East Greenwich Family Medicine

3461 South County Trail, Suite 301, East Greenwich, RI 02818

Phone: (401) 471-6760 Fax: (401) 471-6765

Thank you for choosing our practice for your medical needs. We value our relationship with you and want to serve as your 'Personal Medical Home'.

On your first visit, you will meet with our staff and your family medical practitioner. As a family medicine practice, we will address your current and future medical needs in an effort to detect or prevent other medical conditions. We hope to make your first visit not just an opportunity to deal with any medical concerns you may have but also a time to get acquainted with you.

Enclosed with this letter, please find six important medical forms, which we ask you to complete prior to your visit and return to us either by dropping off, faxing or mailing within **one week of your appointment**. If we have not received this information a staff member will contact you for this information before your appointment.

Check list for your appointment:

Forms returned one week prior to your appointment:

- ☐ Patient Information and Insurance form
- ☐ Medical History Form (2 pages)
- ☐ Request for Confidential Communications – signature needed
- ☐ Authorization for Use and Disclosure of Protected Health information form – signature needed
- ☐ General Consent for Treatment form – signature needed
- ☐ Financial, Cancellation, and Medication Refill Policy Information – signature needed

Day of your appointment:

- ☐ Please bring your current medical card(s) *If necessary please make sure that your insurance carrier is aware you are choosing one of our providers as your Primary Care Physician*.
- ☐ Please bring photo identification

If you are unable to keep your appointment, need to speak to a provider off hours, or are not feeling well and need to be seen that same day, please call our office at **(401) 471-6760.** We set aside extra time for our new patients. Appointments in which you arrive more than 10 minutes late, that are not kept, or that are not canceled within twenty-four (24) hours may result in a no-show fee.

We look forward to meeting you at your first appointment!

Respectfully,

Chris McManus, FACHE
Practice Manager

East Greenwich Family Medicine

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Patient Information and Insurance Form

First Name: _________________________ **MI:**_____ **Last Name:**_____________________________________

Preferred Name: ___________________ **DOB**: ________________________ **Sex:** Male / Female

Street Address:____

City: _______________________ **State**:______ **Zip:**___________ **Email:**_________________________________

Home Phone: _____________________ **Cellphone:** __________________ **Work Phone:** _________________

Please circle preferred Communication: *Home Phone* *Cellphone* *Work Phone* *Email*

Would you like to receive mailing from South County Medical Group? *YES* *NO*

Occupation: ________________________________ **Employer Phone**: ___________________________________

Insurance Information:

Primary Insurance Plan: __________________________
Policy Number:____________________________________
Group Number (*if any*):_________________________
Policy Holder Name & DOB (*if different from patient*):
____

Secondary Insurance Plan: __________________________
Policy Number:____________________________________
Group Number (*if any*):_________________________
Policy Holder Name & DOB (*if different from patient*):
____

Emergency Contact: ___________________________ **Relationship:** _____________ **Phone:**_________________

Preferred Pharmacy Name: _________________________________ **City:** _______________________________

Street Address: ____

Race *(Please check one):*
- American Indian / Alaska Native
- African American
- Asian
- Native Hawaiian / Pacific Islander
- White / Caucasian
- Other
- Decline

Ethnicity *(Please check one):*
- Hispanic or Latino
- Not Hispanic or Latino
- Declined

Marital Status (*Please check one*):
- Single
- Married
- Divorced
- Widowed
- Other

Name: ____ **Date:** _______________ **DOB:** _________________

Medical History Form

Allergies (*Please list ALL allergies*):

____
____
____

Medications (*Please list ALL medications prescribed or OTC with dose and frequency*):

____
____
____
____
____
____

*****Please bring copies of all immunization records*****

Past Medical History (*Please check all that apply*):

Anemia
Anxiety
Bleeding / Clotting Disorder
Blood Transfusion
Cancer
Chicken Pox
Chrone's Disease
Concussion
Depression
Diabetes, Type I
Diabetes, Type II
Emphysema / COPD
Epilepsy / Seizures
Fibromyalgia
Gallbladder Disease
Gastroesophageal Reflux (GERD)
Glaucoma
Gonorrhea, Chlamydia, Herpes, Other STD
Headaches
Hemorrhoids or Rectal Disease
Hepatitis
High Blood Pressure
Irritable Bowel Syndrome (IBS)
Kidney Stones / Nephritis / Kidney Disease
Lyme disease
Macular Degeneration
Mental Illness
Migraine
Osteoarthritis
Osteoporosis
Peptic Ulcers
Pneumonia
Psoriasis
Rheumatic Fever
Rheumatoid Arthritis
Seasonal Allergies
Stroke
Systemic Lupus Erythematosus
Thyroid Disease / Hypothyroid or Hyperthyroid
Tuberculosis
Ulcerative Colitis
Other:
____

Surgical History (*Please list all past surgeries*):____
____
____

Family History:

Has any of your FIRST or SECOND degree relatives been diagnosed with any of the following health conditions? If so, please indicated if it was maternal or paternal side and age diagnosed.

Cancer: ____
Diabetes: ______________________________________
Thyroid Disease: ________________________________
High Cholesterol: _______________________________
High Blood Pressure: _____________________________
Heart Disease: __________________________________
Stroke: ____
Mental Illness: ____________________________________
Alcoholism: ____
Suicide: ____
Asthma: ____
Early Death (prior to 55 years old):_____________________

Name:____ **Date:** _______________ **DOB:**________________

Tobacco

Do you smoke? Yes: ______ No: ______

If yes, how many packs per day? ________

Alcohol

Do you drink alcohol? Yes: ____ No: _____

If yes, how frequently? ______________________

Other:

Do you use any illegal substances? Yes: _______ No: ____

Were you ever treated for a substance abuse problem?

Yes: ______ No: ______

Women Only:

Age at meses onset: ______________________

Date of last period: _______________________

Date of last PAP: __________________________

Colposcopy/Biopsy/Surgery: ________________

Name of GYN: ____________________________

Number of Pregnancies: ___________________

Number of Children: ______________________

Pregnancy Complications: _________________

Men Only:

Weak Urine Stream:	Yes	No
Discharge from Penis:	Yes	No
Painful / Swollen testis:	Yes	No
Prostate Trouble:	Yes	No

Safety:

Are there guns in your home?	Yes	No
Do you wear a seatbelt?	Yes	No

Review of Symptoms: In the past year, have you had any recurrent or persistent problems with any of the following?

Anxiety / Nervousness	Fainting	Muscle	Swollen Feet
Arthritis / Joint Pain	Fatigue	Ache/Weakness	Swollen Glands
Black Stool	Faulty Memory	Nausea	Throat Discomfort
Bloody Sputum/Vomit	Fever / Chills	Nighttime Urination	Trouble Sleeping
Bruise Easily	Hair / Nail Problem	Nose Bleeds	Trouble with Vision
Chest Pain	Headaches	Numbness	Unexpected Weight Gain
Cough (Unexplained)	Hearing Problems	Poor Appetite	Unexpected Weight Loss
Dental/Gum Symptom	Heart Palpitations	Rectal Bleed	Unusual Fears
Depression	Heartburn	Rectal Discomfort	Urgent Urination
Diarrhea	High Cholesterol	Ringing of Ears	Urination Problems
Difficulty Swallowing	Incontinence	Seizures	Voice Change
Dizziness	Increased Thirst	Sexual Problems	Wheezing
Ear Pain / Discharge	Itching	Shortness of Breath	Work/Family Problems
Excess Sweating	Jaundice	Skin Problems	

Legal Forms:

Do you have a medical durable power of attorney?	Yes	No
Do you have an advanced directive?	Yes	No

If yes to either, please provide the office with a copy of the legal documents for our files.

Would you like to receive education about advance directives? Yes No

Do you exercise regularly? Yes No - What kind of exercise? ____

Do you have any specific learning needs or preferences? Yes No - What are they? ____________________________

What is your primary language? ______________________ Are there any language barriers? Yes No

Personal Goals:

Weight loss? ____

Commit to exercise regime? ________________________________

Diet improvement? _______________________________________

Health improvement? _____________________________________

South County Medical Group

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

______________________________ ___/___/___

Patient Name Date of Birth

I request that all communications from:

SCH EG Family Medicine - 3461 South County Trail, Suite 301 - East Greenwich, RI 02818

(Name of Practice)

Check off Preference(s)

❑ For **written** communications:

❑ Address to: ______________________________

____

____

❑ Secure Email: ______________________________

❑ For **oral** communications.

❑ The best number to call: ( ) ______________________

❑ **May we leave a message**? ❑ Yes ❑ No

Who may we discuss your medical condition with if necessary (not including your physician)?

Name: ______________________________

Relationship to patient: ______________________ Medical Durable Power of Attorney ❑ Yes* ❑ No

Telephone # ( ) Form provided ❑ Yes ❑ No *Please present document

Name: ______________________________

Relationship to patient: ______________________ Medical Durable Power of Attorney ❑ Yes* ❑ No

Telephone # ( ) Form provided ❑ Yes ❑ No *Please present document

______________________________ ______________________

Patient's Signature Date

SOUTH COUNTY HEALTH
100 Kenyon Ave Wakefield, RI 02879
401-782-8000

Patient Name: ___________________________________

Date of Birth: ____ /____ /____ MRN: ___________

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I authorize South County Health (SCH) to obtain/release/exchange my health information specific to the following date or time period: ____

RECORDS FROM:

❑ **South County Hospital**

☒ **South County Medical Group**

Physician: _________________________

2. **OBTAIN FROM:**

____
____
____
____

Phone: **Fax:**

RELEASE TO:

SCH EG Family Medicine
3461 South County Trail, Suite 301
East Greenwich, RI 02818

Phone: (401) 471-6760

***Please do not fax medical records**

3. Patients may elect to have copies of their medical record provided electronically. Please check ❑ to indicate your wish to have your medical records provided in an electronic format.

4. Purpose for which disclosure is to be made: New Primary Care Provider (PCP)

5. Information to be disclosed/exchanged:

❑ Discharge Summary ❑ Operative Report ❑ Progress Notes
❑ History and Physical ❑ Pathology ❑ Laboratory
❑ Consultations ❑ Emergency Department ❑ Radiology
❑ Medications ❑ Office Notes

☒ Other: All

I understand this may include health information relating to (check if applicable):

❑ HIV (Human Immunodeficiency Virus) infection ❑ Behavioral Health
❑ Treatment for alcohol and/or drug abuse ❑ Genetic Testing

6. I understand that if the person(s) or entity(s) that receives the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release SCH, its employees and contractors from all liability arising from this disclosure of my health information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

**** Please continue to the second side and complete the authorization. ****

SOUTH COUNTY HEALTH

100 Kenyon Ave Wakefield, RI 02879
401-782-8000

Patient Name: ________________________________

Date of Birth: ____ /____ /____ MRN: ___________

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PAGE 2: AUTHORIZATION

7. I understand that SCH may receive compensation for the authorized use/disclosure of this information.

8. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the department that provided the information, knowing that previously disclosed information would not be subject to my revoke request.

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

10. I understand that this authorization shall be retained as a part of my protected health information in accordance with applicable SCHHS policy. I have received a copy of this authorization.

11. This authorization expires on ______________________________ or ninety days from the date this authorization was signed. I further understand that I may revoke this authorization in writing at anytime except to the extent that action has been taken on it.

______________________________	____ /_____ /_____	______________________________	____ /_____ /_____
Patient or Legal Representative	Date	Witness Signature	Date

Relationship to Patient if signature not patient:____

Photo ID Verified By: ____________________ Receipt Date / Time: ________________/_________________

SOUTH COUNTY MEDICAL GROUP

GENERAL CONSENT FOR TREATMENT

SCH EG Family Medicine
3461 South County Trail, Suite 301
East Greenwich, RI 02818

______________________	____/____/____	______________________
Patient Name	Date of Birth	Practice Name

GENERAL CONSENT FOR TREATMENT

1. I, the undersigned and/or legal representative or relative, hereby consent to, authorize and request South County Medical Group and its medical personnel to perform ambulatory care services, including but not limited to medical examinations, evaluations, treatments, procedures, diagnostic tests, laboratory tests, vaccinations and immunizations during the course of my or the patient's care as may be deemed advisable or necessary. I understand that I have the right to refuse any suggested medical treatment, examination, evaluation or test at any time.

2. I understand that this consent and authorization for treatment is valid and will remain in full force and effect for the duration of my treatment at this Facility unless and until I revoke or otherwise withdraw my consent in writing.

3. I understand and agree that I am ultimately responsible for all charges associated with the ambulatory care services that I receive at this Facility. In the event that my insurance company does not pay for the anticipated portion of any charges, for any reason, I understand and agree to be responsible for all unpaid amounts.

4. I have been given a copy of and had an opportunity to review and understand the South County Health Joint Notice of Privacy Practices. I understand and acknowledge that this Notice describes how my protected health information may be used or disclosed for carrying out medical treatment, billing and payment activities and other healthcare operations. I hereby consent to and authorize such use and disclosure of my protected health information.

5. Consent to obtain medication history:
   I understand that an accurate medication history is very important to helping treat my condition and to avoid potentially dangerous drug interactions. I agree that South County Health may request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

______________________	___/___/___	______________________	___/___/___
Patient Signature or Authorized Person	Date	Witness Signature	Date

Relationship if signature is not patient ______________________

Photo ID verified by: ______________________

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Financial, Cancellation, and Medication Refill Policy Information Form

I hereby authorize South County Medical Group to furnish information to insurance carries concerning my illness and treatment to process my claim. I hereby assign all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any deductibles or any amount not covered by insurance. After 60 days, if no payment has been received by this office, full payment is due and payable for related services.

I also understand that a cancellation fee may be incurred for less than 24 hour notice or more than 10 minutes late for an appointment and I may be asked to reschedule.

I understand I am required to call my pharmacy for all needed medication refills and I am to allow 2 business days for those refills to be submitted.

Print Name: ____ DOB: ___________________

Patient Signature: ____ Date: __________________

Relationship to Patient if Minor____

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Patient Portal Access

Your patient portal provides you with secure access to your personal health records when it's convenient for you.

Features:

- Access to your health information
- Update your personal information
- Ask a **NON-URGENT** clinical question
- Fill out registration form prior to your visit
- More to come!

Here's what to do:

- Go to www.SCMEDGROUP.com
- Create your account
- You will receive a confirmation email and a link back to the patient portal
- Questions? Please call your physician practice.

If you are experiencing a medical emergency, please dial 911 or your local emergency number for immediate assistance