

**Shannon Scott Ellis, M.D.**

**Scott Gogulski, D.O.**

**3280 Henderson Drive Suite C, Jacksonville, NC 28546**

**Phone: 910-219-1713 Fax: 910-577-4984**

# Adult REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | | | | | | | | PCP: | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s full name: | | | | | | |  | | | | | | |  | | | Mr.  Mrs. | | | Miss  Ms. | | | | Marital status | | | | | | |
|  | | | | | | | | | | | | | | | | | Single Mar Div  Sep  Wid | | | | | | |
| Is this your legal name? | | | If not, what is your legal name? | | | | | | | | | (Former name): | | | | | | | | | | Birth date: | | | | | Age: | Sex: | | |
| Yes | No | |  | | | | | | | | |  | | | | | | | | | |  | | | | |  | M | | F |
| Street address/PO Box: | | | | | | | | | | | | | | | Social Security no.: | | | | | | | | | Driver’s License: | | | | | | |
|  | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | |
| Home phone no. | | | | | City: | | | | | | | | | | | | | | State: | | | | | | | ZIP Code: | | | | |
| (     ) | | | | |  | | | | | | | | | | | | | |  | | | | | | |  | | | | |
| Occupation: | | | | | Employer: | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | |
|  | | | | |  | | | | | | | | | | | | | | | | | | (      ) | | | | | | | |
| Chose clinic because/Referred to clinic by (please check one box): | | | | | | | | | | | | | Dr. | | | | | | | | | | | | Insurance Plan | | | | Hospital | |
| Family | | Friend | | Close to home/work | | | | | | Yellow Pages | | | | | | | | | Other | | | | | | | | | | | |
| Other family members seen here: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Insurance Carrier Name | | | | | | | | Policy ID | | | | | | | | | | | | | | | Group# | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | |
| Insured’s Name: | | | | | | | | | | | Soc. Sec. No (if not listed above): | | | | | | | | | | | | Date of Birth (if not listed above) | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | |
| Patient’s relationship to subscriber: | | | | | | Self | | | Spouse | | | | Child | | | Other | | | | |  | | | | | | | | | |
| Secondary Insurance Carrier Name | | | | | | | | Policy ID | | | | | | | | | | | | | | | Group# | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | |
| Insured’s Name: | | | | | | | | | | | Soc. Sec. No (if not listed above): | | | | | | | | | | | | Date of Birth (if not listed above) | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | |
| Patient’s relationship to subscriber: | | | | | | Self | | | Spouse | | | | Child | | | Other | | | | |  | | | | | | | | | |

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| --- |
| required signature |
| I have been provided with the following documents from Onslow Primary Care: Your Rights and Responsibilities as a Patient, Notice of Privacy Practices. These documents are also available online at the practice’s website (www.onlsowprimarycare.org).  I authorize the release of information concerning my healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to Onslow Ambulatory Services, Inc. (For Medicare beneficiaries, this serves as a lifetime authorization assigning payment of Medicare benefits to Onslow Primary Care). I understand that I am personally responsible for all charges not covered by my insurance.  To protect myself as a patient, and this practice, I agree to have my picture taken at my initial visit, which will be kept in my chart. I may decline having my picture taken, but must state so at that time. I understand that I am personally responsible for all charges not covered by my insurance. |
| Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



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# Adult History form

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| |  |  |  |  | | --- | --- | --- | --- | | Name | Dob | Age | Sex  M  F |  |  |  | | --- | --- | | **ALLERGIES** to any medications, X-Ray dyes or other substances? ❑ No ❑ Yes (if yes, please the list the type of reaction) | | |  |  | |  |  | |  |  |  |  |  | | --- | --- | | **MEDICATIONS-**names, dosages (prescriptions, over-the-counter, vitamins, supplements) Please list additional medications on a separate piece of paper. | | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **PAST MEDICAL HISTORY** | | | | | | Abnormal Colonoscopy | Abnormal EKG | Abnormal heart rhythm | Abnormal Mammogram | Abnormal Pap Smear | | Acid Reflux/Heartburn | Anemia | Anxiety | Appendix removal | Arthritis | | Asthma | Bleeding disorder | Blood Clots (legs, lungs) | Blood Transfusion | Breast Lumps | | Cancer | Chronic Kidney Disease | Chronic Low Back Pain | COPD/Emphysema | Depression | | Diabetes | Diverticulosis | Enlarged Prostate/BPH | Erectile Dysfunction | Abdominal Surgery | | Fibromyalgia | Gallbladder removal | Glaucoma | Gout | Heart Attack | | Heart Failure | Heart Murmur | High Blood Pressure | High Cholesterol | HIV/AIDS | | Hysterectomy | Irritable Bowel | Kidney Stones | Liver Disease | Thyroid Disease | | Migraines | Osteoporosis | Rheumatoid Arthritis | Seasonal Allergies | Seizures | | Sexually Transmitted Dz | Skin Disease | Stroke/TIA | Tuberculosis/Pos TB | Other | | Other: | | | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **FAMILY HISTORY** Adopted? Yes- you may skip this section | | | | | | Illness | Father (birth) | Mother (birth) | Sibling (s) | Child (ren) | | Bleeding/Clotting Disorder |  |  |  |  | | Cancer (list the type) |  |  |  |  | | Depression/Anxiety |  |  |  |  | | Diabetes |  |  |  |  | | Heart Attack |  |  |  |  | | High Blood Pressure |  |  |  |  | | High Cholesterol |  |  |  |  |  |  |  | | --- | --- | | **HEALTH MAINTENANCE** | | | Date of you last physical/wellness exam | Date of your last colonoscopy | | Date of your last pap smear (females) | Date of your last mammogram | | Date of you last DtaP | Date of your pneumoccal vaccination(pneumovax)- may not apply to you | | Do you smoke and if so, how many packs per day | Do you drink alcohol?-if so how many drinks per day (beer, wine, mixed) |  |  | | --- | | **I attest that the above information is accurate to the best of my knowledge.**  Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |



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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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| --- | --- | --- | --- |
| Please note if your wish for anyone other than yourself to communicate with the doctor or our staff in regard to your care, appointments or account status. I understand that sensitive information, like STDs (including HIV/AIDS) results, pregnancy test results, mental health or substance abuse will not be shared unless specifically stated by me at the time.  Patient Name       Date of Birth  Do not release information about  Authorized contact name:  Relationship to patient:  Contact phone number:  Authorized contact name:  Relationship to patient:  Contact phone number: | | | |
| Authorized contact name:  Relationship to patient:  Contact phone number: | | | |
| Patient Signature: |  | Date Signed: |  |
| **Phone Release**  I authorize Onlsow Primary Care staff to leave messages with anyone that answers my phone or on my answering machine in regards to appointments, test results, or issues in regard to my care. | | | |
| Patient Signature: |  | Date Signed: |  |