



Dear Patient:

Enclosed in the letter you will find our new patient paperwork. We ask that you complete the paperwork prior to your appointment and either return it to us in the mail, fax it to us or bring it with you to your appointment. 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 864-882-6141. You will receive a reminder call approximately 2 days before your appointment.

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

\_\_\_\_\_ Completed paperwork

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

\_\_\_\_\_ Insurance card(s) and a picture ID

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

\*\*\*Copays will be collected at the time of your appointment.

Thank you,

Upstate Family Medicine



## **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.

The day of your appointment you will be asked to provide your current insurance card and photo identification. Also be prepared to pay any copayment that is printed on your insurance card at that time

## **WHAT TO EXPECT AT YOUR NEW PATIENT 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 24-48 business hours notice is required for all call in prescriptions. We will not accept refill request from pharmacies, the patient is responsible for calling in a refill or making an appointment. Please do not wait until you are out of a medication to call for a refill. Controlled medication prescriptions will need to be picked up in our office.

If you need to cancel an appointment please call our office 24-48 hours prior to your scheduled appointment. Otherwise, failure to cancel your appointment in advance or failure to show for your scheduled appointment will result in a "no-show". No-shows in excess of three could result in dismissal from our practice.

You can reach office staff Monday through Friday from 8:00 a.m. to 12:00 p.m. and 1:00 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			
		COPD/OSA			<b>C P</b> EMOTIONAL
		Asthma			Depression
		Wheezing			Mental Illness
					Mood Swings
<b>C</b>	<b>P</b>	<b>GASTROINTESTINAL</b>			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			
		Abdominal Pain			<b>C P</b> URINARY
		Jaundice			>2 Overnight
		Crohn's Disease			Stress Incontinence
		Peptic Ulcer			Kidney Stones
		Gallbladder			Blood in Urine
		Constipation			Urinary Tract Inf.
		Diarrhea			Painful
		Diverticulosis			Low Flow
		Special Diet			Bed Wetting

## FEMALES ONLY

Menstrual Flow:  
 Regular     Irregular     Pain/Cramps

Date 1<sup>st</sup> 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.

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.

<b>Date:</b> _____	<b>SOCIAL HISTORY QUESTIONNAIRE - (ADULT)</b> 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	
<b>Name (Last, First, M.I.):</b> _____	

**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

<b>Heart/Cardiovascular</b>		<b>Mental Health</b>
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	<b>Musculoskeletal</b>
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
<b>Endocrine/Metabolic</b>		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: _____
<b>Eyes/Ears/Nose/Throat</b>		<b>Neurologic</b>
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
<b>Genetic/Birth</b>		<input type="checkbox"/> Other: _____
Birth Defects: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	<b>Oncologic</b>
<input type="checkbox"/> Other: _____	M F B S MGF MGM PGF PGM	Melanoma: <input type="checkbox"/> Y <input type="checkbox"/> N
<b>Genitourinary</b>		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	<b>Respiratory</b>
<b>Blood/Hematologic</b>		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.**