explained as necessary.

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Signature of Patient (Parent or Legal Guardian)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Guarantor (if different from the patient)