We look forward to your comprehensive exam with us. We would like to provide you with information that will be helpful to you in your interaction with our office. Please read this prior to your visit.

OFFICE HOURS:

Our office is open Monday through Friday 8:00am to 12:00pm and 1:00pm to 4:30pm. In the event of an emergency, after hours or on weekends, please call the office telephone number (828) 258-0397 and follow the instructions given to you on the recording to reach our on-call physician. If for some reason you are unable to reach the on-call physician contact the answering service at (828) 251-4415.

APPOINTMENTS:

Our goal is to see our patients at their scheduled appointment time. Please arrive for your appointment on time. Unfortunately, for patients who arrive late, it may be necessary to re-schedule the appointment as this affects all subsequent appointments. If it is necessary to cancel or change an appointment, kindly notify the office at least 24 hours in advance. Occasionally we do have emergencies requiring more of the physician's time and ask for your understanding in these matters.

BLOOD WORK:

If you have a morning appointment, please do not eat prior to your appointment. If you have an afternoon appointment you should have a "light" breakfast, and no lunch if possible. You may drink tea, black coffee or water. Please take your usual morning medications with water.

MEDICATIONS:

Be sure to bring with you any medications you are taking.

Please ask your physician for refills of your medications during your visit. We do not call medications to "Mail-Order" pharmacies, but will provide you with a written prescription to mail to your drug company. We do not refill medications after hours or on weekends.

INSURANCE:

Before your scheduled appointment you will need to check with your employer or insurance company to verify that your plan allows you to see a physician here at Carolina Internal Medicine...(Because of the ever changing insurance environment, we cannot possibly know every detail of every insurance company). Your insurance policy is a contract between you and your insurance company. It is your responsibility to know and understand your plan's requirements and policies regarding co-payments, co-insurance, deductibles and benefits. Please check with your insurance company to see if you have a wellness plan that will cover a complete physical examination once a year and, if so, notify your physician at the time of your visit. Your co-payment is due, in full, the day of your visit. You may check with your insurance company to determine what your co-payment is. We will file your insurance for you, and you will be responsible for any charges not covered by your insurance.

Unless we participate with your insurance company (have a contractual agreement with them), we will ask that you pay at the time that medical services are rendered.

We will file your office visit to your insurance company and they will then reimburse you for the charges. If you have a second or third insurance company, you will need to get an explanation of benefits (EOB) from your primary insurance company and mail along with the form we give you upon checking out.

Carolina Internal Medicine accepts cash, personal checks, Visa and Master Card. There is a $30.00 charge for all returned checks and you will then be asked to pay cash or money order for future appointments.

If you have any questions please call our Insurance Department at (828) 258-0397.

WELLNESS BENEFIT

Many insurance companies now offer their participants a **Wellness Benefit**. This benefit was designed to encourage yearly physical examinations. Please notify your Nurse or Physician at the time of your physical examination if your insurance plan offers this benefit. Just as there are multiple insurance companies, there are many types of wellness benefits. It will aide us in filing your insurance claim in a timely manner, if you know what services are covered by your particular plan.

Your complete physical may include charges for **Preventive Services** (services that are undertaken unrelated to a specific diagnosis). These services usually include, but are not limited to the following: a review and update of the past medical history, surgical history, social history, family history, immunization status, review of the need for specific screening test (mammograms, sigmoid exams, bone density tests, prostate specific antigen, etc.) Alternatively, the visit may necessarily be coded with an **Evaluation and Management** charge related to a specific disease process (such as thyroid, blood pressure, heart disease, diabetes, etc.)

At Carolina Internal Medicine Associates we believe that periodic comprehensive examinations are an important and necessary part of good quality medical care. We did want to inform you of our billing procedure for these services.

Our goal is to provide the best medical care possible. If you have questions, comments, or suggestions on how we may improve our service, please let us know.
Please visit our website for all information and forms at **www.carolinaim.com.**

Carolina Internal Medicine Physicians and Staff.

Name: _____

NEW PATIENT COMPREHENSIVE EXAMINATION FORM

Chief Concerns: _____

_____

List ongoing Medical illnesses below (such as diabetes, hypertension):

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

List any medications that have caused an **allergic reaction** (rash, shortness of breath, or shock) _____ _____ _____

List medications that you do not **tolerate**: _____ _____

_____ _____

Date of Immunizations:

Pneumovax: _____ Influenza _____ Tetanus: _____

Hepatitis A vaccine: _____ Hepatitis B vaccine: _____

Tuberculosis (PPD) test: _____

Other vaccines: _____

Family History

	Alive/Age	Health Problems	Deceased/Age	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Sons				
Daughters				

Name: _____

PERSONAL HISTORY

(Please circle or answer below where appropriate)

Marital Status: Single Married Divorced Widowed
Occupation: _____
Living Will: Yes No
Tobacco: None
Currently smoke_____packs/day and have done so for_____years
Previously smoked_____packs/day for_____years stopped in_____
Use chewing tobacco: Yes No

Alcohol: None
Liquor: number of ounces per day_____
Beer: number of cans/bottles/day_____
Wine: number of glasses/day_____

Substance Abuse: None currently abuse previously abused
What substance? _____

Caffeine(coffee, tea, caffeinated soda): None 1-3 cups 4-6 cups more than 6 cups/day

Exercise: Type_____ amount per week_____

Diet: No specific diet, diabetic, weight reduction, low saturated fat, low salt
Name: _____

CURRENT MEDICATIONS

Please Bring All Medications With You (In The Bottles) And List All Of The Information Below:

Med. Name/Strength	How Med. Taken	Number of Refills
1._____	1._____	1._____
2._____	2._____	2._____
3._____	3._____	3._____
4._____	4._____	4._____
5._____	5._____	5._____
6._____	6._____	6._____
7._____	7._____	7._____

List Surgeries, major hospitalizations, accidents (with dates):

1._____ 4._____

2._____ 5._____

3._____ 6._____

Date of last complete physical exam: _____

Date of last cholesterol blood test: _____ Result (if known) _____

Date of last eye exam:_____

Have you had your stool checked for blood? Yes No When_____

Flexible Sigmoidoscopy	Yes	No	When_____
Barium Enema	Yes	No	When_____
Colonoscopy	Yes	No	When_____

Date of last EKG: _____ Date of last Chest x-ray:_____

Any other heart (cardiac) studies: _____

For Women only:

Date/Result of last gynecological exam (breast and pelvic):_____

Date of last menstrual period:_____ Date of last pap smear_____

Have you had previous abnormal pap smears? _____

Date/Result of last mammogram:_____

Date/Result of last bone density scan:_____

For Men only:

Date of last prostate exam:_____

Date of last PSA:_____ Result (if known) _____

Name: _____

1. GENERAL: Change in activity and energy, appetite change, weight change, fever, chills, night sweats

2. HEAD: Headache, trauma

3. EYES: Visual changes, double vision

4. EARS: Ringing, hearing loss, infection, drainage, pain

5. NOSE/THROAT: Nose bleed, gum bleeding, tongue soreness, difficulty swallowing, hoarseness

6. LUNGS: Shortness of breath, cough, wheezing, coughing up blood

7. HEART: Chest pain, heart skips, rapid heart rate, exertional shortness of breath

8. ABDOMEN: Stomach pain, sour taste in throat, nausea, vomiting, diarrhea, constipation, black stools, blood in stool

9. URINARY: ***Men***: Difficulty in urination, blood in urine, prostate enlargement, sexual problems, penile discharge
   Women: Painful urination, increase in frequency of urination, blood in urine, vaginal discharge, vaginal bleeding outside of normal menstrual cycle, menopause, vaginal dryness, hot flashes, mood swings

10. JOINTS/MUSCLES: Pain in joints, pain in muscles, weakness joint swelling, Backache

11. NEUROLOGICAL: Dizziness, loss of consciousness, transient loss of function in arms and legs, seizures

12. SKIN: Rashes, non-healing lesions, history of skin cancer

13. BREAST/CHEST: Breast lumps or tenderness, chest wall tenderness

14. EMOTIONAL: Nervousness, mood swings, depression, difficulty coping

15. ENDOCRINE: Thyroid trouble, heat or cold intolerance, diabetes, excessive thirst, hunger or urination

16. BLOOD/GLANDS: Anemia, easy bruising, easy bleeding, swollen glands

EXPLANATIONS: _____

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