BREAM MEDICAL
URGENT CARE | TELEMEDICINE | PRIMARY CARE

NEW PATIENT INFORMATION

First Name	MI	Last		
Address	Apt/Unit #	City	State	Zip Code

DOB	SSN	Gender ☐ Male ☐ Female	Preferred Language

Phone (H)	Cell	PREFERRED METHOD OF CONTACT: ☐ Phone (Voice) ☐ Text ☐ Email

Email Address:

Employer	Employer Phone	Occupation

☐ Workers Comp Case

RACE	ETHNICITY	MARITAL STATUS
☐ White ☐ Asian ☐ Black or Africian American ☐ Other/Decline ☐ Hispanic Native Hawaiian/Other Pacific	Hispanic/Latino Not Hispanic/Latino Declined	Single Married Widowed Divorced

HOW DID YOU HEAR ABOUT US?	REASON FOR YOUR VISIT TODAY:
Drive By Google Website Insurance Referral Facebook Physician/Provider Referral Friend/Family	

Emergency Contact Name	Phone	Relationship to Patient

INSURANCE INFORMATION

Primary Insurance:	Relationship to Insured ☐ Primary (Self) ☐ Dependent	Name & DOB of Primary Holder Name: _____ DOB: _____
Secondary Insurance:	Relationship to Insured ☐ Primary (Self) ☐ Dependent	Name & DOB of Primary Holder Name: _____ DOB: _____

Self Pay:

☐ YES ☐ NO

FINANCIAL RESPONSIBILITY

IF PATIENT IS A MINOR, PLEASE FILL OUT BELOW

Responsible Party Name	Relationship to Patient	SSN	DOB

Primary Phone	Address

BREAM MEDICAL
URGENT CARE | TELEMEDICINE | PRIMARY CARE

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 MEDCINE AND FOODS AND YOUR REACTIONS

NAME OF MEDICATION	REACTION	NAME OF FOOD	REACTION

SURGICAL HISTORY

TYPE OF SURGERY	DATE OF SURGERY (IF KNOWN)

BREAM MEDICAL
URGENT CARE | TELEMEDICINE | PRIMARY CARE

Patient Name:_____

Patient DOB:_____

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

____Acid Reflux/GERD	____ COPD	____Obesity
____Acne	____Depression	____Osteoporosis
____ADD/ADHD	____Diabetes	____Psychiatric Issues
____Allergies	____Heart Disease	____STD
____Anxiety	____Hypertension	____Other:_____
____Arthritis	____Hypothyroidism	_____
____Asthma	____High Cholesterol	_____
____Cancer	____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

Do you smoke? ☐ **YES** ☐ **NO**

If yes, how many per day?

Do you drink alcohol? ☐ **YES** ☐ **NO**

If yes, number of drinks in a week?_____

Do you use drugs? ☐ **YES** ☐ **NO**

Type of drugs:

HEALTH SCREENINGS

_____**Colonoscopy** **Date:**	_____**Blood Work** **Date:**
_____**Bone Density** **Date:**	_____**Echocardiogram** **Date:**
_____**Mammogram** **Date:**	_____**EKG** **Date:**
_____**Prostate Screen** **Date:**	_____**Other**

PHYSICAL EXAM

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

FOR WOMEN

When was your last pap smear?

When was your last mammogram?

Have you had a hysterectomy? Yes or No

If yes, full or partial Date:

BREAM MEDICAL
URGENT CARE | TELEMEDICINE | PRIMARY CARE

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: 336-560-6004

☐ **BREAM MEDICAL (SALISBURY)**
721 GROVE ST
SALISBURY, NC 28144
PHONE: 704-216-1263
FAX: 704-216-1693

I,_____(Name), herby 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:_____

BREAM MEDICAL
URGENT CARE | TELEMEDICINE | PRIMARY CARE

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: _____

BREAM MEDICAL
URGENT CARE | TELEMEDICINE | PRIMARY CARE

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 is 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:_____