

NEW PATIENT INFORMATION

First Name		MI	Last		
Address		Apt/Unit #	City	State	Zip Code
DOB	SSN		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Preferred Language
Phone (H)	Cell		PREFERRED METHOD OF CONTACT: <input type="checkbox"/> Phone (Voice) <input type="checkbox"/> Text <input type="checkbox"/> Email		
Email Address:					
Employer		Employer Phone		Occupation	
<input type="checkbox"/> Workers Comp Case					
RACE			ETHNICITY		MARITAL STATUS
<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Other/Decline <input type="checkbox"/> Hispanic Native Hawaiian/Other Pacific			Hispanic/Latino Not Hispanic/Latino Declined		Single Married Widowed Divorced
HOW DID YOU HEAR ABOUT US? Drive By Google Website Insurance Referral Facebook Physician/Provider Referral Friend/Family			REASON FOR YOUR VISIT TODAY:		
Emergency Contact Name			Phone		Relationship to Patient
INSURANCE INFORMATION					
Primary Insurance:		Relationship to Insured <input type="checkbox"/> Primary (Self) <input type="checkbox"/> Dependent		Name & DOB of Primary Holder Name: _____ DOB: _____	
Secondary Insurance:		Relationship to Insured <input type="checkbox"/> Primary (Self) <input type="checkbox"/> Dependent		Name & DOB of Primary Holder Name: _____ DOB: _____	
Self Pay: <input type="checkbox"/> YES <input type="checkbox"/> NO					
FINANCIAL RESPONSIBILITY					
IF PATIENT IS A MINOR, PLEASE FILL OUT BELOW					
Responsible Party Name		Relationship to Patient		SSN	DOB
Primary Phone		Address			

Patient Name: _____

Patient DOB: _____

PREFERRED PHARMACY			
Pharmacy Name	Pharmacy Address (if known)	City	Phone

CURRENT MEDICATIONS		
PLEASE LIST ALL MEDICATIONS AND DOSAGES YOU ARE TAKING AS WELL AS OVER THE COUNTER MEDICATIONS		
NAME OF MEDICATION	STRENGTH	FREQUENCY TAKEN

ALLERGIES			
PLEASE LIST ALL ALLERGIES TO MEDICINE AND FOODS AND YOUR REACTIONS			
NAME OF MEDICATION	REACTION	NAME OF FOOD	REACTION

SURGICAL HISTORY	
TYPE OF SURGERY	DATE OF SURGERY (IF KNOWN)

Patient Name: _____
Patient DOB: _____

MEDICAL HISTORY
HAVE YOU HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING

<input type="checkbox"/> Acid Reflux/GERD	<input type="checkbox"/> COPD	<input type="checkbox"/> Obesity
<input type="checkbox"/> Acne	<input type="checkbox"/> Depression	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Psychiatric Issues
<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> STD
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hypothyroidism	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Cholesterol	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Insomnia	

Type: _____

FAMILY HISTORY

RELATIVE	CIRCLE ONE: Alive or Deceased	AGE (or age deceased)	Heart Disease	Diabetes	Colon/Rectal Cancer	Prostate Cancer	Depression	Alcohol/Drug Abuse	Thyroid Issue	Other:
Father	Alive Deceased									
Mother	Alive Deceased									
Father's Father	Alive Deceased									
Father's Mother	Alive Deceased									
Mother's Father	Alive Deceased									
Mother's Mother	Alive Deceased									

SOCIAL HISTORY	HEALTH SCREENINGS
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Do you smoke? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, how many per day? Do you drink alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, number of drinks in a week? _____ Do you use drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO Type of drugs: _____	<input type="checkbox"/> Colonoscopy Date: _____	<input type="checkbox"/> Blood Work Date: _____
	<input type="checkbox"/> Bone Density Date: _____	<input type="checkbox"/> Echocardiogram Date: _____
	<input type="checkbox"/> Mammogram Date: _____	<input type="checkbox"/> EKG Date: _____
	<input type="checkbox"/> Prostate Screen Date: _____	<input type="checkbox"/> Other _____

PHYSICAL EXAM

When was your last physical exam? _____ **Doctors Name/Practice:** _____

FOR WOMEN

When was your last pap smear? _____ **Have you had a hysterectomy? Yes or No**
When was your last mammogram? _____ **If yes, full or partial Date:** _____



MEDICAL RELEASE FORM

Patient Name _____ Date of Birth _____

Address _____ City _____

_____ State _____ Zip Code _____

Phone _____

INFORMATION REQUESTED FROM

Practice Name _____ Physician Name _____

Address _____ City _____

_____ State _____ Zip Code _____

Phone _____ Fax _____

SEND MY INFORMATION/RECORDS TO

BREAM MEDICAL (STOKESDALE)

8422 US HIGHWAY 158
STOKESDALE, NC 27357
PHONE: 336-560-6033
FAX: 336-560-6044

BREAM MEDICAL (SALISBURY)

721 GROVE ST
SALISBURY, NC 28144
PHONE: 704-216-1263
FAX: 704-216-1693

I, _____ (Name), hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the physician / person/ facility/ entity

Printed Name: _____ Date: _____

Signature _____ Date: _____



HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the member(s) allowed and their relationship:

This consent was signed by: _____ (PRINT NAME PLEASE)

Signature: _____ Date: _____



NO CALL/ NO SHOW - CANCELLATION POLICY

Due to the demand for appointments with Dr. Bream and his providers, Bream Medical will charge a \$40 fee for any appointments cancelled within 24 hours of your appointment time. No call or No-Show appointments will also be charged \$45 and will not be allowed to reschedule or be seen until this fee is paid in full. We encourage everyone to be mindful and courteous of our provider's and our other patient's time.

I am aware of the Bream Medical NO CALL/ NO SHOW – Cancellation Policy and understand that I can be charged if I don't comply with their written policy.

Patient Name: _____(PRINTED)

Patient Signature: _____Date: _____