PATIENT INFORMATION FORM

+rmc Primary Care of the Regional Medical Center

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

+rmc Primary Care of the Regional Medical Center

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
- ☐ Fever
- ☐ Sweats

ALLERGY
- ☐ Seasonal
- ☐ Symptoms
- ☐ Sneezing
- ☐ Itchy eyes
- ☐ Runny nose
- ☐ Nasal congestion
- ☐ Postnasal drip

CARDIOVASCULAR
- ☐ Chest pain or pressure
- ☐ Ankle swelling
- ☐ Palpitations

ENDOCRINE
- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Heat intolerance
- ☐ Cold intolerance

EYES
- ☐ Blurred vision
- ☐ Changing vision

GENITOURINARY
- ☐ Urinary frequency
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Awaken at night to urinate

HEMATOLOGIC
- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Hard to stop bleeding

MENTAL HEALTH
- ☐ Insomnia
- ☐ Guilt
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal thoughts

EAR/NOSE/THROAT
- ☐ Ear pain
- ☐ Runny nose
- ☐ Sneezing
- ☐ Postnasal drip

NUTRITION
- ☐ On a special diet
- ☐ Weight gain or loss greater than10 pounds

GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Blood in stool

MUSCULOSKELETAL
- ☐ Joint swelling
- ☐ Joint pains
- ☐ Muscle pains

RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Shortness of breath with exertion

SKIN
- ☐ Rash
- ☐ Changing mole
- ☐ Itching
- ☐ Slow healing wounds

NEUROLOGIC
- ☐ Numbness
- ☐ Tingling
- ☐ Headaches
- ☐ Weakness

DAILY LIVING
- ☐ Violence in your home
- ☐ Problems with sex
- ☐ Changes in functional ability
- ☐ Exposure to sexually transmitted disease
- ☐ Changes in eating habits
- ☐ Changes in sleeping habits
- ☐ 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 drank 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. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 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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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

This is to acknowledge that I have received, understand, and have been given the opportunity discuss further with a privacy contact person, the RMC Primary Care Notice of Privacy Practices.

Signature of Patient **Date Signed**

If patient refuses to sign, listed below are the efforts made to get the patient to sign:

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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
Lisa A. Bozik, MD
William L. Baly, MD
Melanie T. Sheppard, PA
1750 Village Park Drive | Orangeburg
803-395-4160
Fax: 803-531-8810

☐ **EDISTO PRACTICE**
John H. Hayden Jr., MD
Stacy W. Weaver, PA
1619 Carolina Avenue | Orangeburg
803-395-3057
Fax: 803-531-7457

☐ **BAMBERG**
Kelenne V. Tuitt, DO, MS
Dana L. Wolfe, APRN
498 North Street
803-395-3600
Fax: 803-245-6277

☐ **BRANCHVILLE**
William E. O'Quinn, MD
Hailey B. Libengood, PA
215 Dorange Road
803-395-3650
Fax: 803-274-8817

☐ **DENMARK**
Tara Hook, MD
Rachel R. Danford, DNP, APRN
5073 Carolina Highway
803-395-3048
Fax: 803-793-0644

☐ **HOLLY HILL**
Sarah M. Crickman, MD
Constance B. Simons, APRN
Matthew N. Kunkelman, PA
187 Bunch Ford Road
803-395-3068
Fax: 803-496-7713

☐ **NORTH**
Tara Hook, MD
Brenda K. Wilhite, APRN
4631 Savannah Highway
803-395-3038
Fax: 803-247-2650

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

Date of Birth: _____

Social Security #: _____

Signature: _____

Date: _____

Phone Number: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

+rmc Primary Care of the Regional Medical Center

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:** _____