MRN:

NCIAP
People's Medical Care
non profit medical care services for the uninsured

Patient Name/Nombre: _____ **DOB/Fecha Nacimiento:** _____

Sex/Sexo: M F **Marital Status:** single/soltero married/casado divorce/divorcio widow/viudo(a)

Address/Direcion: _____ **Apt #:** _____

City/Ciudad: _____ **Zip Code/Codigo Postal:** _____

Telephone/Telefono: _____ **Email/Correo Electronico:** _____

In case of emergency/En caso de emergencia contactar:

Name/Nombre: _____ Relationship/Relacion: _____

Phone/Telefono: _____

Medical Conditons/ Condicion Medicas:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Allergies/Alergias:

1. _____ Reaction/Reacion: _____

2. _____ Reaction/Reacion: _____

3. _____ Reaction/Reacion: _____

Current Medicatons/Medicamentos Presente:

1. _____ Dosage/Dosis: _____
2. _____ Dosage/Dosis: _____
3. _____ Dosage/Dosis: _____
4. _____ Dosage/Dosis: _____
5. _____ Dosage/Dosis: _____
6. _____ Dosage/Dosis: _____
7. _____ Dosage/ Dosis: _____
8. _____ Dosage/Dosis: _____

- **Would you like someone to have access to your records? Y N**
  I give permission to _____ to have access to my information.

- **¿Le gustaría que alguien tenga acceso a sus registros? Si No**
  Doy permiso a _____ tener acceso a mi información.

- **How did you hear about us?** Family/Friend Radio Ad Newspaper/flyer Other: _____

- **¿Como supiste de nosotros?** Familia/Amigo Anuncio de radio Periódico/Volante Otro: _____

Patient Signature/Firma: _____ **Date/Fecha:** _____

NCIAP MEDICAL CARE

Patient History/Historial del Paciente

Name/Nombre:_____ DOB/Fecha De Nacimiento:_____

Symptoms---Please circle if in the last 2 weeks you have been experiencing the following problems:

Simtomas----Por favor circule si en las ultimas 2 semanas usted a estado experimentado los siguientes

Fever/Fiebre	Unexplained weight loss/ Perdida de peso inexplicable	Chills/Escalofrios
Changes in vision/Cambios en la vista	Difficulty swallowing/Difficultad al pasar	Problems with hearing/Problemas al oir
Chest pain/Dolor en el pecho	Palpitations/Palpitaciones	Cough/Tos
Wheezing/Resuello	Shortness of breath/Falta de respiracion	Stomach pain/Dolor en el estomago
Blood in stools/Sangrado en las feces	Constipation/Estrenimiento	Blood in urine/Sangrado en la orina
Burning with urination/Ardor al orinar	Frequent urination/Frecuencia al orinar	Nauseа/Nauseas
Depression/Depresion	Anxiety/Ansiedad	Panic attacks/ Ataques de panico
Sore throat/Dolor en la garganta	Swollen glands/Glandulas inflamadas	Foot swelling/Inchason en el pie
Weakness/Debilidad	Easy bleeding/Sangrado facil	Frequent Headaches/Dolores de cabeza frecuentes
Loss of consciousness/ Falta de Conosimiento	Numbness in arms-legs/Adormecimiento en manos o piernas	Skin lesions/Lesiones en la piel
Skin rashes/Rosaduras en la piel	Ear pain/Dolor en los oidos	Joint Pain/Dolor en coyunturas

Medical History Historial Personal medico	**Year Diagnosed Ano que fue diagnosticado**	**Family History/Historial Familiar**	**Family member/ Miembro de familia**
Heart Disease/Enfermo del Corazon		Heart Disease/ Enfermedo del corazon	
High Blood Pressure/Hipertension		High blood Pressure/Hipertension	
Diabetes:Type/Diabetes:Tipo		Diabetes:Type/Diabetes:Tipo	
Cancer		Cancer	
Kidney Disease/Enfermedad Renal		Kidney Disease/Enfermedad Renal	
Other/Otro		Other/Otro	

For Females	**Only**	**Solo Para Mujeres**	
Is there any chance you are pregnant? Existe la posibilidad de que este embarazada	Yes/Si No	When was your last mammogram? Cuando fue su ultimo mamografia?	Date: Fecha:
When was your last pap? Cuando fue su ultimo papanicolau	Date: Fecha:	Have you ever had an abnormal mammogram? Alguna vez ha tenido una mamografia anormal?	Yes/Si No
Have you ever had an abnormal pap? Alguna vez has renido un papanicolau anormal?	Yes/Si No	Your last menstrual period began on Cuando fue su ultima menstruasion? Number of pregnancies/Numero de embarazos	Date: Fecha: #

Do you smoke? Ustd. Fuma?	Yes/No How Much/Cuanto
Do you drink? Ustd. Toma?	Yes/No How much/Cuanto
Do you exercise? Hace Ejercisio	Yes/No

List any past surgeries/Apunte cualquier cirujia que tuvo en el pasado

_____

_____

_____

NCIAP Medical Care

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for NCIAP **Medical Care** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **NCIAP Medical Care** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **NCIAP Medical Care** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to NCIAP Medical Care, 5720 Creedmoor Rd, Suite 200, Raleigh NC 27612, Att: Sudha Rathie.

With this consent, **NCIAP Medical Care** may call my home or other alternative location and leave a message on voice mail 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 test results, among others.

With this consent, **NCIAP Medical Care** 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 as long as they are marked "Personal and Confidential."

With this consent, **NCIAP Medical Care** may e-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 **NCIAP Medical Care** restrict how it uses or discloses my PHI to carry out TPO. 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 allow **NCIAP Medical Care** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **NCIAP Medical Care** may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian/Firma

_____ _____

Print Patient's Name/Nombre de paciente Date/Fecha