Kintegra Health

School Health Alliance FOR FORSYTH COUNTY
Keeping students healthy, fit and ready to learn.

ADULT Patient Information

PATIENT DEMOGRAPHICS

DATE OF COMPLETION *(mm/dd/yyyy):* _____

Legal Name (Last, First, MI):	***Preferred Name:***	***Primary Doctor:***

Date of Birth (mm/dd/yyyy):

_____ /_____ /_____

SSN: _____-_____-_____

Race:
- ☐ Black/African American
- ☐ White
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ More than one race
- ☐ Unreported/Refuse to report race

Ethnicity:
☐ Hispanic ☐ Non-Hispanic

Birth Sex:
☐ Female ☐ Male ☐ Other ☐ Undefined

Sexual Orientation:
- ☐ Straight or Heterosexual
- ☐ Lesbian, gay or homosexual
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not answer

Gender Identity*: *(Check one)
- ☐ Male
- ☐ Female
- ☐ Transgender Male/Female-to-Male
- ☐ Transgender Female/Male-to-Female
- ☐ Gender Queer
- ☐ Other, please specify: _____
- ☐ Choose not to answer

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed/widower

Home Address:	***City***	***State***	***Zip code***

Home Phone:	***Cell Phone:***	***Work Phone:***	***Email Address:***

Preferred method of communication: ☐ Postal Mail ☐ Phone ☐ Email ☐ Text

Emergency Contact 1:	***Relationship:***	***Home Phone:***	***Cell Phone:***
Emergency Contact 2:	***Relationship:***	***Home Phone:***	***Cell Phone:***

Responsible Party:	***Relationship:***	***Date of Birth*** (mm/dd/yyyy):	**SSN**:
		_____ /_____ /_____	_____-_____-_____

Responsible Party Home Address:	***City***	***State***	***Zip code***

Employer/School:

Footnote: Kintegra Health, with headquarters in Gastonia, North Carolina, includes Kintegra Medical, Dental, Integrated Medicine, and Behavioral Health Practices throughout North Carolina. ***Affiliate***: Local Health Departments: Catawba, Davie, Davidson, Forsyth, Gaston, Iredell, Lincoln, Mecklenburg.
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PATIENT CONSENTS

Patient Name: _____ Date of Birth: _____

Consent for Healthcare and Release of Personal Health Information:

I voluntarily consent to comprehensive healthcare treatment including medical care and behavioral healthcare services that the providers and staff of SHA, Kintegra Health, Inc. and all its affiliates. I consent to all necessary treatment of illness and injuries and preventative care including screenings, lab work, (including HIV testing), immunizations, and referrals. I am aware that neither the practice of medicine nor the delivery of mental/behavioral health treatment is an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I understand that SHA/Kintegra employs a "team based" approach to the delivery of healthcare and that health information may be exchanged between Kintegra providers and staff members involved in my care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of Protected Health Information (PHI) about me for treatment, payment, and healthcare operations. I understand that my medical information could include medical history or information regarding diagnosis and treatment for a communicable disease (such as a sexually transmitted infection, HIV/AIDS or hepatitis), mental illness, alcohol or substance use. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Title's V, XVIII, and/or XIX of the Social Security Act is correct. I certify that I have read and understand this form. I understand that I am automatically enrolled in the Health Information Exchange, but at any time can opt-out by completing an Opt-out form provided by my provider. This consent is renewable annually. I may withdraw authorization for services at any time. **Initial _____**

Notice of Privacy Practice Acknowledgement:

We are required by law to provide you with our Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you as follows: http://www.kintegra.org, by writing to Kintegra Health Privacy Office, 200 E. Second Ave, Gastonia, NC 28052, or by requesting one at any Kintegra Health Provider locations. **Initial _____**

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Kintegra Health and its affiliates for all charges for services provided to me unless specifically waived based on family size and income, in accordance with the Kintegra Health Billing Policy. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of medical, surgical, and behavioral health benefits, which would otherwise be payable to me, to Kintegra Health for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, VIII, and/or XIX of the Social Security Act is correct. **Initial _____**

_____ _____

Signature of Patient or Authorized Person | Date

INSURANCE INFORMATION

Primary Insured's Name: _____ ***Date of Birth (mm/dd/yyyy)*** | ***SSN:*** _____-_____-_____ _____ /_____ /_____		***Primary Insurance Address:***		
Primary Insurance:	***Employer:***	***City:***		
Insurance ID Number:	***Group Number:***	***State:***	***Zip Code:***	***Phone Number:***

Permission to Communicate - Authorization for Release of Information

Name of Patient: _____ **Date of Birth (MM/DD/YYYY):** _____

School Health Alliance for Forsyth County is authorized to release protected health information about the above named patient in the following manner and to identified persons.

So that Kintegra Health may serve you better, you have the option of providing us with a list of caregivers with whom we may discuss your appointments, referrals, test, lab results and any other health information.

Who can receive information	**Describe the information to be released.** Check each that can be given to the person on the left in the same section.
Primary Care Physician: (Provider and/or Name of Office: _____	☐ Medical (appointments, referrals, test and lab results and any other health information) ☐ Other_____
Other person(s): Name / Phone Number / Relationship: _____ _____ _____	☐ Medical (appointments, referrals, test and lab results and any other health information) ☐ Other _____
☐ Email communication - Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Medical (Appointments, referrals, test and lab results and any other health information)
☐ Text communication – Provide phone number* _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ *For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand I am automatically enrolled in the Health Information Exchanges, but at any time can opt-out by completing an Opt-Out form provided by my provider.

This authorization will remain in effect until revoked by the patient.

_____ _____ Date _____

Signature of Patient or Personal Representative

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Date Completed _____

Name _____ Date of Birth _____

Preferred Pharmacy _____

Reason for Visit _____

Please take time to fill out this form. Thank you for trusting us with your care.

PATIENT MEDICAL HISTORY

☐ Blood Disease	☐ Heart Disease	☐ Osteoporosis
☐ Breast Disease	☐ High Blood Pressure	☐ Rheumatology/Arthritis
☐ Cancer	☐ HIV	☐ Skin Problems
☐ Diabetes/Thyroid Problems	☐ Kidney Problems	☐ Stroke/Seizures
☐ Female Problems	☐ Lung Problems (COPD, Asthma)	☐ Stomach Problems
☐ Head, Eyes, Ear, Nose, Throat	☐ Male Problems	☐ STI/STD
	☐ Mental Illness	☐ Other

LAST SPECIALTY VISIT/HOSPITALIZATION/SURGERY

Reason Date

_____

_____

☐ None

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children	Don't Know
Bleeding Problems	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes/Thyroid Problems	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐	☐	☐
Mental Illness /Depression	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Stroke/Seizures	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐

MEDICATION

List any prescription and non-prescription medication you take regularly (include OTC, herbals, vitamins, etc.)

_____

_____

_____

_____

ALLERGIES

Allergies **Reaction**

_____

_____

☐ No Known Allergies