CALDWELL
UNC HEALTH CARE

Dear Patient,

Welcome to RiverCrest Medical Park, a division of Caldwell UNC Healthcare. Thank you for considering us as your healthcare provider. In order to allow our staff and practitioners to focus their energy on your healthcare needs, please take a few minutes to read and fully complete the enclosed packet of information.

Please be sure to bring your completed packet back to our office **at least** three days prior to your appointment. If for any reason you have not completed and returned this packet at that time, our office will contact you to have it brought in by the end of that business day. **Failure to do** so will result in your appointment being canceled and rescheduled for a later date.

As a courtesy, the day prior to your appointment, our office will send out a reminder call regarding your appointment date and time.

(Please provide an **accurate** phone number for contact purposes.)

Return the pages titled “New Patient Demographics & Medical History” (7 pages) and the release of information form found on the Rivercrest Medical Park website (http://caldwellmemorial.org/office/54-rivercrest-medical-park) indicating your current primary care provider so we may request all previous medical records before your first visit with us. We want a comprehensive picture of your health!

Rivercrest Medical Park
160 River Bend Dr Ste A
Granite Falls, NC 28630
phone: 828-757-5060
fax: 828-757-5068

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Important Information for New Patients

We are a **Patient Centered Medical Home**, meaning we focus on:

- Enhancing Patient Experience
- Improving Population Health
- Reducing Costs
- Improving Provider and Staff Work Life

We want to partner with you and your family to understand and respect your unique needs, culture, values, and preferences. Along with your physician and other healthcare providers, you are the most important person in managing your health!

Medical Records

The patient portal, MyUNCChart, is the best way to manage personal health records. See information within this packet or ask the front-desk how to sign-up at your first visit!

Your medical records may also be obtained through the office by signing a release of information form and in some instances- if the records are sent to another healthcare provider, a form is not required. We are happy to transfer your records to other healthcare providers per your request.

Making and Canceling Appointments

Appointments may be scheduled through the office or via MyUNCChart.

- Patients who present to the clinic 15 minutes *after* the appointment time for clinic visits and arrival time for procedures will be considered **late**.
- Patients who do not attend their scheduled appointment will be considered **no- show patients**.
- Patients who notify a member of the department scheduling staff *more than 24* hours before their scheduled appointment to cancel the appointment via MyChart note, phone call, in person, voicemail, or vendor (e.g., TeleVox) appointment reminder responses are considered a **patient cancellation**.
- Patients who notify a member of the scheduling staff *less than 24 hours* before their scheduled appointment to cancel the appointment via MyChart note, voice mail, in-person, or phone call are consider a **same-day patient cancellation.**
- For the first and second occurrences of same-day cancellations and no-shows, patients will be notified via phone call and/or letter. Patients who no-show, arrive late (and cannot be accommodated the same day), or cancel within 24 hours of the scheduled appointment **three times within 12 months** with an individual clinic or provider, may be dismissed from the provider's or discipline's clinic. All patient dismissals are made at the provider's discretion.
- It is the responsibility of the patient to:
    - Arrive for their scheduled appointment at the instructed arrival time to insure timely operation of the clinic and a positive experience for themselves and other patients. Late patients are not guaranteed to be seen for their scheduled appointment and may need to be rescheduled.
    - Notify the scheduling department as early as possible of a cancellation so they can be rescheduled and the slot can be available to other patients

It is of utmost importance to Rivercrest Medical Park that your appointments are kept so that we are able to work together to improve and maintain your health. Because we value your time and health, we enforce a No-Show Policy consistently with all patients. Patients who miss an appointment without prior notification to the office may pose a risk to not only their own health, but also may pose a risk to other members of the community.

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Making and Canceling Appointments Continued

We understand that conflicts arise and ask you notify us as soon possible; we will always do our best to reschedule your appointment. We truly value our communication with you, it is key to managing your health needs. Questions regarding no-shows and cancellations should be directed towards the practice manager and/or office nurse case manager.

Referrals

Your provider and care team will coordinate referrals for specialty care and diagnostic referrals.

Clinical advice & Prescription Refills

During office hours, contact the office and follow the prompts to speak with the clinical staff or request a prescription refill. For non-urgent clinical advice or prescription refills, you may also send a request through My UNC Chart. Patients have access to extended hours care through Caldwell Memorial Hospital's PLUS Urgent Care services and after-hours care by contacting Caldwell Memorial Hospital (828-757-5100) and asking for the provider on-call.

Caldwell's Plus Urgent Care Offices

Blowing Rock Medical Park PLUS Urgent Care	
8439 Valley Blvd.	*MON-FRI 8:00A-6:00P*
Blowing Rock, N.C. 28605	*SAT-SUN 10:00A-6:00P*
Anderson Medical Park PLUS Urgent Care	
270 Pine Mountain Rd., Suite 4	*MON-FRI 8:00A-7:30P*
Hudson, NC 28638	*SAT-SUN 10:00A-6:00P*
Rivercrest Medical Park PLUS Urgent Care	
160 River Bend Dr. Ste. A	*MON-FRI 8:00A-7:30P*
Granite Falls, NC 28630	*SAT-SUN 10:00A-6:00P*
Robbins Medical Park PLUS Urgent Care	
322 Mulberry St. SW	*MON-FRI 8:00A-7:30P*
Lenoir, NC 28645	*SAT-SUN 10:00A-6:00P*
The Falls Pediatrics PLUS Urgent Care	
4355 Hickory Blvd. Upper Suite 3	*MON-FRI 8:00A-8:00P*
Granite Falls, NC 28630	*SAT-SUN 10A-4:00P*

PLUS Urgent Care is available on holidays at Anderson Medical Park 8:00 a.m. - 4:00 p.m. and Blowing Rock Medical Park 8:00 a.m. 12:00 p.m.

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NOTICE:
NORTH CAROLINA CONTROLLED SUBSTANCE REGISTRY

Because of the enormous problem of misuse of prescription drugs, North Carolina's Department of Health and Human Services maintains a website that tracks prescriptions including controlled substances like narcotics, anti-anxiety, and sedatives. Examples of those medications include Valium, Percocet, OxyContin, Vicodin, Xanax, Lortab, Etc.

The Providers (Doctor's, Physician Assistants, and Family Nurse Practitioners) utilize this website to screen and confirm all medications that have been prescribed to patients seeking care in this Clinic. This website assists the providers in providing safe, effective medication management for patients.

The providers do not provide pain management services for chronic conditions. Additionally if you are under another doctor's care for pain management, then additional pain medications will not be prescribed.

Caldwell UNC HealthCare complies with all applicable laws governing healthcare. For questions or clarification, please call Risk Management at 828-757-5456.

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myUNCChart™

STAY WELL CONNECTED

More health care. *Online. All the time.*

Now more than ever, *My UNC Chart* allows you access to your UNC care team and your medical records all in one, secure, easy-to-use online portal.

Connect with your provider

Pay bills online

Access test results

Manage accounts of loved ones

Manage your appointments

*Get the **MyChart** mobile app*

Request prescription refills

Track your health

SIGN UP *to* GET CONNECTED NOW *at* MYUNCCHART.ORG | UNC HEALTH CARE

CALDWELL UNC HEALTH CARE

NEW PATIENT MEDICAL HISTORY & DEMOGRAPHICS

Full Name: First Middle Last				
Birth Date: M M / D D / Y Y Y Y	**Age:**	**Sex:** ☐Male ☐Female	**SSN #:**	
Preferred Provider/Physician:	**Today's Date:** M M / D D / Y Y Y Y			
How did you hear about us?	**Name of patient if referred by patient currently being seen by practice (*optional*):**			

Contact Information:

Mailing Address:		**City:**	
State:	**Zip:**	**Primary Phone:** ☐(**H**)ome ☐(**W**)ork ☐(**C**)ell	
Secondary Phone: ☐**C** ☐**H** ☐**W**		**Other Phone:** ☐**C** ☐**H** ☐**W**	
E-mail:		**Emergency Contact Name:**	
Emergency Contact Relation:		**Emergency Contact Number:** ☐**C** ☐**H** ☐**W**	

Employment:

1. Occupation: **(or most recent):** _____ **Employer:**_____	**Current Employment Status:**	☐Full-time ☐Part-time ☐Unemployed ☐Retired ☐Leave of Absence ☐Disabled
2. Additional Occupation if more than one: _____ **Employer:**_____	**Additional Employer Status:**	☐Full-time ☐Part-time ☐Unemployed ☐Retired ☐Leave of Absence ☐Disabled
3. Retirement Date:_____ ☐**N/A**	**4. Do you work nightshift?** ☐Yes ☐No ☐ N/A	

Other:

1. Marital Status ☐Single ☐Legally Separated ☐Widowed ☐Divorced ☐Married ☐Domestic Partner	**2. Race:** ☐American Indian or Alaskan Native ☐Black or African American ☐Asian ☐Unknown/Other Race ☐White/Caucasian	
3. Ethnicity: *Please check **one**…* ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Unknown	**4. Preferred Language:**	

Insurance Information:

Primary Insurance	**Secondary Insurance**
Member #/ID for patient:	Member #/ID for patient:
Group #:	Group #:
Subscriber Name (name on card):	Subscriber Name (name on card):
Subscriber Birthdate:	Subscriber Birthdate:
Relationship to Patient:	Relationship to Patient:

Complete if patient is a minor or if you are healthcare power of attorney (HCPOA):

Documentation for HCPOA must be provided with new patient paperwork…

1. Primary Caregiver Name:	**2. Primary Caregiver DOB:**	**3. Is Primary Caregiver Guarantor?**	☐Yes ☐No
4. Primary Caregiver's Relation:	**5. Primary Caregiver Phone:** ☐C ☐H ☐W		
6. Secondary Caregiver Name:	**7. Secondary Caregiver DOB:**	**8. Is Secondary Caregiver Guarantor?**	☐Yes ☐No
9. Secondary Caregiver's Relation:	**10. Secondary Caregiver Phone:** ☐C ☐H ☐W		

CALDWELL UNC HEALTH CARE

NEW PATIENT DEMOGRAPHICS & MEDICAL HISTORY

*Patient Name:*_____
DOB: _____

Allergies | *List all to include food, animals, drug, etc.* ☐ **NO ALLERGIES**	
Allergy	**Allergic Reaction**
1.	
2.	
3.	
4.	

Medications | *Include ALL over the counter (i.e. Aspirin) & Prescriptions* ☐ **NO MEDICATIONS**	
Pharmacy:	Pharmacy City:

Medication (Please List All)	**Dose (Mg, pill, etc.)**	**Frequency (Times Per Day/ Hour/ Week)**
1.		☐As Needed ☐Day ☐Hr ☐Wk
2.		☐As Needed ☐Day ☐Hr ☐Wk
3.		☐As Needed ☐Day ☐Hr ☐Wk
4.		☐As Needed ☐Day ☐Hr ☐Wk
5.		☐As Needed ☐Day ☐Hr ☐Wk
6.		☐As Needed ☐Day ☐Hr ☐Wk
7.		☐As Needed ☐Day ☐Hr ☐Wk
8.		☐As Needed ☐Day ☐Hr ☐Wk

Please write additional medications on a blank sheet of paper with dose and frequency.

Medical History | *Indicate whether you have experienced difficulties "Current," "Past," or "Never" with the following conditions…*

Disease/Condition	**Current**	**Past**	**Never**	**Comments**
1. Alcoholism				
2. Anxiety				
3. Asthma				
4. Bipolar				
5. Cancer				Type:
6. Depression				
7. Diabetes				
8. Drug Abuse				Type:
9. Emphysema (*COPD*)				
10. Heart Disease				

Disease/Condition	Current	Past	Never	Comments
11. High Blood Pressure (*Hypertension*)				
12. High Cholesterol				
13. Suicidal				
14. Thyroid Disease				☐Hypo ☐Hyper ☐Unknown/Unspecified
15. Renal (*Kidney*) Disease				
16. Migraine Headaches				
17. Stroke				
18. Suicidal:				
19. Other:				
20. Other:				
21. Other:				

Surgeries | *Please provide details to the best of your knowledge, your care team may request records as needed.*

Type (Specify Left/Right)	**Date**	**Provider & Facility**
1.		
2.		
3.		
4.		
5.		
6.		

Women's Health History | *Please provide details to the best of your knowledge, your care team may request records as needed.*

1. Date of Last Menstrual Cycle:	☐**N/A**	**6. Pregnancy Complications:**	
2. Age of First Menstruation:	☐**N/A**	**7. Obstetric History:**	
3. Age of Menopause:	☐**N/A**	**8. Date of Last Pap Smear**	
4. # of Live Births:		**9. Result of Pap Smear:**	
5. Total # of Pregnancies:		**10. Date of Last Mammogram:**	

CALDWELL UNC HEALTH CARE

NEW PATIENT DEMOGRAPHICS & MEDICAL HISTORY

*Patient Name:*_____
DOB: _____

FAMILY MEDICAL HISTORY | ☐ UNKNOWN

CHECK ALL THAT APPLY	Alcohol Abuse	Drug Abuse	Asthma	Cancer	Emphysema (COPD)	Anxiety	Depression	Bipolar	Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:____	Other:____
1. Mother																				
2. Father																				
3. Brother/s																				
4. Sister/s																				
5. Son																				
6. Daughter																				
7. Maternal Grandmother																				
8. Maternal Grandfather																				
9. Paternal Grandmother																				
10. Paternal Grandfather																				
11. Other: _____																				

CALDWELL UNC HEALTH CARE

NEW PATIENT DEMOGRAPHICS & MEDICAL HISTORY

*Patient Name:*_____
DOB: _____

Review of Systems| Check if significant problems within the last **3 months**.

Skin		Ears		Eyes	
☐Y ☐N	Rash	☐Y ☐N	Loss/Decrease Hearing	☐Y ☐N	Blurry Vision
☐Y ☐N	Sores	☐Y ☐N	Drainage from Ears	☐Y ☐N	Drainage from Eyes
☐Y ☐N	Changes with a Mole	☐Y ☐N	Ringing	☐Y ☐N	Pain
☐Y ☐N	Itching/Dryness	☐Y ☐N	Earache	☐Y ☐N	Vision loss/changes
☐Y ☐N	Hair or Nail Changes			☐Y ☐N	Flashing lights/dots
Lungs		**Heart**		**Skeleton**	
☐Y ☐N	Cough	☐Y ☐N	Heart Murmur/ Palpitations	☐Y ☐N	Pain in Joints
☐Y ☐N	Difficulty/painful breathing	☐Y ☐N	Chest pains/discomfort/ tightness	☐Y ☐N	Stiffness
☐Y ☐N	Coughing up Blood	☐Y ☐N	Swelling	☐Y ☐N	Swollen Joints
☐Y ☐N	Wheezing	☐Y ☐N	Leg Pain when Walking	☐Y ☐N	Back Pain
Gastro		**Urinary**		**Neurologic**	
☐Y ☐N	Change in Appetite	☐Y ☐N	Frequency	☐Y ☐N	Dizziness
☐Y ☐N	Problems Swallowing	☐Y ☐N	Urgency	☐Y ☐N	Fainting
☐Y ☐N	Abdominal Pain	☐Y ☐N	Burning or Pain	☐Y ☐N	Seizures
☐Y ☐N	Wheezing	☐Y ☐N	Blood in Urine	☐Y ☐N	Weakness
☐Y ☐N	Nausea/diarrhea	☐Y ☐N	Incontinence	☐Y ☐N	Numbness
☐Y ☐N	Change in bowel habits	☐Y ☐N	Change in Urinary Strength	☐Y ☐N	Tingling
☐Y ☐N	Rectal Bleeding			☐Y ☐N	Tremor
☐Y ☐N	Constipation				
Endocrine		**Head**		**Psychiatric**	
☐Y ☐N	Heat/Cold Intolerance	☐Y ☐N	Headaches/Migraines	☐Y ☐N	Nervousness
☐Y ☐N	Sweating	☐Y ☐N	Neck Pain	☐Y ☐N	Stress
☐Y ☐N	Thirst	☐Y ☐N	Head Injury	☐Y ☐N	Depression
☐Y ☐N	Change in Appetite			☐Y ☐N	Memory Loss
Breast		**Vaginal**		**Prostate**	
☐Y ☐N	Lump(s)	☐Y ☐N	Discharge	☐Y ☐N	Lump(s)
☐Y ☐N	Pain	☐Y ☐N	Hot Flashes	☐Y ☐N	Pain with Sex
☐Y ☐N	Discharge	☐Y ☐N	Change in Periods	☐Y ☐N	Lesions/Sores
☐Y ☐N	Tenderness	☐Y ☐N	Itching or Dryness	☐Y ☐N	Loss of Sex Drive
☐Y ☐N	Color Changes	☐Y ☐N	Pain with Sex	☐Y ☐N	Hernia
		☐Y ☐N	Loss of Sex Drive		
		☐Y ☐N	Lesions/Sores		

List other Problems Here:

CALDWELL UNC HEALTH CARE

NEW PATIENT DEMOGRAPHICS & MEDICAL HISTORY

*Patient Name:*_____
DOB: _____

Lifestyle					
1. Tobacco	**Do you or have you used tobacco in the past?** ☐Yes ☐No *(If no, move to alcohol use)*			**Type(s):** ☐Cigarettes ☐Pipe ☐Cigar ☐Snuff ☐Chew ☐E-Cigarettes	
	Current: Packs /day:	# of years:	**Past:** Quit Date:	Packs /day:	# of years:
2. Alcohol	**Do you drink alcohol?** ☐Yes ☐No *(If no, please move to drug use)*			**Drinks/day:**	
	Type(s): ☐Beer ☐Wine ☐Liquor				
3. Drugs	**Do you use marijuana or recreational drugs?** ☐Yes ☐No If yes, specify: _____ **Have you ever taken someone else's drugs?** ☐Yes ☐No				
4. Sexual History	**Are you sexually active?** ☐Yes ☐No			**Partner(s) *(current & past)*:** ☐Male ☐Female	
	Birth Control: ☐None ☐Condom ☐Pill ☐Ring ☐Patch ☐Injection ☐IUD ☐Vasectomy				
5. Exercise	**Do you exercise regularly?** ☐Yes ☐No *(If no, move to sleep.)*				
	What kind of exercise?		**Duration:**	**How long?** _____ **minutes** **Times/week:** _____	
6. Sleep	**How many hours, on average, do you sleep per night/day (if nightshift worker)?**				
7. Diet	**How would you rate your diet?** ☐Good ☐Fair ☐Poor				
8. Safety	**Do you use a bike helmet?** ☐Yes ☐No		**Do you use seat belts consistently?** ☐Yes ☐No	**If you have guns, are they locked-up?** ☐Yes ☐No	
	Do you have a working smoke detector in your home? ☐Yes ☐No			**Is violence at home a concern for you?** ☐Yes ☐No	
	Have you completed an Advanced Directive for Health Care, Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? ☐Yes ☐No				
9. Other	**Do you have children?** ☐Yes ☐No		**If yes, how many?** _____		

Additional Information	
1. Have you traveled outside of the country in the past 30 days?	☐Yes ☐No If yes, specify where: _____
2. Have you served in the military?	☐Yes ☐No If yes, how long & which branch? _____
3. Were you deployed?	☐Yes ☐No If yes, specify where: _____

CALDWELL UNC HEALTH CARE

NEW PATIENT DEMOGRAPHICS & MEDICAL HISTORY

*Patient Name:*_____
DOB: _____

Health Maintenance Screening History | *Please provide details to the best of your knowledge, your care team may request records as needed.*

Screening Item	Result	Date of Screening	Facility/Provider
1. Cholesterol	☐Normal ☐Abnormal ☐Unknown		
2. Colonoscopy /Sigmoid	☐Normal ☐Abnormal ☐Unknown		
4. Bone Density	☐Normal ☐Abnormal ☐Unknown		
5. Hep C	☐Normal ☐Abnormal ☐Unknown		
6. Eye Exam	☐Normal ☐Abnormal ☐Unknown		

Vaccination History | List to the best of your knowledge, your care team may need to request records of vaccines.

Vaccin	Date	Location:
1. Last Tetanus Booster/ TDAP		
2. Last Flu Vaccine		
3. Last Zoster Vaccine (Shingles)		
4. Last Pneumovax (Pneumonia)		
5.		
6.		

Other Providers/Specialists

Specialist	Name	Last Visit
1. Cardiology		
2. Gastroenterologist		
3. OB/GYN		
4. Neurology		
5. Pulmonary		
6. Other:_____		
7. Other:_____		