

PATIENT INFORMATION FORM

Date: _____

Patient's Name: _____ DOB: _____
Last First Middle

Maiden Name: _____

Patient's Address: _____
Street or P.O. Box

City/State/Zip: _____

Social Security Number: _____ Sex: M F Marital Status: S M D W

Home Phone: _____ Cell Phone: _____

Email address: _____

Employer: _____ Work Phone: _____

Address: _____ City/State/Zip: _____

GUARANTOR INFORMATION *(Person responsible if the insurance doesn't pay all)*

NOT Employed Self-Employed

Guarantor's Name: _____

Relation to Patient: Self Parent Guardian Spouse

DOB: _____ Social Security: _____

Guarantor's Address: _____
Street or P.O. Box Phone Number

Guarantor's Employer: _____

Work Number: _____ Occupation: _____ Full Time Part Time

EMERGENCY CONTACT

Name: _____ Phone Number: _____

INSURANCE INFORMATION

No Insurance

Name of Insurance: _____ Policy Number: _____

Group Number: _____ Group Name: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Social Security: _____

A COPY OF THE PATIENT'S INSURANCE CARD AND PICTURE ID ARE REQUIRED.

PATIENT HEALTH HISTORY FORM

Patient's Name: _____ Date: _____

Date of Birth: ____/____/____ Sex: Male Female

Marital Status: Married Single Separated Divorced Widowed

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

Please Check Any Of The Following Problems That Apply To You: _____ NO PROBLEMS

GENERAL <input type="checkbox"/> Fever <input type="checkbox"/> Sweats	ENDOCRINE <input type="checkbox"/> Excessive urination <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Fatigue <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance	HEMATOLOGIC <input type="checkbox"/> Easy bruising <input type="checkbox"/> Easy bleeding <input type="checkbox"/> Hard to stop bleeding	NUTRITION <input type="checkbox"/> On a special diet <input type="checkbox"/> Weight gain or loss greater than 10 pounds	RESPIRATORY <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of breath with exertion
ALLERGY <input type="checkbox"/> Seasonal <input type="checkbox"/> Symptoms <input type="checkbox"/> Sneezing <input type="checkbox"/> Itchy eyes <input type="checkbox"/> Runny nose <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Postnasal drip	EYES <input type="checkbox"/> Blurred vision <input type="checkbox"/> Changing vision	MENTAL HEALTH <input type="checkbox"/> Insomnia <input type="checkbox"/> Guilt <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Suicidal thoughts	GI <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in stool	SKIN <input type="checkbox"/> Rash <input type="checkbox"/> Changing mole <input type="checkbox"/> Itching <input type="checkbox"/> Slow healing wounds
CARDIOVASCULAR <input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Ankle swelling <input type="checkbox"/> Palpitations	GENITOURINARY <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Burning with urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Awaken at night to urinate	EAR/NOSE/THROAT <input type="checkbox"/> Ear pain <input type="checkbox"/> Runny nose <input type="checkbox"/> Sneezing <input type="checkbox"/> Postnasal drip	MUSCULOSKELETAL <input type="checkbox"/> Joint swelling <input type="checkbox"/> Joint pains <input type="checkbox"/> Muscle pains	NEUROLOGIC <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Headaches <input type="checkbox"/> Weakness
DAILY LIVING <input type="checkbox"/> Violence in your home <input type="checkbox"/> Problems with sex <input type="checkbox"/> Changes in functional ability <input type="checkbox"/> Exposure to sexually transmitted disease <input type="checkbox"/> Changes in eating habits <input type="checkbox"/> Changes in sleeping habits <input type="checkbox"/> Problems urinating				

SOCIAL HABITS:

Have you ever smoked? Yes No Use: Current Past

Type: Cigarettes Cigars Oral Pipe Other Number per Day: _____ Number of Years: _____

Have you ever drunk alcohol? Yes No Use: Current Past Type: Beer Wine Liquor

Amount: 1-2 times per year 1-2 times per month 1-2 times per week 3-5 times per week daily
 Several times per day

Have you ever used illegal drugs? Yes No Use: Current Past

Type: Amphetamines Inhalants Glues Solvents Cocaine Marijuana Ecstasy Hallucinogen
 Methamphetamines LSD Prescription Medications Heroin Other _____

Amount: 1-2 times per year 1-2 times per month 1-2 times per week 3-5 times per week daily
 Several times per day

How many glasses/cups of caffeine do you drink daily? _____

Do you wear seat belts? Always Usually Sometimes Never

What is your occupation? _____

Are you sexually active? Yes No If so, 1 partner Multiple partners With women With men

Are you coping well with your stress? Yes No

Do you often feel depressed or down for more than a few days with no apparent cause? Yes No

Do you exercise? Yes No Duration (Average Number of Minutes) _____ per session?

How many times per week? 1-2 times 2-3 times 3-4 times 4-5 times 5-6 times daily

Type of exercise: Walking Aerobics Running Swimming Weight Lifting Yoga Other: _____

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

ILLNESS	Mother If deceased, enter age at death ____	Father If deceased, enter age at death ____	Brothers/Sisters If deceased, enter age at death ____	Paternal Grandparent	Maternal Grandparent
High Blood Pressure					
Heart Attack/ Heart Surgery					
Diabetes					
Stroke					
Seizures					
COPD					
Kidney Disease					
Cancer (Type/Location)					
Osteoporosis					
Thyroid Problems					
Mental Illness					
Rheumatoid Arthritis					
Lupus					

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

- High blood pressure/hypertension High Cholesterol Liver Disease Diabetes ("sugar") Asthma
 Thyroid Problems Kidney Disease Heart Attack/By-pass Surgery COPD Ulcers Stroke
 Seasonal Allergies/Hay fever Heart Failure Heart Murmur Irregular Heartbeat Migraines
 GI Bleed Seizures/Epilepsy Stomach Problems Intestinal Problems Reflux Disease Glaucoma
 Psychiatric Illness Arthritis Abnormal PAP

Other: _____

Cancer: Type & Location _____

List any hospitalizations: _____

List any surgeries, dates, and who performed them: _____

SCREENINGS AND IMMUNIZATIONS:

SCREENINGS	DATE	IMMUNIZATIONS	DATE RECEIVED
Mammogram		Tetanus	
Pap Smear		Pneumovax	
Colonoscopy		Shingles	
Bone Density		Hepatitis B	
PSA		PPD (TB skin test)	
Vision Screening			

FEMALE ONLY: How often do you examine your breasts? _____ Do you see an OB/GYN doctor? Yes No
of pregnancies _____ # of live births _____

MALE ONLY: Do you do self-testicular exams? Yes No Do you have any problems with erections? Yes No

List any Allergies: _____

List ALL CURRENT MEDICATIONS (including over the counter, vitamins, herbal, and health food preparations):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Are Blood Transfusions Acceptable to Patient in Emergencies? Yes No

How many people live with you? _____

Do you have: Advanced Directive Living Will Healthcare Power of Attorney

How do you learn best? Read it Tell me Show me Highest level of education completed? _____

Have you fallen in the past 30 days? Yes No

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CONSENT TO MEDICAL TREATMENT

I am suffering from a condition requiring medical/surgical services, and hereby consent to the rendering of such care. Medical/surgical treatment may include routine diagnostic procedures and such medical treatment as the attending physician(s) is authorized to perform by the State of South Carolina.

Signature of Patient

Date

If the patient is a minor, the signature of a parent or guardian is required.

If the patient is unable to sign for himself/herself, the patient should mark an "X" and RMC Primary Care staff will write "Mark of (patient's name)", and two staff members will witness the mark.

If anyone other than the patient is signing, we need the patient's name and the name of the signing adult along with their relationship to the patient.

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ASSIGNMENT OF MEDICARE AND/OR MEDICAID BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled to RMC Primary Care including Medicare and Medicaid.

Medicare patients will be asked to review and sign an Advance Beneficiary Notice (ABN) for all services, which may be deemed not medically necessary.

Signature of Insured

Date

ASSIGNMENT OF BENEFITS

I hereby assign all medical and /or surgical benefits to which I am entitled to RMC Primary Care, including private insurance and any/all other third party coverage.

If we do not participate with your insurance plan, we request that your charges for office visits be paid at the end of each visit.

Signature of Insured

Date

PAYMENT GUARANTEE

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, the undersigned individually obligates himself/herself to pay the account of RMC Primary Care in accordance with the regular rates and terms of the practice. Furthermore, the undersigned is obligated to make weekly or monthly payments, if requested. She the account be turned over to a collection agency or an attorney for collection, the undersigned shall pay all collection fees and reasonable attorney's fees.

I understand that I am responsible to RMC Primary Care for charges incurred by me and not paid for by Medicare, Medicaid, or third party benefits.

INSURANCE COLLECTIONS

In order for RMC Primary Care to file your insurance for you, a copy of your insurance card (front and back) is required.

RMC Primary Care will submit the standard CMS 1500 billing form to your insurer. If your employer/insurance carrier requires other claim forms, these must be submitted completely filled out, and signed. (You are always responsible for the entire amount of the charges.) All applicable coinsurance and deductibles are due upon Check Out.

I acknowledge that I have read or had read to me the entire above document. I understand it and I agree that RMC Primary Care may bill me and that I will pay for non-covered services or services determined to be not medically necessary.

Signature of Insured

Date

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MEDICAL RECORDS REQUEST FORM

I, _____ hereby authorize my medical records at

Dr. _____

Phone/Fax: _____

Address: _____

be transferred to / shared with:

THE VILLAGE

Yongxin (John) Li, MD, PhD
William L. Baly, MD
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BAMBERG

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HOLLY HILL

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EDISTO PRACTICE

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BRANCHVILLE

William E. O'Quinn, MD
Latosha L. Corley, APRN
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803-395-3650
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ST. MATTHEWS

Timothy S. Shaver, MD
Tjuana F. Durden-Seidl, MS, PA-C
725 Harry C. Raysor Drive
803-395-3755
Fax: 803-874-3905

Date of Birth: _____

Social Security #: _____

Signature: _____

Date: _____

Phone Number: _____

IMPORTANT: This transmission contains confidential information, some or all of which may be protected health information as defined by the Federal Health Insurance Portability & Accountability Act (HIPPA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to which it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of the information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone to arrange the return or destruction of the information and all copies.

Do you currently have a diagnosis of depression or bipolar disorder? Yes No

If yes, please skip to the HEALTH LITERACY portion below.

Over the last 2 weeks, how often have you been bothered by any of the following? Circle to answer.

	Not at all	Several days	More than half the days	Nearly every day
1). Little interest or pleasure in doing things	0	1	2	3
2). Feeling down, depressed, or hopeless	0	1	2	3
3). Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4). Feeling tired or having little energy	0	1	2	3
5). Poor appetite or overeating	0	1	2	3
6). Feeling bad about yourself or that you are a failure or have let yourself down	0	1	2	3
7). Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8). Moving or speaking so slowly that other people have noticed _ Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9). Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Add columns _____ + _____ + _____
Total: _____

HEALTH LITERACY

Please check appropriate box for each question.

	Always	Often	Occasionally	Never
1). Appointment papers are easy to read and understand				
2). Medical forms are easy to read, understand, and fill out				
3). Medicine labels are easy to read and understand				
4). Education hand-outs are easy to read and understand				
5). Our signs are easy to read and understand				
6). How often do you understand information or directions from your provider?				
7). How often do you need help reading forms?				
8). How often do you feel confused about your health?				

This line for internal use. -----

Level: _____