



Dear Patient:

Enclosed in this packet, you will find our new patient forms. We ask that you complete the paperwork prior to your appointment and either return it to us in the mail, or bring it with you to your appointment. If you choose to bring it to your appointment, please arrive 30 minutes prior to your scheduled time. If we do not have your completed paperwork you may be asked to reschedule your appointment. If you have any questions, please phone us at 864-882-2314.

Appointment checklist: (please be sure to bring to your appointment)

_____ Completed paperwork, all insurance cards to include prescription coverage if applicable and your drivers license or picture ID

_____ Detailed medication list completed (prescription and over the counter medications) or you may bring all your medications in their original bottles with you.

Your appointment is scheduled for _____ at _____ am/pm with
Dr. _____.

***Copayments will be collected at the time of your appointment.

**Thank you for choosing Seneca Medical Associates
for your health care needs.**



HOW TO PREPARE FOR YOUR NEW PATIENT VISIT

The New Patient Pack that you received in the mail or picked up at our office will need to be filled out completely and returned to our office *at least three days* before your scheduled appointment.

Please be sure to bring all your medication bottles to each of your appointments. This should include all prescription drugs, over the counter medications and/or any herbal remedies you have been taking.

WHAT TO EXPECT AT YOUR NEW PATIENT VISIT

At check in you will be asked to provide your current insurance card and photo identification. Also be prepared to pay any co payment that is printed on your insurance card at the time of your visit.

At every appointment your height, weight, temperature, pulse and blood pressure will be checked. We will go over your medical, family, and social history. The provider will do a limited exam and order any necessary diagnostic tests. Please be aware that complete physicals and pelvic exams will not be done at your initial new patient visit. A follow up visit will be scheduled for you at check out if necessary.

OFFICE COURTESIES

A 48 business hours notice is required for all call in prescriptions. Please do not wait until you are out of a medication to call for a refill.

If you need to cancel an appointment please call our office 24-48 hours a head of time. This will allow an opening for the physician to see other patients that may be in need of an appointment.

You can reach office staff Monday through Friday from 8:30 a.m. to 12:00 p.m. and 2:00 p.m. to 5:00 p.m.



Welcome To Our Practice

We would like to take this opportunity to welcome you to our practice, and look forward to the privilege of meeting your health care needs. Please don't hesitate to let us know at any time if we are not meeting your needs or if you have questions. We have a satisfaction survey that we would like for you to complete after your visit. This will allow us to know how we can better improve our service.

As a member of Oconee Physician Practices and an affiliated health partner with Oconee Medical Center; we are dedicated to providing high quality health care. We are a local non-profit medical group sponsored by the hospital. As a result, any bill you receive from us will have the name of **Oconee Physician Practices** as well as your physician name versus the name of this individual practice location.
Completely

For your convenience, you may pay any open balances from other practices affiliated with Oconee Physician Practices at any of our locations.

PLEASE FIND BELOW A LIST OF ALL OUR PRACTICES:

Between the Lakes Primary Care
Blue Ridge Women's Center
Clemson-Seneca Pediatrics
Keowee Family Urology
Mountain Lakes Community Care
Mountain Lakes ENT and Allergy Center
Mountain Lakes Internal Medicine
Oconee Heart Center
Oconee Kidney Center
Oconee Multi-Specialty Clinic
Rheumatology Consultants
Seneca Medical Associates
Upstate Family Medicine
Upstate Surgical Associates



Patient Information

Last Name				Social Sec #			
First Name				Birth Date			
Middle Name				Sex (M or F)			
Street Address				Race			
Suite / Apt #				Primary Language			
City		State		Zip		Marital Status	
Mailing Address				Legal Guardian			
City		State		Zip		Legal Guardian's Primary Phone	
Home Phone			Work Phone			Cell Phone	
Email Address							

Guarantor Information (Person Responsible For Bill)

Last Name				Social Sec #			
First Name				Birth Date			
Middle Name				Sex (Male or Fem)			
Street Address				Relationship			
City		State		Zip		Home Phone:	
Mailing Address				Work Phone:			
City		State		Zip		Cell Phone:	

Employment Information

Patient's Employer				Employer Phone			
Spouse's Employer							

Emergency Contact Information

Name		Relationship		Phone	
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Physician Information

Name of Family Physician			City/State
Name of Referring Physician			City/State

Insurance Information For Patient– Provide complete and provide copy of insurance card(s)

Primary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Secondary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Additional Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:

I give permission to the provider's to treat the patient. _____

Signature of Responsible Party/Self

Assignment of Benefits: I hereby authorize payment of medical benefits directly to Oconee Physician Practices for their services and to release any information acquired in the course of my examination or treatment for insurance purposes. I understand that records may be transmitted electronically or by mail as required.

Signature Of Patient Or Guardian >>

Date:

HEALTH HISTORY QUESTIONNAIRE – Adult

Questions contained in this questionnaire are strictly confidential and will become part of your medical record.

BASIC INFORMATION

Patient Name:	Date of Birth:
Last Provider Seen/Date:	
Allergies/Reaction: (<input type="checkbox"/> None)	

PERSONAL HISTORY

CHILDHOOD ILLNESSES	DATES (most recent):	IMMUNIZATIONS	DATES (most recent):	HEALTH MAINTENANCE	DATES (most recent):
<input type="checkbox"/> Measles:		<input type="checkbox"/> Tetanus:		<input type="checkbox"/> Eye Exam:	
<input type="checkbox"/> Mumps:		<input type="checkbox"/> Hepatitis:		<input type="checkbox"/> EGD:	
<input type="checkbox"/> Rubella:		<input type="checkbox"/> Flu:		<input type="checkbox"/> EKG:	
<input type="checkbox"/> Chickenpox:		<input type="checkbox"/> H1N1:		<input type="checkbox"/> Colposcopy:	
<input type="checkbox"/> Rheumatic Fever:		<input type="checkbox"/> Gardasil:		<input type="checkbox"/> Colonoscopy:	
<input type="checkbox"/> Polio:		<input type="checkbox"/> Pneumonia:		<input type="checkbox"/> Bone Density Screening:	
<input type="checkbox"/> Other:		<input type="checkbox"/> Zostavax:		<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:		<input type="checkbox"/> PPD:		<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	

MEDICAL HISTORY

Please check box labeled C if the problem is Current, and P if the problem occurred in the Past.

C	P	RESPIRATORY/ENT	C	P	CARDIOVASCULAR
		Hearing Problems			High Blood Pressure
		Ringing in Ears			Irregular Pulse
		Prolonged Hoarseness			Fainting Spells
		Sinus Trouble			Swollen Ankles
		Vision Problems			Cold Numb Feet
		Bronchitis			Varicose Veins
		Chronic Cough			Dizzy Spells
		Shortness of Breath			Leg Pain/Fatigue
		Eye Pain			Chest Pain/Pressure
		Nose Bleeds			Palpitations
		Sore Throat			Heart Murmur
		Pneumonia	C	P	EMOTIONAL
		COPD/OSA			Depression
		Asthma			Mental Illness
		Wheezing			Mood Swings
C	P	GASTROINTESTINAL			Thoughts of Death
		Appetite			Sleep Problems
		Difficulty Swallowing			Lack of Concentration
		Bloody/Tar-Like Stool			Decreased Work Performance
		Hepatitis			Anxiety
		Nausea/Vomiting			Bipolar
		Bowl Changes	C	P	URINARY
		Abdominal Pain			>2 Overnight
		Jaundice			Stress Incontinence
		Crohn's Disease			Kidney Stones
		Peptic Ulcer			Blood in Urine
		Gallbladder			Urinary Tract Inf.
		Constipation			Painful
		Diarrhea			Low Flow
		Diverticulosis			Bed Wetting
		Special Diet			

FEMALES ONLY

Menstrual Flow:
 Regular Irregular Pain/Cramps

Date 1st day of last period:
 Flushing/Menopause

Sexually Active: Sexual Problems:
 Yes No Yes No

Birth Control Method:
of Pregnancies: # of Miscarriages:
of Live Births: # of Abortions:
 Vaginal C-Section

Date of last Pap Smear:
 Normal Abnormal

Date of last Mammogram:
 Normal Abnormal

MALE ONLY

Check all that apply:
 Vasectomy Circumcision Inguinal Hernia

Sexually Active: Sexual Problems:
 Yes No Yes No

Prostate Problems: Last PSA date:
 Yes No

Other:

SURGERIES:

Name (Last, First, M.I.):

DOB:

LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING: (List additional on back)

Please use the below example when completing the medication section.

Pharmacy name and address
Number used by the drugstore to identify this drug for your refills
Person who gets this drug
Instructions about how often and when to take this drug
Name of drug and strength of drug
Number of refills before certain date
Doctor's name
Drugstore phone number
Prescription fill date
Don't use this drug past this date

Local Pharmacy
123 MAIN STREET
ANYTOWN, USA 11111 (800) 555-5555
DR C. JONES
NO 0060023-08291 DATE 06/23/09
JANE SMITH
456 MAIN STREET ANYTOWN, US 11111
TAKE ONE CAPSULE BY MOUTH THREE TIMES DAILY FOR 10 DAYS UNTIL ALL TAKEN
AMOXICILLIN 500MG CAPSULES
QTY MRG
NO REFILLS - DR. AUTHORIZATION REQUIRED
USE BEFORE 06/23/12
SLF/SLF

Medication Name	Dose/Strength	Frequency

Person Completing Form: _____ Date: _____



SOCIAL HISTORY QUESTIONNAIRE - (ADULT)

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date: _____	SOCIAL HISTORY QUESTIONNAIRE - (ADULT) All questions contained in this questionnaire are strictly confidential and will become part of your medical record.
Home # : _____	
Birth date: _____	
<input type="checkbox"/> M <input type="checkbox"/> F	
Name (Last, First, M.I.): _____	

TOBACCO PRODUCTS:

Do you have a history of smoking or currently smoke: Yes No

Type: cigarette cigar pipe

Start Date: _____ End Date: _____

Amount of cigarettes:

less than 1 cigarette/day

light (1-9 cigs/day)

moderate (10-19 cigs/day)

heavy (20-39 cigs/day)

very heavy (40+ cigs/day)

Interested in quitting smoking: yes no

STOP DATE: _____

Smokeless:

Do you have a history with smokeless tobacco or currently use:

Yes No

Type: chew snuff powder

Start Date: _____ End Date: _____

Amount: _____

Interested in quitting smokeless:

yes no

STOP DATE: _____

Comments: _____

ALCOHOL USE:

Non-drinker

Current alcohol user

Type: beer hard liquor wine

Average drinks/week: _____

Drinks/day on typical drinking day: _____

High risk alcohol use: yes

Binge drinker: yes

Past heavy use: yes

Patient has been in an alcohol treatment program: yes no

Comments: _____

CAFFEINE USE:

No caffeine use

Uses caffeine

Type: coffee tea soda

energy drinks caffeine supplements

Total Amount:

excessive (equiv to 10+ 8oz coffee/day)

heavy (equiv to 4-9 8oz coffee/day)

moderate (equiv to 1-3 8oz coffee/day)

minimal (equiv to < 1 8oz coffee/day)

Comments: _____

DIET NUTRITION:

Difficulty chewing: yes

Difficulty swallowing: yes

History of eating disorder: yes

Financial issues affecting the ability to buy the needed food: yes

Special diet:

diabetic gluten free low fat

low sodium renal vegan

vegetarian weight reduction other

Comments: _____

ENVIRONMENT:

Lives alone yes no

Patient/Person Completing Form: _____

Relationship: _____

FAMILY HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

BASIC INFORMATION

Patient Name:	Date of Birth:	Today's date:
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FAMILY HISTORY

Please check the box and circle the family member's code that had any of the items listed below.

M=Mother F=Father B=Brother S=Sister MGF=Maternal Grandfather MGM=Maternal Grandmother PGF=Paternal Grandfather PGM=Paternal Grandmother

Heart/Cardiovascular		Mental Health
Angina/Chest Pain/CAD: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Alcoholism: <input type="checkbox"/> Y <input type="checkbox"/> N
Heart Attack/Heart Disease: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Attention Deficit Disorder: <input type="checkbox"/> Y <input type="checkbox"/> N
High Cholesterol: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Bipolar Disorder: <input type="checkbox"/> Y <input type="checkbox"/> N
High Triglycerides: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Depressive Disorder: <input type="checkbox"/> Y <input type="checkbox"/> N
High Blood Pressure: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Mental Disorder: <input type="checkbox"/> Y <input type="checkbox"/> N
Ischemic Heart Disease: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Schizophrenia: <input type="checkbox"/> Y <input type="checkbox"/> N
Sudden Death: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	<input type="checkbox"/> Other:
PVD/AAA: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Musculoskeletal
Blockage of Arteries Location(s): _____ <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Osteoarthritis: <input type="checkbox"/> Y <input type="checkbox"/> N
Aneurysm: _____ <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Rheumatoid Arthritis: <input type="checkbox"/> Y <input type="checkbox"/> N
Endocrine/Metabolic		Osteoporosis: <input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes Mellitus: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Multiple Sclerosis: <input type="checkbox"/> Y <input type="checkbox"/> N
Thyroid Disorder: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Scleroderma: <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Other:	M F B S MGF MGM PGF PGM	Lupus: <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Other:	M F B S MGF MGM PGF PGM	<input type="checkbox"/> Other:
Eyes/Ears/Nose/Throat		Neurologic
Glaucoma: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Alzheimer's disease: <input type="checkbox"/> Y <input type="checkbox"/> N
Hearing Loss: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Dementia: <input type="checkbox"/> Y <input type="checkbox"/> N
Loss of Vision: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Migraine: <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Other:	M F B S MGF MGM PGF PGM	Stroke: <input type="checkbox"/> Y <input type="checkbox"/> N
Genetic/Birth		<input type="checkbox"/> Other:
Birth Defects: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Oncologic
<input type="checkbox"/> Other:	M F B S MGF MGM PGF PGM	Melanoma: <input type="checkbox"/> Y <input type="checkbox"/> N
Genitourinary		Ovarian Cancer: <input type="checkbox"/> Y <input type="checkbox"/> N
Endometriosis: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Prostate Cancer: <input type="checkbox"/> Y <input type="checkbox"/> N
Kidney Disease: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Skin Cancer: <input type="checkbox"/> Y <input type="checkbox"/> N
Ovary Disease: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Stomach Cancer: <input type="checkbox"/> Y <input type="checkbox"/> N
Toxemia of Pregnancy: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	M F B S MGF MGM PGF PGM	Respiratory
Blood/Hematologic		Asthma: <input type="checkbox"/> Y <input type="checkbox"/> N
Clotting Disorder: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Pulmonary Embolism: <input type="checkbox"/> Y <input type="checkbox"/> N
Anemia: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	COPD/Emphysema: <input type="checkbox"/> Y <input type="checkbox"/> N
Leukemia: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Cystic Fibrosis: <input type="checkbox"/> Y <input type="checkbox"/> N
Lymphoma: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Sleep Apnea: <input type="checkbox"/> Y <input type="checkbox"/> N
Hemophilia: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Tuberculosis: <input type="checkbox"/> Y <input type="checkbox"/> N
Sickle Cell Anemia: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	<input type="checkbox"/> Other:

Additional Comments: _____

Person Completing Form: _____



- Between the Lakes
- Blue Ridge Women’s Center
- Clemson-Seneca Pediatrics
- Keowee Family Urology
- Mountain Lakes Community Care
- Mountain Lakes ENT & Allergy Center
- Mountain Lakes Internal Medicine
- Oconee Geriatric & Palliative Medicine
- Oconee Heart Center
- Oconee Kidney Center
- Rheumatology Consultants
- Seneca Medical Associates
- Upstate Family Medicine
- Upstate Surgical Associates

Release of Information Authorization Form

Acknowledgement of Receipt of Notice of Privacy Practices and Financial Policy

This signed form acknowledges that you have received a copy of our practice’s Notice of Privacy Practices as required by Federal Law and our Financial Policy. By signing below you are acknowledging that you understand and have read the notices. The notices are yours to keep.

With whom may we discuss patient’s financial information?

Patient Only: []

Name: _____ Relationship: _____
For patient over age of 18 only

Name: _____ Relationship: _____
For patient over age of 18 only

May we leave messages regarding appointments?

(Messages regarding any other information will be left as call back request only)

- YES _____
What Phone Number
- NO

With whom may we discuss patient’s medical information?

Patient Only: []

Name: _____ Relationship: _____
For patient over age of 18 only

Name: _____ Relationship: _____
For patient over age of 18 only

Print Patient Name

Patient Date of Birth

 Signature of Guarantor/ Patient/ Legal Guardian

 Date

This authorization is in effect until revoked in writing.



FINANCIAL POLICY

COLLECTION OF PATIENT AMOUNTS DUE

Insurance companies require that we collect any co-pay or co-insurance amounts at the time of service. We will collect the co-pay amounts at the time of check-in to avoid a wait at check-out. All co-insurance amounts will be collected at the time of check-out. Please understand that you will be responsible for any amounts not paid by your insurance company. OPP also offers a 20% discount to uninsured patients if the balance is paid at the time of service or within 30 days of the visit.

We understand that temporary financial problems may effect timely payment of your balance. We encourage you to communicate any such problems so that we may assist you in the management of your account.

We understand that there may be special agreements between parents regarding a child's medical expenses. However, the parent that brings the child in for a visit is responsible for making payment on that date of service.

PRESCRIPTION REFILL REQUESTS BY PHONE

We will generally need to see an existing patient back in the office prior to calling in a prescription. However, in rare cases where it's appropriate to write the prescription, there will be a \$15.00 charge in order to cover operating costs. This is not generally covered by your insurance.

DISMISSAL OF PATIENTS FOR FINANCIAL REASONS

Patients can be dismissed from the practice for a number of reasons, including the following financial situations:

1. Collection Agency Turnover will result in a dismissal from the practice if a patient fails to pay his or her balance within thirty days of turnover.
2. Expedited dismissal occurs when a patient is not honoring his or her financial responsibilities.

All patients should be given at least thirty days notice before being dismissed from practice unless instructed otherwise by physician.

This notice is yours to keep.