Patrick V. McConnell, PA-C
5710 Oleander Drive Suite 103
Wilmington, NC 28403
Phone: 910-772-2092
Fax: 910-772-2093

www.landfallfamilypractice.com

Today's Date: ___/____/____

PATIENT INFORMATION

Social Security #:__________________________

Patient's First Name __________________________________ MI_____ Last Name________________________________

Mailing Address: ____

City: ____State: ____________________ Zip: __________________________

Birth date: ____/______/_____ Age: ______ Sex: ☐ Male ☐ Female Married ☐ Single ☐ Divorced ☐ Widow ☐

Email Address: ____

Phone: (home) ________________________ (cell) ___________________________ (work) __________________________

Are you currently employed? If yes please list employer and job title on the line below. Retired? Disabled? Unemployed? List past occupation if applicable?

____

Highest Level of Education: ____

INSURANCE INFORMATION

Please circle primary insurance: United Health Care BCBS Aetna Cigna Medicare Medicaid Other

Please circle secondary insurance: United Health Care BCBS Aetna Cigna Medicare Medicaid Other

Policy Holder name:____ & Social Security #:__________________________

Policy holder birth date:___/____/____ Policy #: _______________________________ Group #: _________________

Patient relationship to policy holder: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of a local friend or relative (not living at same address) ____

Relationship:__________________ Phone number:______________________ alternate number:______________

In an effort to serve you better, we request that you provide us with the following information. All questions contained in this questionnaire are strictly confidential, will become part of your records, and will only be released with your written consent.

Name: ____ Date of Birth:________________

How did you learn about Landfall Family Practice, PLLC? Dr.________________ Insurance Carrier TV Website

Web Search Friend _________________ Phone Book Newspaper Mailing Hospital/Clinic Magnet

Other (be specific) ____

HEALTH HISTORY QUESTIONNAIRE

Name of previous Dr. or PCP? ______________________ date of last visit:___________________________

Female patients: What GYN do you see for annual checkups?___________________________________

Personal Health History

Immunizations and dates:	**Health maintenance screenings:**
Tetanus___________________	last mammogram__________________
Tdap______________________	bone density______________________
Shingles___________________	colonoscopy______________________
HPV/Gardasil______________	EKG______________________________
Influenza__________________	sleep study_______________________
Hepatitis__________________	rectal exam_______________________
Pneumonia________________	eye exam_________________________
Chickenpox________________	cardiovascular/stress test____________

Social History

Exercise:	none	occasional	moderate	heavy
Alcohol:	none	occasional	moderate	heavy
Caffeine:	none	occasional	moderate	heavy
Tobacco:	never	former (quit when?)_______	Current (how much?)________	

Type of tobacco: ___________________ Age started? ____________________

Illicit drug use: ____

Health Questionnaire Cont.

Allergies

Drug Allergies: ____

Name of Drug: ____________________________________ reaction you had: ______________________________

Name of Drug: ____________________________________ reaction you had: ______________________________

Name of Drug: ____________________________________ reaction you had: ______________________________

Food Allergies: ____

Environmental Allergies: ____

Prescribed and Over the Counter Medications

Name of drug: ______________________________ Strength: _________________ Frequency taken: ___________

Name of drug: ______________________________ Strength: _________________ Frequency taken: ___________

Name of drug: ______________________________ Strength: _________________ Frequency taken: ___________

Name of drug: ______________________________ Strength: _________________ Frequency taken: ___________

Name of drug: ______________________________ Strength: _________________ Frequency taken: ___________

Name of drug: ______________________________ Strength: _________________ Frequency taken: ___________

Name of drug: ______________________________ Strength: _________________ Frequency taken: ___________

Name of drug: ______________________________ Strength: _________________ Frequency taken: ___________

Name of drug: ______________________________ Strength: _________________ Frequency taken: ___________

Name of drug: ______________________________ Strength: _________________ Frequency taken: ___________

Refill Policy - DO NOT WAIT until you are out of medicine to call for a refill. Contact your preferred pharmacy to request a refill, if they say that you are out of refills, ask them to please fax a refill request to our office. Refills can take up to 3 days to complete. All **controlled substance prescriptions** require an office visit **every 1 or 3 months depending on the medication.** ***Landfall Family Practice, Patrick V. McConnell, PAC, **DOES NOT PRESCRIBE CHRONIC PAIN MEDICINE**

What pharmacy do you prefer to use? So we can send your prescriptions there. ______________________________

Health Questionnaire Cont.

Do you wear a seat belt? Y N

Are there guns in your home? Y N If yes, are they locked? Y N

Do you exercise? Y N If yes, what exercises do you do and how long each time?___________________________

How many hours of sleep do you get each night? ______ Do you snore? Y N

Do you have restless legs? Y N Do you use a CPAP/BiPAP? Y N

Who lives in your home including pets? ____

CONDITIONS (Circle any that apply to you)

ADD/ADHD	AIDS	Alcoholism	Anemia	Anorexia
Anxiety	Appendicitis	Arthritis	Asthma	Bleeding Disorders
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts
Changing Mole	Chicken pox	Cholesterol	COPD	Coronary Artery Disease
Depression	Diabetes	Drug Addiction	Emphysema	Epilepsy
Fibromyalgia	Gerd/Reflux/Heartburn		Glaucoma	Goiter
Gonorrhea	Gout	Heart Disease	Hepatitis	Hernia Herpes
High Blood Pressure	HIV positive	Irregular Heart Beat		Kidney Disease
Liver Disease		Measles	Migraine Headaches	Miscarriage
Mononucleosis	Multiple Sclerosis	Mumps	Osteoporosis	Pacemaker
Pneumonia	Polio	Prostate Problems	Psychiatric Care	Rheumatic Fever
Scarlet Fever	Seasonal Allergies	Stroke	Suicide Attempt	Thyroid Problems
Tuberculosis	Ulcers	Vaginal Infections	Varicose Veins	Venereal Disease
OTHER CONDITIONS (please specify):				

What are you here for today?

____

____

Surgical History

Year: ___________ Procedure: ____ Dr. or Clinic: ________________________

Year: ___________ Procedure: ____ Dr. or Clinic: ________________________

Year: ___________ Procedure: ____ Dr. or Clinic: ________________________

Year: ___________ Procedure: ____ Dr. or Clinic: ________________________

Family History

	Problem	Onset Age	Notes	Died of Age
Mother:				
Father:				
Maternal Grandparents:				
Paternal Grandparents:				

I certify that the above information is correct to the best of my knowledge; I will not hold my physician or any members of his staff responsible for any errors or omissions that I have made in completion of this form.

Signature X____ Date_______________________________

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Authorization to Disclose Health Information

Patient Name: ____DOB:_______________
Patient Medical Record #________________________Patient SS#______________
I ____ hereby authorize
____to disclose specific health information from the records of the above named patient to Landfall Family Practice, Patrick V. McConnell, PA-C (address and phone # stated above) for the specific purpose(s):
____Continuity of Care and Treatment_____________ Specific information to be disclosed:
____ All Pertinent Info, ie. OV notes, labs, radiology reports, Rx list, and immunizations_____
I understand that this authorization will expire on the following date, event or condition:
____

I understand that if I fail to specify an expiration date or condition this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the **Revocation Section** on the bottom of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.
I understand that my information may not be protected from re-disclosure but the requester of the information; however if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not disclose this information without my further written authorization unless otherwise provided for by state or federal law.
I understand that if my record contains information related to HIV infection, AIDS, or AIDS related conditions, alcohol or drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.
I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits. I also understand that services may be denied if service is requested by a non-treatment provider (insurance company) for the sole purpose of creating health information (physical exam). I further understand that I may request a copy of this signed authorization.

Patient/Guardian signature:___________________________________date:_____________
Patient/guardian printed name:____

Revocation Section

I _______________________________ am revoking this authorization on this date ________
(print name)
Patient Signature:____

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ADULT HIPAA / RELEASE OF INFORMATION PER PATIENT'S ASSIGNMENT

I have acknowledged/received a written copy of Landfall Family Practice, PLLC's "Notice of Privacy Practices".

Patient's Name _________________________________ DOB ____/____/______

________ Initial here if you **DO NOT** authorize assignment of any person(s) to communicate with Landfall Family Practice for any reason, including your emergency contact.

OR

I hereby give permission to Landfall Family Practice, PLLC to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), relative(s), and/or close personal friend(s):

____
Name Phone # Relationship

____
Name Phone # Relationship

____
Name Phone # Relationship

The duration of this authorization is undefined unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Patient/Representative Signature: ____

Date: ___________________ Relationship (if other than patient)________________

Landfall Family Practice, PLLC

Controlled Substance Agreement

Patient Name: ___________________________ DOB: ____________

Narcotic pain medications are useful for short-term pain or cancer pain and to help dying patients with pain. There is little evidence that long-term use of narcotic pain medications helps chronic non-cancer pain and in fact could worsen it by leading to inactivity. Side effects of narcotic pain medication include but are not limited to: drowsiness, dizziness, constipation, nausea, confusion, respiratory depression, and death. I may also become psychologically or physically addicted to these medications. I understand my prescriber may choose alternative treatment options and it may be necessary to gradually decrease the amount of medication I am taking. To ensure that the medications are used in a safe manner, I agree to the following:

1. **I am responsible for my controlled substance medications.**
   a. I will take the medication only as prescribed.
   b. Prescriptions/medication will not be replaced if it is lost, misplaced/stolen or if I use it up sooner than prescribed.
   c. I agree to not share, sell, or otherwise permit others, including my family and friends, to have access to these medications.
   d. I will not participate in the diversion of my medications for illegal use.
   e. I understand I cannot drive while taking these medications or engage in activities that put me at risk.
2. **As a condition to receiving controlled substances, I understand my prescriber may require me to:**
   a. Pursue non-medication pain management therapies such as physical therapy or cognitive behavioral therapy or non-opioid medications. If I fail to do so, this agreement may be terminated.
   b. Obtain an opioid reversal medication, such as naloxone.
   c. Submit drug screens.
3. **I understand that prescriptions for controlled substance medications:**
   a. Will be provided only at regular office visits. I will not page my prescriber/health care providers to request a refill nor will I call them at home. Prescriptions will be sent electronically unless a technology issue prevents this.
   b. Will not be provided if I miss an appointment.
   c. Will not be provided if I run out of the medication early. I am responsible for taking the medication as it is prescribed and for keeping track of the amount remaining.
   d. May take up to 72 hours to process.
4. **This agreement will be terminated for:**
   a. Hostile behavior towards staff, attempting to refill prescriptions early, or too frequently
   b. Altering, forging, or attempting to get medications in an illegal manner; these type actions will be reported to the proper authority
   c. When deemed to be in the best interest as determined by my prescriber
   d. If I am arrested or incarcerated related to legal or illegal drugs
   e. Saving up medications or taking more than prescribed
   f. Failure to give a urine sample when requested or presence of unapproved drugs or lack of expected drugs in urine
5. Should my prescription medication or dosage need to be changed prior to my due date, all unused medications must be brought to our office for disposal.
6. I understand the prescription of controlled substances is under the supervision of many government agencies and adherence to regulations is my responsibility. If the responsible legal authorities have questions concerning your treatment, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.
7. I give my prescriber permission to discuss all diagnostic and treatment details with dispensing pharmacies or other healthcare professionals for the purpose of maintaining accountability
8. I will not hold my prescriber liable if I am involved in an accident while taking the controlled substance they have prescribed
9. **FOR FEMALES:** I understand that if I become pregnant, or I suspect that I may be pregnant, I will notify the staff of the office. I further accept that any medication may cause harm to my embryo/fetus/baby and hold the office and all staff harmless for any injuries to the embryo/fetus/baby.
10. I will only accept a prescription from ___________________________, and I will not request or accept controlled substance medication from any other prescriber, healthcare provider, or individual. The only exception is if the medication is prescribed while I am admitted to the hospital.
11. I will select and ONLY use one pharmacy to fill my controlled medication prescriptions. My pharmacy is
    ____

I have been fully informed regarding my treatment with the medications listed above as well as the reason for this agreement. I will receive a copy of this agreement and the original will be kept in my medical record at my prescribers' office.

Patient Signature: ____Date: ____________
Prescriber Signature: ____ Date: ____________