

Chestnut Ridge Medical

Contact Us

Phone & Fax

Phone: (828) 386-3350

Fax: (828) 386-3352

Hours

Monday - Friday: 8:00 a.m. - 5:00 p.m.

Location

623 Chestnut Ridge Parkway
Blowing Rock, NC 28605



Thank you for choosing Chestnut Ridge Medical as your healthcare provider. We look forward to seeing you at your appointment.

This new patient information packet includes directions to our office and contact information for your records. Also enclosed is the paperwork that you will need for your upcoming appointment. Please complete the paperwork enclosed and bring it to your appointment. Our Billing & Insurance Information, Notice of Privacy Practices and Patient Bill of Rights & Responsibilities are available online at unhealthappalachian.org.

Chestnut Ridge Medical is committed to providing the finest quality, evidence-based medical care available. The goal of the practice is to help patients achieve and preserve the best quality of health/life for as many years as possible. Committed to lifelong learning, our providers welcome questions on new and emerging treatments and strategies for preventive health.

Gynecology and Women's Health: Chestnut Ridge Medical provides gynecology and women's health services. We work closely with the obstetrics providers and midwives at Women's Health. Chestnut Ridge Medical meets a woman's needs throughout her life cycle, ranging from well-women care to complex medical and surgical management of gynecological disorders.

New Patient Checklist

For your first appointment, please arrive 15 minutes early and bring the following:

- Insurance Card
- Pharmacy Information
- Medical Records
- Payment
- Current Medications/Prescription Bottles
- Questions for doctor
- Photo ID
- Completed forms from this packet

_____ has an appointment with

Mon. Tues. Wed. Thurs. Fri.

_____ date _____ a.m./p.m.

To reschedule your appointment, please call (828) 386-3350.

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unhealthappalachian.org

HDF9218 02/17/25



Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

New Patient Medical History Form-OB/GYN
Chestnut Ridge Medical
Form #11440

Please list any medical problems that you have: _____

Have you had any hospitalization, injuries, fractures or motor vehicle accidents? Yes No

CIRCLE if you have or have you ever had:

- | | | | | |
|------------------------|------------------------------|------------------------|--------------------|----------------------|
| Blood clots | Anesthetic reaction | Bleeding disorder | Asthma | Anemia |
| Cancer | Alcohol abuse | Drug & substance abuse | Depression/anxiety | Eating disorder |
| Heart disease | High blood pressure | High cholesterol | Hepatitis/Jaundice | Diabetes |
| Kidney stones | Irritable bowel syndrome | Thyroid problems | Seizure disorder | Stroke |
| Tuberculosis | Mitral valve prolapse | Stomach ulcers | Rheumatic fever | Transfusion reaction |
| Chronic lung condition | Lupus or autoimmune disorder | | | |

List all medications that you take with the dose and timing (including birth control pills): None

Drug	Dose	Frequency	Reason for Medication

List all non-prescription medications that you take regularly including vitamins, herbs and anti-inflammatory medication None

Type	Dose	Timing

Allergies: List all adverse reactions or allergies you have to medications and what happened: None

Surgical History: List all surgeries you have had including breast biopsies, breast augmentation, tonsillectomy, appendectomy, tubal ligation, LEEP. None

Date	Operation	Diagnosis	Surgeon/Hospital

General Health

- How much alcohol do you drink each day? None Average less than 1/day Average 1/day Average more than 1/day
- Do you smoke? No Yes Amount/day _____ How many years? _____
- If you quit smoking, when did you stop? _____
- Have you used marijuana or other drugs in the last 5 years? No Yes What kind? _____
- Do you have concerns regarding your relationship / significant other? No Yes
- What pharmacy do you use? _____ Who is your primary care provider? _____
- Occupation: _____
- Education Level: _____

Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

Gynecologic History

- Date of last pap smear: _____ None
- Date/place of last mammogram: _____ None Normal: Yes No
- Date/place of last Colonoscopy: _____ None Normal: Yes No
- Date/place of last DEXA scan: _____ None Normal: Yes No
- Do you perform self breast examinations monthly? Yes No
- Are you currently pregnant? Yes No Maybe
- When was the FIRST day of your last menstrual period? : _____
- Length of cycle from first day to first day each month: _____ days Irregular Regular
- Average length of each period: _____ Heavy Moderate Light
- What do you use to keep from getting pregnant? Nothing Vasectomy Condoms Rhythm
 Tubal ligation IUD Diaphragm Birth Control Pills / Patch Abstinence Depo-Provera
 Implanon Other _____
- Have you received the HPV vaccine? _____ Did you get all 3 injections? _____

Please CIRCLE if you have or have had any of the following:

- | | | | | |
|--------------------------|----------------------------|--------------------|---------------------|-------------|
| Menstrual Cramps | PMS | HPV | Endometriosis | Fibroids |
| Ovarian cysts | Pelvic adhesions | Herpes | Gonorrhea | Syphilis |
| Chlamydia | Condyloma (warts) | Abnormal pap smear | Recurrent vaginitis | Trichomonas |
| Recent change in periods | Laser / Freezing of Cervix | Leaking urine | Constipation | |

OB history: None

- Number of times pregnant _____ Full-term births _____ Premature births _____
- Elective termination _____ Miscarriages _____ Ectopic pregnancies _____
- Adopted children _____ Step children _____ Twins _____

Pregnancies lasting more than 20 weeks:

Date	Length of Pregnancy	Vaginal/ C-Section	Sex	Weight	Hospital/Doctor	Complications

Family history:

	Age if Living	Health-if good, state why	Age at Death	Cause of Death
Father				
Mother				
Husband				
Brother & Sister				

Circle any of the following that affects your family: Diabetes, High Blood Pressure, Kidney Problems, Blood Clots, Heart Disease, Stroke, Osteoporosis, Cancer, Mental Illness, Tuberculosis

Patient Signature: _____ Date: _____ Time: _____

Is there any other patient information you would like to share with us? _____

Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

Patient Registration Form (ARMA)

Form #11332

Patient Name: First _____ M/I _____ Last _____

Date of Birth: ___/___/___ **Gender:** Male Female **Social Security #:** ___-___-___

Marital Status: Married Single Divorced Separated Widowed Life Partner

Mailing Address: Street- _____

City- _____ State- _____ Zip Code- _____

Primary Phone #: _____ Cell Home

Secondary Phone #: _____ Cell Home

Work Phone #: _____ **Employer/Occupation:** _____

E-mail: _____

Emergency Contact: _____ **Relationship to patient:** _____ **Ph #:** _____

I consent to Appalachian Regional Medical Associates (“ARMA”) or its representatives: calling my phone and leaving a message texting me (message and data rates may apply) e-mailing me about balances due, financial assistance, appointments, pre-registration, lab results, and other healthcare information. Methods of contact may include pre-recorded voice messages and the use of automatic dialing services.

What is your ethnicity? Hispanic or Latino Not Hispanic or Latino

Select one or more races to indicate what you consider yourself to be: Asian White

American Indian or Alaskan Native Black or African American

Native Hawaiian or other Pacific Islander Other: _____

Preferred language? English Spanish Other: _____

How did you hear about us?

Billboards Doctor Friends/Family Magazine Newspaper Social Media Radio TV

ARHS Website Other _____

If patient is a minor please print Guardian Name:

First: _____ M/I: _____ Last: _____

If patient has a guarantor (someone else responsible for the bill) please provide information below:

Patient’s relationship to Guarantor: _____

Guarantor’s Name: First: _____ M/I: _____ Last: _____

Mailing Address: Street- _____

City- _____ State- _____ Zip- _____

Date of Birth: ___/___/___ Social Security #: ___-___-___ Phone #: _____

Employer: _____ Employer Phone #: _____

Signature of Patient/ Legal Representative ▶		Date: Time:
Name of Patient/ Legal Representative (Please Print) ▶	Relationship of Legal Representative ▶	

GENERAL CONSENT FOR TREATMENT (PAGE 1 of 2)

HIM #129s

I understand that the University of North Carolina Health Care System (UNC Health) is an integrated health system made up of various entities as reflected at www.unchealthcare.org/documentapplicability (each referred to in this form as a “UNC Health affiliate” or collectively as “UNC Health affiliates”). **This consent will be effective for 1 year after the date I sign it at any UNC Health affiliate of which I am a patient; however, this consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect.**

Consent for Treatment/Care

I consent to treatment and care by UNC Health affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through electronic communications/telemedicine. I also consent to treatment and care by physicians and health care providers who are not employees or agents of UNC Health affiliates (including but not limited to physicians and providers in the specialties of emergency medicine, anesthesia, surgery, pathology, psychiatry, obstetrics and gynecology, radiology, oncology, cardiology, neurology, pediatrics and internal medicine) but are authorized by UNC Health affiliates to provide treatment and care to me as a patient of the UNC Health affiliate, and who provide services to the UNC Health affiliates’ patients in accordance with their professional judgment (collectively, “Independent Providers”). I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care that I have received from UNC Health affiliates. I understand that my care team at UNC Health affiliates may include resident physicians and students or other trainees. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

Consent for Use and Release of Information

I give permission to UNC Health affiliates – including their treating and referring providers and other staff members – to release any information about me, my health, the health services provided to me, or payment for my health services as permitted by law. For more detailed information about the way my information may be used or released, I can read UNC Health’s *Notice of Privacy Practices*.

I give permission to UNC Health affiliates and their employees, agents, and contractors to take photographs or make videos of me for permissible treatment, payment, health care operations, education and for research purposes where either I have given consent or an Institutional Review Board has approved as long as such recordings are consistent with policies and laws that protect my rights.

Consent for Use Within UNC Health

I further give permission to UNC Health affiliates and their treating providers and other staff members to disclose to each other any of my sensitive information necessary for my treatment, including information related to behavioral and/or mental health (including records of my treatment by a facility whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, developmentally disabled, or substance abusers, as defined by N.C.G.S. Chapter 122C, Articles 1 and 3), drugs and alcohol (including records of a provider that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

Financial Responsibility

I understand and agree that physician charges for medical and related professional services performed or supervised by a physician will be billed separately from hospital charges. I understand that my actual charges may be different from charge estimates given to me. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, guardian, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges. If I have overpaid any of my accounts with a particular UNC Health affiliate, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with other UNC Health affiliates. I designate UNC Health as my authorized representative with respect to any health or liability insurance policy or any group health plan, fund or program applicable to me, and I authorize UNC Health to exercise on my behalf any grievance, claim or appeal rights, including external review rights, I may have under any such health or liability insurance policy or group health plan, fund or program.

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to the appropriate UNC Health affiliate on my behalf. I authorize UNC Health affiliates to bill directly and assign the right to



* S D C O N A U T *

all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the appropriate UNC Health affiliate.

Social Security Number

I have given my social security number voluntarily. UNC Health affiliates may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

Wireless Telephone Number and Electronic Mail

UNC Health affiliates, Independent Providers (as defined above), and/or any of their respective agents, representatives, or business associates (including their billing service providers or debt collectors), may contact me by electronic mail or telephone (including phone calls, prerecorded messages using automated technology, or text messages) at any electronic mail address or number contained in my UNC Health affiliate's or my Independent Provider's records, including wireless telephone numbers, for the purposes of communicating with me about my health care, requesting information about patient satisfaction, servicing my account, and/or collecting amounts due. I also understand that UNC physician researchers or members of their research team may also contact me via phone or electronic mail to determine my interest in participating in human subjects research. I consent to receive electronic mail, text messages, phone calls, and prerecorded messages using automated technology from UNC Health Care affiliates, Independent Providers, and/or any of their respective agents, representatives or business associates, including their billing service providers or debt collectors. I understand that consent to receive electronic mail, text messages, phone calls, and prerecorded messages using automated technology is not required to receive health care services. I understand that if I wish to revoke consent to receive communications from UNC Health affiliates via phone calls, text messages, prerecorded messages using automated technology, or electronic mail, I may do so by following the instructions in the communication regarding opt-out, if any, or by calling UNC Health Customer Service at (888) 996-2767. If I wish to revoke consent to receive communications from an Independent Provider via phone calls, text messages, prerecorded messages using automated technology, or electronic mail, I may do so by following the instructions in the communication regarding opt-out, if any, or by contacting the Independent Provider directly.

Personal Property

Unless I am a resident of a skilled nursing facility, I understand that UNC Health affiliates do not assume responsibility for my personal belongings that I keep in my possession, and I release UNC Health affiliates from all liability for the loss or theft of, or damage to, such belongings.

I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY ANY UNC HEALTH CARE AFFILIATE, OR IN PROGRESS.

I AUTHORIZE UNC HEALTH CARE AFFILIATES TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I HAVE READ AND UNDERSTAND THIS FORM, BEEN OFFERED A COPY, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.

DATE: _____ TIME: _____
PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME

RELATIONSHIP, if not patient: _____

GUARANTOR OF PAYMENT: This line may be signed by someone who wishes to agree to be responsible for payment *other than*: 1) the patient, 2) the patient's spouse, or 3) a minor patient's parent.

By signing as guarantor below, I agree to pay all charges of any UNC Health Care affiliate not paid, **even if I am otherwise not legally obligated to pay.**

DATE: _____ TIME: _____
GUARANTOR OF PAYMENT SIGNATURE

PRINTED NAME



Patient Name _____
Date of Birth _____



Limited Release of Information to Family/Friends for Physician Clinics
HIM# 1315s

I give my permission to my physician practice that is part of the UNC Health Care System to share certain personal health information about me with the individuals listed below. These individuals will only be given information about me that is related to their involvement in my care or payment for my care.¹ I understand that I am not required to complete this form in order to obtain health care.

Name: _____ Phone Number: _____

Relationship: _____ Talk to this person about (*check each box that applies*):

Any non-sensitive² information regarding my health care or payment for my health care.

OR

Only these things:

<input type="checkbox"/>	My appointments – scheduling & reminders	<input type="checkbox"/>	My test results
<input type="checkbox"/>	My after visit summary (AVS)	<input type="checkbox"/>	My bills
<input type="checkbox"/>	Other:		

Name: _____ Phone Number: _____

Relationship: _____ Talk to this person about (*check each box that applies*):

Any non-sensitive² information regarding my health care or payment for my health care.

OR

Only these things:

<input type="checkbox"/>	My appointments – scheduling & reminders	<input type="checkbox"/>	My test results
<input type="checkbox"/>	My after visit summary (AVS)	<input type="checkbox"/>	My bills
<input type="checkbox"/>	Other:		

If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes.

DATE: _____ TIME: _____

PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME & RELATIONSHIP (if not patient): _____

¹ This form is not a substitute for a health care power of attorney or other formal designation of an individual authorized to make health care decisions for you if you are not able. If an individual listed above is your guardian or agent (under a power of attorney), or is otherwise authorized by law to act on your behalf, your health care provider may share as much of your personal health information with that person as the law permits.

This form is not a substitute for a valid HIPAA compliant written authorization when it is required to release copies of medical and billing records or information.

² Non-sensitive information excludes mental health, alcohol and substance abuse, HIV and other communicable diseases, and genetic testing. **This form is not considered sufficient authorization to release sensitive information.**

