



Duke Primary Care
North Hills Internal Medicine

Dear

Thank you for choosing North Hills Internal Medicine to provide your medical care. We look forward to assisting you with all of your health care needs. Your appointment is scheduled for _____ with _____.

Your health safety is important to us. For this reason, we ask that you bring your medications to each and every visit to our office. This includes both over the counter and prescription medication. This is best way to insure accuracy and safety in handling your medicines. It is best to bring your actual bottles, but if that is not possible, bring a complete list of your medication including name, strength and how often you take it.

The clinical and support staff strives to offer you the highest level of care. To assist us with this task, please complete the enclosed forms thoroughly and present them upon arrival for your appointment. Please feel to call us if you have any questions regarding these forms. If for any reason you are unable to complete these forms, please arrive a minimum of 30 minutes prior to your scheduled appointment time to allow adequate time for completion.

Our providers strive to be on time for your appointment. Please understand that failure to arrive at the requested time may require you to reschedule your appointment.

Sincerely,

The Staff of North Hills Internal Medicine

Directions:

We are located in the Medical Office Building 6 adjacent to Duke Raleigh Hospital. Take I-440 to exit 10. Head north on Wake Forest Road. Turn right into the hospital parking lot and bear to the right for entrance to the parking garage. Our office is located on the 3rd floor.

PATIENT INFORMATION:

Date _____

Last Name _____ First Name _____ MI _____

Date of Birth _____ e-mail Address _____

Street Address _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____ Cell () _____

Name & Address of Employer _____

In case of emergency, notify: _____ Relationship to patient _____

Home Phone () _____ Work Phone () _____ Cell () _____

Preferred Pharmacy _____ Address _____ Phone _____

Mail Order Prescriptions: Yes No Name of mail order pharmacy _____ ID# _____

RESPONSIBLE PARTY (If other than patient)

Last Name _____ First Name _____ MI _____

Street Address _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____ Cell () _____

Name & Address of Employer _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Company and address _____

Policyholder's Name _____ Relationship to Patient _____

I.D. # _____ Group # _____

Policyholder Date of Birth _____ Policyholder SS# _____

Policyholder Employer Name & Address _____

Secondary Insurance Company and address _____

Policyholder's Name _____ Relationship to Patient _____

I.D. # _____ Group # _____

Policyholder Date of Birth _____ Policyholder SS# _____

Policyholder Employer Name & Address _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

Name: _____ Sex Male Female Date _____

Date of Birth ___ / ___ / ___ Marital Status: Married Single Separated Divorced Widowed

Do you have any health concerns? If yes, please list

PAST MEDICAL HISTORY: Check conditions that doctors have followed you for in the past:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> High blood pressure/hypertension | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes ("sugar") |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Heart Attack/By-pass Surgery | |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Reflux Disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Abnormal PAP |
| <input type="checkbox"/> Cancer: Type & Location _____ | | | |
| <input type="checkbox"/> Other: _____ | | | |

Have you ever had: Positive Tuberculosis Test Yes No
Rheumatic Fever Yes No
Blood Transfusion Yes No

List any hospitalizations or surgeries you have had (including C-section):

List any drug allergies:

Are you allergic to latex? Yes No

List all current medications (including vitamins, herbal, and health food preparations):

PREVENTATIVE CARE: When was your last:

Tetanus Booster _____ Flu Shot _____ Pneumonia Vaccine _____ Hepatitis Vaccine _____

Flexible Sigmoidoscopy/Colonoscopy _____ Bone Densitometry _____

Female Only: How often do you examine your breasts? _____	Do you see an OB/GYN doctor? _____
When was your last mammogram? _____	When was your last PAP smear? _____
Male Only: Do you do a testicular exam? _____	Do you have any problems with erections? _____
When was your last: prostate blood test (PSA) _____	Prostate/rectal exam? _____

PLEASE COMPLETE BACK OF FORM

SOCIAL HABITS

Have you ever used tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind? _____ How much? _____ For how many years? _____ Date quit? _____	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No How many drinks per week? _____ Have you ever felt you need to cut down? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever felt guilty about our drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No What type? _____ How often? _____
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How many glasses/cups of caffeine do you drink daily? _____ Do you have guns in your home? _____
Do you exercise outside of your job? _____ Do you wear seatbelts? always usually sometimes never
What is your occupation? _____ Who do you live with? _____
How do you learn best? Read it Tell me Show me How much education have you completed? _____
Are you: sexually active If so, 1 partner multiple partners with women with men

A parent If so, how many children? _____

FAMILY HISTORY: Has anyone in your family had any of the following? (Check appropriate box)

	Mother	Father	Maternal Grandparent	Paternal Grandparent	Brothers/Sisters	Other
High Blood Pressures/Hypertension						
Heart Attack/Heart Surgery						
Diabetes						
Stroke						
Cancer (Type/Location)						
Osteoporosis						
Thyroid Problems						
Mental Illness						
Glaucoma						

Please check any of the following problems that apply to you: _____ no problems

- | | | | | | |
|--|---|--|--|--|---|
| General | Genitourinary | Skin | Endocrine System | Allergy | Eyes |
| <input type="checkbox"/> fever | <input type="checkbox"/> urinary frequency | <input type="checkbox"/> rash | <input type="checkbox"/> excessive urination | <input type="checkbox"/> seasonal symptoms | <input type="checkbox"/> blurred vision |
| <input type="checkbox"/> sweats | <input type="checkbox"/> burning with urination | <input type="checkbox"/> changing mole | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> sneezing | <input type="checkbox"/> changing vision |
| Respiratory | <input type="checkbox"/> blood in urine | <input type="checkbox"/> itching | <input type="checkbox"/> fatigue | <input type="checkbox"/> itchy eyes | |
| <input type="checkbox"/> cough | <input type="checkbox"/> problems urinating | <input type="checkbox"/> slow healing | <input type="checkbox"/> heat intolerance | <input type="checkbox"/> runny nose | GI System |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> awoken at night to urinate | wounds | <input type="checkbox"/> cold intolerance | <input type="checkbox"/> nasal congestion | <input type="checkbox"/> nausea |
| <input type="checkbox"/> wheezing | <input type="checkbox"/> problems with sex | Cardiovascular | Neurologic System | <input type="checkbox"/> post nasal drip | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> shortness of breath with exertion | <input type="checkbox"/> exposure to sexually transmitted disease | <input type="checkbox"/> chest pain or pressure | <input type="checkbox"/> numbness | Hematologic System | <input type="checkbox"/> constipation |
| | Mental Health | <input type="checkbox"/> ankle swelling | <input type="checkbox"/> tingling | <input type="checkbox"/> easy bruising | <input type="checkbox"/> abdominal pain |
| | <input type="checkbox"/> insomnia | <input type="checkbox"/> palpitations | <input type="checkbox"/> headaches | <input type="checkbox"/> easy bleeding | <input type="checkbox"/> diarrhea |
| Ear/Nose/Throat | <input type="checkbox"/> guilt | Daily Living | <input type="checkbox"/> weakness | <input type="checkbox"/> hard to stop bleeding | <input type="checkbox"/> blood in stool |
| <input type="checkbox"/> ear pain | <input type="checkbox"/> depression | <input type="checkbox"/> violence in your home | | Musculoskeletal | Nutrition |
| <input type="checkbox"/> runny nose | <input type="checkbox"/> anxiety | <input type="checkbox"/> changes in functional ability | | <input type="checkbox"/> joint swelling | <input type="checkbox"/> On a special diet |
| <input type="checkbox"/> sneezing | <input type="checkbox"/> suicidal thoughts | <input type="checkbox"/> changes in eating habits | | <input type="checkbox"/> joint pains | <input type="checkbox"/> weight gain or loss greater than 10 pounds |
| <input type="checkbox"/> post nasal drip swelling | | <input type="checkbox"/> changes in sleeping habits | | <input type="checkbox"/> muscle pains | |

Health. Under certain circumstances, we may use and disclose health information about you for research purposes. All research activities, however, are subject to a special approval process. Before we disclose medical information for research, the project will have been approved through this research approval process. We may, however, use medical information about you in preparing to conduct a research project, for example, to look for patients with specific needs, so that the medical information reviewed does not leave our entity.

Identified Government Functions. We may disclose protected health information about you if it relates to military and veterans' activities, national security and intelligence activities, protective services of the President, and medical suitability or determinations of the Department of State.

Users' Compensation. We may release your health information for users' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Waiver. If you are an inmate of a correctional institution or under the jurisdiction of a law enforcement official, we may release your health information to the correctional institution or law enforcement official. A release is required: (1) for the institution to provide you with health services; (2) to protect your health and safety or the health and safety of others; and (3) for the safety and security of the correctional institution.

HEALTH INFORMATION

Under certain circumstances, we may use and disclose health information about you for research purposes. All research activities, however, are subject to a special approval process. Before we disclose medical information for research, the project will have been approved through this research approval process. We may, however, use medical information about you in preparing to conduct a research project, for example, to look for patients with specific needs, so that the medical information reviewed does not leave our entity.

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YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding the health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and obtain a copy of your health information. To inspect and copy your health information, please call 1-800-688-1867 for instructions on how to submit your written request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We will respond to you within 30 days of receiving your written request. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. You have the right to request that we make amendments to clinical, billing and other records used to make decisions about you. Your request must be in writing and must explain your reasons for the amendment. We may deny your request if:

- The information was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- The information is not part of the health information used to make decisions about you.
- We believe the information is correct and complete.
- You would not have the right to inspect and copy the record as described above.

We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name that have received your protected health information. Please call 1-800-688-1867 to obtain the appropriate form to request amendment to your record.

Right to an Accounting of Disclosures. You have the right to receive a written list of certain disclosures we made of your protected health information. You may ask for disclosures made up to six (6) years before your request (not including disclosures made prior to April 14, 2003). We are required to provide a listing of all disclosures except the following:

- For your treatment.
- For billing and collection of payment for your treatment.
- For our healthcare operations.
- Occurring as a by-product of permitted uses and disclosures.
- Made to or requested by you or that you authorized.
- Made to individuals involved in your care, for directory or notification purposes, or for disaster relief purposes.
- Allowed by law when the use and/or disclosure relates to certain specialized government functions or relates to correctional institutions and in other law enforcement custodial situations.
- As part of a limited set of information which does not contain certain information which would identify you.

The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure. To request this list or accounting of disclosures, you must submit your request on the appropriate DHE form which can be obtained by calling 1-800-688-1867.

Right to Request Restrictions. You have the right to request that we restrict the use and disclosure of your protected health information. We are not required to agree to your requested restrictions. And, if we agree to your request, there are certain situations when we may not be able to comply with your request. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures that do not require your authorization. You may request a restriction by submitting the appropriate DHE form, which can be obtained by calling 1-800-688-1867.

Right to Request Alternative Ways of Communication. You have the right to request how and where we contact you about medical matters. For example, you may request that we contact you at your work address or phone number. Your request must be in writing. We will accommodate reasonable requests, but when appropriate, may condition that accommodation on your providing us with information regarding how payment, if any, will be handled and your specification of an alternative address or other method of contact. You may request alternative means of communications by submitting the appropriate DHE form, which can be obtained by calling 1-800-688-1867.

Right to a Paper Copy of This Notice. We will provide a paper copy of this notice to you no later than the date you first receive service from us except for emergency services, in which case we will provide the Notice to you as soon as practicable. You may also obtain a copy of this notice at any time from our website, www.dukehealth.org or from any of the DHE treatment facilities listed in this brochure.

CONTACTOR QUESTIONS OR COMPLAINTS

If you have any questions regarding this Notice or if you believe your privacy rights have been violated or you wish to file a complaint about our privacy practices, you may contact:

Privacy Office
Duke University Health System
DUMC Box 3162, Durham, NC 27710
1-800-688-1867

You may also send a written complaint to the United States Secretary of the Department of Health and Human Services.

You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice and to make new notice provisions effective for all protected health information that we maintain by:

- Posting the revised notice at our facilities.
- Making copies of the revised notice available upon request (either at our facilities or through the contact listed in this notice).
- Posting the revised notice on our website, www.dukehealth.org



Duke Health Enterprise Organized Health Care Arrangement

NOTICE OF PRIVACY PRACTICES

WE ARE COMMITTED TO PROTECTING THE PRIVACY OF YOUR HEALTH INFORMATION. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of our privacy practices explains:

1. How we may use and disclose your health services to you.
 2. What rights you have with respect to your health information. These include the right:
 - To inspect and obtain a copy of your health information.
 - To request that we amend health information in our records.
 - To receive an accounting of certain disclosures we have made of your health information.
 - To request that we restrict the use and disclosure of your health information.
 - To request how and where we contact you about medical matters.
 3. How to file a complaint if you believe your privacy rights have been violated.
- If you have questions about this document or any other questions regarding the privacy of your medical information, please call 1-800-688-1867.

Effective Date: April 14, 2003

Si necesita una copia en español
por favor pídasela a un empleado
del hospital o de la clínica. Gracias.

The Duke Health Enterprise Organized Health Care Arrangement covers the following entities:

- Duke University Health System, Inc.
- Duke University Hospital
- Durham Regional Hospital
- Raleigh Community Hospital
- Duke University Affiliated Physicians, Inc.
- Private Diagnostic Clinic, PLLC
- Duke Health Community Care, Inc.
- Associated Health Services, Inc.
- Davis Ambulatory Surgical Center
 - Duke PRMO, LLC
- Duke University School of Medicine
- Duke University School of Nursing
- Duke Clinical Research Institute
- Durham Regional Hospital Medical Staff
- Raleigh Community Hospital Medical Staff
- Davis Ambulatory Surgical Center Medical Staff
- Counseling and Psychological Services (CAPS)
- Duke University Student Health
- Sexual Assault Support Services (SASS)
- Duke University Police Department
- Personal Assistant Services (PAS)
 - Live for Life

IR PLEDGE REGARDING HEALTH INFORMATION:

We are committed to protecting the privacy of health information about you and that can identify you, which we call "protected health information." Protected health information includes information about your past, present or future health, healthcare we provide you, and payment for your healthcare contained in the record of care and services provided by Duke University Health System and the entities within the Duke Health Enterprise (collectively, the "Duke Health Enterprise"). This notice will apply only to records of your health information at facilities of Duke University, Duke University Health System, Duke University Hospital, Durham Regional Hospital, Raleigh Community Hospital, Davis Ambulatory Surgical Center, and the services of Duke University Affiliated Physicians, Duke Health Community Care, Private Diagnostic Clinic, CAPS, Duke University Student Health, SASS, PAS and Live for Life, and records maintained by Duke Clinical Research Institute and Duke UMO (collectively, "DUHS Sites"). Our privacy practices concerning your protected health information are as follows:

We will safeguard the privacy of protected health information that we have created or received.

We will explain how, when and why we use and/or disclose your protected health information.

We will only use and/or disclose your protected health information as described in this Notice.

HOW TO FOLLOW THIS NOTICE

This notice describes the practices of the Duke Health Enterprise (DHE) at DUHS Sites and that of:

- Any health care professional authorized to enter information into your medical record at DHE.

- All departments and units of DHE.
- All employees, staff, volunteers and other DHE personnel.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we may use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within at least one of the categories.

For Treatment. We may use your protected health information to provide, coordinate or manage your health care treatment and related services. This may include communication with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different DHE departments may also access your protected health information in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We may also disclose your protected health information to people, such as home health providers, who may be involved in your medical care after you leave our care.

For Payment. We may use and disclose your protected health information to other providers so they may bill and collect payment for treatment and services they provided to you. Before you receive scheduled services, we may share information about these services with your health plan(s) to obtain prior approval or to determine whether your insurance will cover the treatment. We may also share your medical information with billing and collection departments or agencies, insurance companies and health plans to collect payment for services, claims associated with that care and to consumer reporting agencies (e.g., credit bureaus). For example, if you have a broken leg, we may need to give your health plan(s) information about your condition, supplies used (medications or crutches) and services you received (x-rays or surgery). This information is given to our billing agency and your health plan so we can be paid or you can be reimbursed.

For Health Care Operations. We may use and disclose your protected health information for health care operations. These uses and disclosures allow us to improve the quality of care we provide and reduce health care costs. Examples of uses and disclosures for health care operations include the following:

- Reviewing and improving the quality, efficiency and cost of care that we provide to you and other patients.
- Evaluating the skills, qualifications, and performance of healthcare providers taking care of you.
- Providing training programs for students, trainees, health care providers or non-health care professionals (for example, billing clerks) to help them practice or improve their skills.
- Cooperating with outside organizations that assess the quality of care we provide. These organizations might include government agencies or accrediting bodies like the Joint Commission on Accreditation of Healthcare Organizations and the Accreditation Association of Ambulatory Healthcare, Inc.
- Cooperating with outside organizations that evaluate, certify or license health care providers, staff or facilities in a particular field or specialty. For example, we may use or disclose protected health information so that one of our nurses may become certified in a specific field of nursing.

SPECIAL SITUATIONS

We may use and/or disclose protected health information about you for a number of circumstances in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object. Those circumstances include:

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law or other judicial or administrative proceedings. For example, we may disclose your protected health information in response to an order of a court or administrative tribunal.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent or reduce the threat.

Public Health Risks. We may disclose your health information to appropriate government authorities for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability.
- To report births and deaths.
- To report child abuse or neglect.
- To report reactions to medications or problems with products.
- To notify people of recalls of products they may be using.
- To be at risk for contracting or spreading a disease or may be at risk for contracting or spreading a disease.
- To notify the appropriate government authority if we believe an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or consent or required or authorized by law.
- To support public health surveillance and combat bioterrorism.

Health Oversight Activities. We may disclose your health information to a federal or state health oversight agency that is authorized by law to oversee our operations.

Law Enforcement. We may release health information if asked to do so by a law enforcement official and such release is required or permitted by law. For example, we may disclose your protected health information to report a gunshot wound. However, if you request treatment and rehabilitation for drug dependence from us, your name will be treated as confidential and we will not disclose your name to any law enforcement officer unless you consent.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release health information to funeral directors as necessary for them to carry out their duties.

Organ and Tissue Donation. We may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.