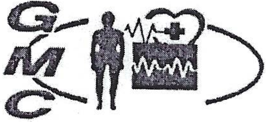


GOLDSBORO MEDICAL CENTER

Professional Association

2400 Wayne Memorial Drive, Suite J
Goldsboro, NC 27534

MUIN M. DUGOM, MD, FACP

Tel: (919) 739-9599
Fax: (919) 739-5535

NEW PATIENT INFORMATION

Date: ____/____/____

Patient Name: ________________________________ Date of Birth: ____/____/____

Address: ____
Street City State Zip Code

Home Phone# ____________________ Cellphone# ____________________

Email: ____________________ Appt Reminders: Phone Call or Text Message

Social Security# ____________________ Sex: Male Female

Race/Ethnicity: ________________________________

Marital Status: Single Married Divorced Widowed

If married, Spouse's Name: ________________________________

Phone# ________________________________

Employer: ____________________ Phone# ____________________

Do you have a Living Will? YES NO Power of Attorney? YES NO

Emergency Contact Name: ________________________________

Relationship: ____________________ Phone# ____________________

INSURANCE INFORMATION (Please provide a copy of insurance cards)

Primary Insurance	Secondary Insurance
____________________	____________________
Policy Number	Policy Number
____________________	____________________
Group Number	Group Number
____________________	____________________
Policy Holder Name	Policy Holder Name
Date of Birth: ____/____/____	Date of Birth: ____/____/____

GOLDSBORO MEDICAL CENTER, P.A.

PATIENT QUESTIONNAIRE

Patient Name: ______________________________ Date of Birth: ___/___/___

Current Medications:

____

____

____

____

Allergies: ____

Health Habits: ✎Caffeine ✎Tobacco ✎Alcohol ✎Sexual Partners ✎Other

Occupation: ✎Stress ✎Hazards ✎Heavy Lifting ✎Other

PAST MEDICAL HISTORY

Childhood Illness: ____

Adult Illness: ____

Hospitalizations: ____

Injuries: ____

Do you currently have or have been treated for : (PLEASE CHECK)

✎Herpes ✎Tuberculosis ✎Hypertension ✎Liver Disease

✎Eating Disorders ✎Stroke/TIA ✎Thyroid Disease ✎Glaucoma

✎High Cholesterol ✎Gout ✎Heart Disease ✎Kidney Disease

✎Seizure Disorder ✎Anemia ✎Venereal Disease ✎Lung Disease

✎Arthritis ✎Stomach Ulcers ✎HIV Infection ✎Rheumatic Fever

✎Cancer ✎Migraines ✎Bleeding Disorder ✎Breast Lumps

✎Psychiatric Illness ✎Diabetes ✎Addictions ✎Miscarriage

✎Pacemaker ✎Prostate Problems ✎Other: ____________________

Do you experience ANY of the above :

✎Chest Pain/Pressure ✎Fever/Chills ✎Bowel Changes

✎Shortness of Breath ✎Thirst/Urination ✎Memory Problems

✎Irregular Heartbeat ✎Weight Loss ✎Muscle/Joint Pain

✎Leg Pain ✎Blood(Stool/Urine) ✎Fainting

✎Depression ✎Nausea/Vomiting ✎Ankle Swelling

✎Headaches ✎Bleeding Problems ✎Ear Pain

✎Poor Appetite ✎Visual Problems ✎Swallowing Problems

Women ONLY!
#Pregnancies: __________ #Children: __________
Last Pap: ______________ Last Mammogram: ______________

Family History:

Relation	Age	Living	Deceased	Cause of Death
-Father	___	______________		______________
-Mother	___	______________		______________
-Siblings	___	______________		______________
-	___	______________		______________
-	___	______________		______________
-	___	______________		______________

Please check if your blood relatives had any of the following:

DISEASE	RELATIONSHIP TO YOU:
✎Heart Disease	______________________________
✎Cancer	______________________________
✎Diabetes	______________________________
✎High Blood Pressure	______________________________
✎Kidney Disease	______________________________
✎High Cholesterol	______________________________
✎Other: __________	______________________________

____
Patient Signature

____
Date of Signature

Goldsboro Medical Center, P.A.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Goldsboro Medical Center, P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Goldsboro Medical Center, P.A. Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Goldsboro Medical Center, P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Goldsboro Medical Center, P.A. Privacy Officer at 2400 Wayne Memorial Drive, Suite J, Goldsboro, NC 27534.

With this consent, Goldsboro Medical Center, P.A. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Goldsboro Medical Center, P.A. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Goldsboro Medical Center, P.A. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Goldsboro Medical Center, P.A. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Goldsboro Medical Center, P.A. may decline to provide treatment to me.

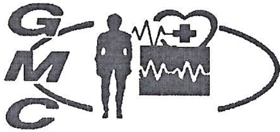
I have had the opportunity to read Goldsboro Medical Center's, P.A. **Notice of Privacy Practices**, and had the opportunity to review the document and ask any questions that I may have.

____
Signature of Patient or Legal Guardian

____
Date

____
Patient's Name

____
Patient's Date of Birth



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Medical Record Release Form

Patient's Full Name:________________________________ Date of Birth:______________
Address: ________________________________Phone Number: ______________
City, State, Zip: ____

I authorize:

____
Office Name/Person(s)

____
Address

____
City/State/Zip

____
Phone Fax

To release my personal health information to/from:

____
Office Name/Person(s)

____
Address

____
City/State/Zip

____
Phone Fax

These medical records are being release for the purpose of: (Please select and option)
__Transfer to another practice because of: ________________________________
__Copy for self
__Other, please be specific: ________________________________

This information should include:
__Complete medical record
__Labs
__ Other ________________________________

________________________ ________________________
Patient full name Date

________________________ ________________________
Patient Signature Witness by