Patient Demographic

Are you here because of an injury? ☐ **Yes** ☐ **NO** **Date of Injury** ____/____/____ ☐ **Work** ☐ **Auto** ☐ **Other**

PATIENT INFORMATION

PATIENT NAME (Last, First, Middle Initial)		SOCIAL SECURITY NUMBER		DATE OF BIRTH	SEX ☐ **M** ☐ **F**
MAILING ADDRESS	APT/SUITE#	CITY	STATE	ZIP	
PHYSICAL ADDRESS (IF DIFFERENT)	APT/SUITE#	CITY	STATE	ZIP	
RACE	LANGUAGE	ETHNICITY	MARITAL STATUS		
HOME PHONE	CELL PHONE	EMAIL ADDRESS			
PRIMARY CARE PHYSICIAN	**PHONE NUMBER**	PREFERRED CONTACT NUMBER WHERE WE MAY LEAVE MESSAGES ABOUT YOUR HEALTHCARE? ☐ **Home Phone** ☐ **Work Phone** ☐ **Cell Phone**			
EMPLOYER	WORK PHONE	HOW WOULD YOU LIKE TO BE NOTIFIED OF FUTURE APPOINTMENTS? ☐ **TEXT** ☐ **PHONE CALL** ☐ **BOTH**			
EMPLOYER ADDRESS	SUITE#	CITY	STATE	ZIP	
EMERGENCY CONTACT (first name last name)		PHONE	DATE OF BIRTH	RELATIONSHIP	

INSURANCE INFORMATION

PRIMARY INSURANCE

POLICY HOLDER NAME	RELATIONSHIP TO PATIENT ☐ **Self** ☐ **Spouse** ☐ **Parent**	SOCIAL SECURITY NUMBER	DATE OF BIRTH	EFFECTIVE DATE
INSURANCE CARRIER	POLICY #	GROUP #	EMPLOYER	

SECONDARY INSURANCE

POLICY HOLDER NAME	RELATIONSHIP TO PATIENT ☐ **Self** ☐ **Spouse** ☐ **Parent**	SOCIAL SECURITY NUMBER	DATE OF BIRTH	EFFECTIVE DATE
INSURANCE CARRIER	POLICY #	GROUP #	EMPLOYER	

Medicare Patients only: Are you entitled to Medicare because □**AGE** □ **DISABILITY** □ **ESRD**
Is someone else or another entity responsible for the billing claim from this visit? ☐ YES ☐ NO WHO_____

PARENT/GUARDIAN INFORMATION *(please fill out the section below for any child under the age 18)*

NAME (last, first)	SOCIAL SECURITY NUMBER	DATE OF BIRTH		SEX ☐ **M** ☐ **F**
ADDRESS	CITY	STATE	ZIP	
RELATIONSHIP (check all that apply) ☐ **Mother** ☐ **Father** ☐ **Guardian** ☐ **Other** ☐ **Guarantor** (person financially responsible)	CELL PHONE	HOME PHONE		MARITAL STATUS
NAME (last, first)	SOCIAL SECURITY NUMBER	DATE OF BIRTH		SEX ☐ **M** ☐ **F**
ADDRESS	CITY	STATE	ZIP	
RELATIONSHIP (check all that apply) ☐ **Mother** ☐ **Father** ☐ **Guardian** ☐ **Other** ☐ **Guarantor** (person financially responsible)	CELL PHONE	HOME PHONE		MARITAL STATUS

The information provided above is complete and accurate to the best of my knowledge.

Patient/Guardian Signature_____ ***Date***_____

Saint Mary's Medical Group

Patient Demographics

PATIENT LABEL

8.22.18 LE

ARGER, KOSTA, M.D.
BIDART, CHAD. M.D., F.A.C.C.
BIRKNER, TRACY, PA-C
BRYAN JR., RICHARD H., M.D., F.A.C.C.
CARREA, FRANK, M.D., F.A.C.C.
CHALLAPALLI, SRIDEVI, M.D., F.A.C.C.
CHALLAPALLI, RAM, M.D., F.A.C.C.
DESAI, DEVANG, M.D., F.A.C.C., F.S.C.A.I.
DRUMMER, ERIC. M., M.D., F.A.C.C.
FERRETTO, WENDY, A.P.R.N
GOICOECHEA, GRETCHEN, PA-C
KEDIA, ANITA, M.D., F.A.C.C.
MYATT, JEFFERY JOHN "JJ", PA-C
POULIN, MICHAEL, APRN
SHELLEY, MELISSA, PA-C
STEVENSON, JOSEPH, D.O., F.A.C.C.

NAME: _____ DATE: _____

REFERRING MD: _____ AGE: _____

MAJOR REASON FOR VISITING THIS OFFICE: _____

_____

DO YOU HAVE ANY OF THE FOLLOWING?

- ☐High blood pressure
- ☐ Heart murmur
- ☐ Leg cramps while walking
- ☐ Diabetes
- ☐ Chest pain
- ☐ High cholesterol
- ☐ Rapid or irregular heart beat
- ☐ Episodes of passing out
- ☐ Dizziness/lightheadedness
- ☐ Swollen Legs

HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES?

- ☐ A stress test
- ☐ Heart catherization
- ☐ Coronary artery bypass surgery
- ☐ Electrophysiology study
- ☐ An echocardiogram
- ☐ Angioplasty or stent placement
- ☐ Valve surgery
- ☐ Pacemaker of defibrillator

PAST MEDICAL HISTORY

1. Rheumatic Fever as a child? ☐ Yes ☐ No

2. Surgeries/Operations (list type and approximate year)

_____ _____

_____ _____

_____ _____

3. Other Major Hospitalizations (list reason and approximate year)

_____ _____

_____ _____

_____ _____

Saint Mary's Medical Group

PATIENT HISTORY CHECK IN

PATIENT LABEL

4. **Family History**

Has anyone in your family had:

Heart attack:	☐ Yes	☐ No	Relative(s): _____
Died suddenly:	☐ Yes	☐ No	Relative(s): _____
Heart murmur:	☐ Yes	☐ No	Relative(s): _____
Hypertension:	☐ Yes	☐ No	Relative(s): _____

5. **Social history**

Do you smoke?	☐ Yes	☐ No	Number per day: _____
			For how many years: _____
Do you drink alcohol?	☐ Yes	☐ No	Amount per day: _____
Do you drink caffeine?	☐ Yes	☐ No	Amount per day: _____
Do you exercise?	☐ Yes	☐ No	Amount per week: _____

Occupation? _____

6. **Medications** (you are currently taking – name, dose, frequency)

_____ _____
_____ _____
_____ _____
_____ _____

7. **Allergies**

_____ _____
_____ _____

CHECK ANY SYMPTOMS YOU MAY HAVE:

Constitutional

☐ Recent weight gain ☐ Recent weight loss ☐ Fatigue

Eyes

☐ Eyesight problems ☐ Decreased vision ☐ Loss of vision

ENT

☐ Nosebleeds ☐ Loss of hearing ☐ Hoarseness

Respiratory

☐ Shortness of breath ☐ Cough ☐ Wheezing ☐ Difficulty breathing with lying down

Cardiovascular

☐ Chest pain ☐ Palpitations ☐Syncope ☐ Dizziness

Gastrointestinal

☐ Heartburn ☐ Nausea ☐ Bleeding from rectum

Genitourinary

☐ Urinating at nighttime ☐ Urinating often ☐ Blood in urine

Musculoskeletal

☐ Muscle aches ☐ Back pain ☐ Joint pain

Integumentary

☐ Skin lesions ☐ Itching ☐ Skin discoloration

Neurological

☐ Limb weakness ☐ Balance problems ☐ History of TIA

Psychiatric

☐ Anxiety ☐ Depression

Extremities

☐ Swelling ☐ Pain with walking ☐ Varicose veins

Hematologic

☐ Easy bleeding ☐ Easy bruising

Endocrine

☐ Cold intolerance ☐ Heat intolerance

Other

Any other symptoms? _____

PATIENT CONSENT & ACKNOWLEDGEMENT

PATIENT DOCUMENTS RECEIVED:

- Notice of Privacy Practices _____ (initial)
- Patient Financial Policy _____ (initial)
- Patient Portal Access and Use Agreement _____ (initial) **Email Address**: _____

TREATMENT: I consent to and authorize Saint Mary's Medical Group and Saint Mary's Urgent Care Providers to examine and provide treatment.

PALLIATIVE CARE PATIENTS: I consent to and authorize Saint Mary's Medical Group Palliative Care to review my medical records, discuss goals of care, advanced care planning, assist with appropriate referrals/coordination of care and provide recommendations to my attending/referring physician as necessary.

RELEASE OF INFORMATION

- I authorize a copy of my record to be sent to my family provider or provider of referral following my appointment. **Preservation of Records Notice**: The Medical Group is authorized to dispose of patient's medical record after the 10th anniversary of the date the patient was last treated. For minor patients (less than 18 years of age) the medical group is authorized to dispose of patient's medical records after patient's 23rd birthday for those records which have been retained for at least 5 years or for any longer period provided by federal law.
- I authorize Saint Mary's Medical Group and Saint Mary's Urgent Care to speak to the named person (s) listed below regarding my medical condition(s) and care. Please be aware that we will not be able to speak to anyone other than the patient unless named below.

Name _____ Relationship_____ Phone _____

Name _____ Relationship _____Phone _____

PRESCRIPTIONS: I authorize Saint Mary's Medical Group and Saint Mary's Urgent Care and its designees to view my pharmaceutical history from external sources. Our practice uses Surescripts for this purpose.

PALLIATIVE CARE PATIENTS: Saint Mary's Palliative Care physicians do not prescribe medications. Medications may be filled at the discretion of your attending/referring physicians.

EMPLOYEE OR PROVIDER EXPOSURE TO BLOOD AND BODY FLUIDS: Patient understands that in the event an employee or provider is exposed to patient's blood or body fluids, a blood sample for HIV (AIDS), Hepatitis B and Hepatitis C antibodies will be obtained. Patient understands that the patient will be notified of testing. Patient understands that the results are confidential and will not be released to a third party without patient's permission except as permitted or required by law

INTERPRETER INFORMATION: If the patient speaks a language other than English or is communicatively disabled, I have accurately and completely read the forgoing documents to _____ (name of patient/person legally authorized to give consent) in the patient's or patient's representative primary language. He/she understood all the terms and conditions and acknowledged his/her agreement thereto by signing this document in my presence.

_____	_____	_____	_____ AM / PM
(SMMG Representative Name)	(SMMG Representative Signature)	(Cyracom ID #)	(Time)

By signing below, I agree to abide by the terms and conditions outlined above including the patient documents received.

Patient/Representative Name (Please Print) _____ Date _______________

Patient/Representative Signature _____ Date _______________

Saint Mary's Medical Group

Patient Consent & Acknowledgement

PATIENT LABEL

PARENT CONSENT FOR TREATMENT OF MINOR CHILD
PARENT OR LEGAL GUARDIAN NOT PRESENT

In the event that the parent(s) or legal guardian(s) of the patient named below is/are not available at the time of service and at the sole discretion of the Provider of Care and/or Management, this form may be used to document authorization for treatment received by phone if patient is accompanied by an authorized person 18 years or older.

Parent or person having legal custody/legal guardianship authorizes:

_____ _____
(name of person accompanying patient) (*date of birth)*

To consent for treatment for _____ _____
(patient's name) *(patient's Date of Birth)*

We spoke with _____ _____
(parent or legal guardian name) *(date of birth)*

Identification on file _____
(*indicate relationship)*

at (_____) _____ - _____ *(number called)* at _____ am / pm *(circle one)*

We further acknowledge that we obtained verification of the identity of the patient's parent or legal guardian using established standard operating procedure.

Verified all information as above. Verbal consent obtained

Staff Member #1: Print Name_____

Signature_____ Date_____

Staff Member #2: Print Name_____

Signature_____ Date_____