SENECA
Medical Associates

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.

11082 North Radio Station Road, Seneca SC 29672 Phone (864) 882-2314 Fax (864) 888-3677

SENECA
Medical Associates

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

OCONEE
Physician Practices

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	

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:** _____

Today's Date:
Home #:
Cell #:
Work #:

HEALTH HISTORY QUESTIONNAIRE – Peds

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

Name *(Last, First, M.I.):* *Nickname:* ☐ M ☐ F	**DOB:**
Allergies/Reaction: ☐ None	**Race:** ☐ African American ☐ Asian ☐ Caucasian
Food Allergies: ☐ None	☐ Native American ☐ Hispanic ☐ Mixed

PAST MEDICAL HISTORY (FOR CHILD/PATIENT)

Delivery
Please check the one that applies:
☐ Vaginal
☐ C-Section

Length of pregnancy: _____ Birth weight: _____ Length: _____

Pregnancy/delivery/nursery complications: _____
_____

Immunizations up to date? ☐ Yes ☐ No **Can you provide record?** ☐ Yes ☐ No **Any reactions:**_____

Hospitalizations/Surgeries - please list dates (approximate) and reasons: _____

_____

_____

_____

LIST ALL MEDICATIONS CHILD IS CURRENTLY TAKING: (please put name, dose, and how often taken)

1.	4.
2.	5.
3.	6.

ILLNESSES/INJURIES
Has your child had (please circle)

Yes	No	Frequent ear infections
Yes	No	Frequent throat infections
Yes	No	Asthma / wheezing
Yes	No	Vision / hearing problems
Yes	No	Allergy / sinus problems
Yes	No	Heart murmur
Yes	No	Convulsions/seizures
Yes	No	Broken bones
Yes	No	Behavior/learning problem
Yes	No	Urinary tract infections
Yes	No	Psychological Issues
Yes	No	ADHD
Yes	No	Bedwetting
Yes	No	Other:

FAMILY MEDICAL HISTORY
Please circle if any of the following run on either side of the child's family.
Include child's parents, brother and sister, grandparents, aunts and uncles.

Alcoholism/drug abuse	Allergies/hay fever	Arthritis at a young age	Asthma/bronchitis
Attention deficit disorder	Birth defects	Cancer/leukemia	Colon/bowel disease
Cystic fibrosis	Depression/suicide	Diabetes/"sugar"	Genetic disorder
Headache/migraine	Heart attack/bypass surgery	Heart disease as a child	High blood pressure
High cholesterol	Kidney/urinary disease	Learning disability	Mental retardation
Mental/emotional problems	Seizures/epilepsy	Sickle cell anemia or trait	Stroke
Tuberculosis (TB)	Vision/hearing problems	Childhood / Adolescent sudden deaths	Other:

HOME LIFE (List all the people who live in the home with your child) – list additional on back

Name	Year of Birth	Relation to Child

Home is? apartment mobile home house
Does child sleep in his own bed? ☐ Yes ☐ No
Type of drinking water: city well bottle
What kind of milk? Skim 1% 2% whole
Type of heating: central kerosene woodstove
Are there smokers in the family? ☐ Yes ☐ No
School currently attending? _____
Active in sports? ☐ Yes ☐ No What?_____

Does your child eat a balance diet including milk, cereal, fruits, vegetables, meat? ☐ Yes ☐ No
Pets (inside/outside): _____
Last grade in school finished by mother: _____
Last grade in school finished by father: _____
Are there family/marital problems? ☐ Yes ☐ No
Grade in school? _____
History of abuse/neglect? ☐ Yes ☐ No

Is there anything else you would like us to know about your child?

Person Completing Form: _____ Date: _____
Relationship to Patient: _____

OCONEE
Physician Practices

Date:	
Home # :	
Birth date:	
☐ M ☐ F	
Name *(Last, First, M.I.):*	

SOCIAL HISTORY QUESTIONNAIRE - (PEDS)

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

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:_____
_____

CANCER ENVIRONMENTAL RISK (OTHER THAN TOBACCO:
☐ Has known environmental risk factors for cancer
☐ No known environmental risk factors for cancer

Uses sun protection consistently: ☐ yes ☐ no
Hx of excessive sun exposure: ☐ yes ☐ no
Melanoma high risk: ☐ yes ☐ no
Hx of radiation exposure to neck: ☐ yes ☐ no

Comments:_____
_____
_____

HOME SAFETY RISK: ☐ Has significant home safety risk factors ☐ No significant home safety risk factors	Abusive home environment: ☐ yes ☐ no Guns, rifles, or other firearms in home: ☐ yes ☐ no Seat belt worn consistently: ☐ yes ☐ no Smoke detectors in home: ☐ yes ☐ no	Child safety seat use: ☐ yes ☐ no Helmet worn consistently: ☐ yes ☐ no Fall risk: ☐ yes ☐ no Knows how to swim: ☐ 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:

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

Additional Comments: _____

_____

Person Completing Form: _____

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

Name: _____ Relationship: _____

May we leave messages regarding appointments?

YES☐ _____

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

☐ NO

With whom may we discuss patient's medical information?

Patient Only: [ ]

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I give permission to the following person(s) to bring my child in for an appointment:

Parents Only: [ ]

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Print Patient Name **Patient Date of Birth**

_____ _____

Signature of Guarantor/ Patient/ Legal Guardian Date

This authorization is in effect until revoked in writing.

OCONEE
Physician Practices

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.

301 Memorial Drive, Suite F ● Seneca, SC 29672 ● (864) 885-7989 ● FAX (864) 885-7867