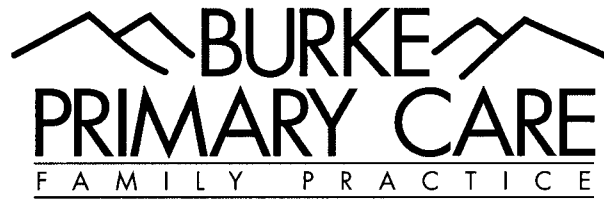


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Bill G. Vaassen, PA-C
David Lange, PA-C
Deborah F. Crawford, GNP

OFFICE USE ONLY: Patient Number: _____

Patient Name: _____ **Home Phone:** _____

Mailing Address: _____ **City:** _____

State: _____ **Zip:** _____ **Social Security #:** _____ **Birthdate:** _____

Email Address: _____ **Cell Phone:** _____

Sex: Male Female **Race:** White Black Indian Hispanic Other

Marital Status: Single Married Divorced Widow

Employer/School: _____ **Work Phone:** _____

Occupation: _____

Emergency Contact: _____

Phone: _____ **Cell Phone:** _____

Spouse or Guarantor: _____ **Date of Birth:** _____

Relationship: _____ **Employer:** _____

Mailing Address: _____ **City:** _____

State: _____ **Zip:** _____ **Social Security #:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Burke Primary Care's Notice of Privacy Practices has been provided to me for my review. I understand the purpose of this notice is to inform me of my rights regarding my Protected Health Information and also the way in which the practice may use my Protected Health Information.

Patient/Representative Signature: _____ **Date:** _____

INSURANCE ASSIGNMENT OF BENEFITS

I understand that payment is due at the time of service and that Burke Primary Care files insurance as a courtesy to our patients. I further understand that any outstanding balance will be my responsibility to pay, and failure to remit may result in termination of services and possible collection procedures.

I hereby authorize direct payment to Burke Primary Care of medical benefits otherwise payable to me, including major medical insurance, payment of surgical and medical benefits, including major medical directly to the attending physician. I understand that I am financially responsible to Burke Primary care and my physician for charges not covered by this assignment.

Furthermore, Burke Primary Care and attending physicians are authorized to release copies of my medical records and any medical information required in the processing of applications/claims for financial coverage or for payment of services rendered during the patient physician relationship.

Patient/Representative Signature: _____ **Date:** _____



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103 Medical Heights Drive
Morganton, NC 28655
Voice: (828) 437-4211

PLEASE RETURN THIS FORM WITH
RECORDS TO:
FAX: (828) 438-4109

Name: _____

Address: _____

Address: _____

Birthdate: _____

Telephone: _____

CONSENT TO RELEASE OR RECEIVE MEDICAL INFORMATION

I, hereby authorize and request that you release copies of my medical record:

TO: Burke Primary Care

FROM: Burke Primary Care

FROM: _____

TO: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

MEDICAL INFORMATION REQUESTED:

Complete Record Limit to Specific Information/Reports _____

Please Note: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes.

AUTHORIZATION:

This authorization will automatically expire 90 days from the date of signature. At that time, no express revocation shall be needed to terminate my consent, but I understand that I may revoke this consent at any time prior, except to the extent that action has been taken in reliance on this authorization.

Signed: _____ Date: _____
Parent/Guardian

OFFICE USE ONLY:
Chart #: _____ Provider: _____ Appt Date: _____ Directive: _____

CHILD'S PATIENT HISTORY FORM (BELOW AGE 12)

Please fill out the following information on your child's family history:

Relatives	Age (or Age at Death)	Health Problem (or Cause of Death)
Father		
Mother		
Sister(s)		
Brother(s)		
Grandparents		
Other Family History:		

Child's Name: _____ Grade In School: _____

Overall School Performance: _____

Are your child's vaccines up to date? Yes..... No..... Unknown Has your child ever had a "flu" vaccine?.. Yes.. No

Does your child?

Drink caffeinated beverages..... Yes..... No
 If, yes, how much _____
 Eat a Special Diet Yes..... No
 Wear a bike helmet when riding a bike Yes..... No

Exercise..... Yes..... No
 Wear a Seatbealt Yes..... No
 Practice trampoline & pool safety Yes..... No

Does your family?

Have a family fire plan Yes..... No
 Have the poison control number near the phone..... Yes..... No
 Have firearms in the home Yes..... No
 If Yes, are they safely stored Yes..... No

Have any smokers in the family Yes..... No
 Live in an older home Yes..... No
 Drink city water Yes..... No

What are your child's hobbies/interests? _____

Has your child ever been hospitalized? Yes..... No If Yes, list below

Date	Reason for Hospitalization/Surgery

List all medications currently taking (including vitamins & herbs): _____

Any known allergies? _____

List any current symptoms or concerns you would like to discuss with the doctor: _____

Please check if your child is having/had any of the following:

- | | | | |
|---|--|---|---|
| Recent vision changes <input type="checkbox"/> | Prolonged hoarseness <input type="checkbox"/> | Chronic cough <input type="checkbox"/> | Constipation <input type="checkbox"/> |
| Difficulty breathing <input type="checkbox"/> | Sore that will not heal <input type="checkbox"/> | Weight loss <input type="checkbox"/> | Chronic diarrhea <input type="checkbox"/> |
| Blood in stools or urination <input type="checkbox"/> | Change in bowel habits <input type="checkbox"/> | Enlarged lymph nodes <input type="checkbox"/> | Behavior changes <input type="checkbox"/> |

Signature of Parent/Guardian

Date