SOUTH COUNTY MEDICAL GROUP

Primary Care Wakefield

70 Kenyon Ave, Suite 211, Wakefield, RI 02879
Phone: (401) 789-8543 Fax: (401) 782-8766
Robert Casci, DO • Hana Hagos, MD • Heather Mackey-Fowler, MD • Gloria Sun, MD • Mark Zullo, MD

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 medical practitioner. As a primary care medical 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/Attached please find our 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 two weeks of your appointment. *Failure to submit these forms prior to your appointment or walking in at the time of your appointment with forms in hand may result in a reschedule.*

Check list for your appointment:

Forms to be returned two weeks prior to your appointment:

- ☐ Information and Insurance form
- ☐ Medical history form (2 pages)
- ☐ Signed policy information form
- ☐ Authorization for release of Protected Health information form
- ☐ Consent for treatment form

Day of your appointment:

- ☐ Please bring your current medical card(s) and *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) 789-8543.** We set aside extra time for our new patients. Appointments 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,
Robert Casci, DO
Hana Hagos, MD
Heather Mackey-Fowler, MD
Gloria Sun, MD
Mark Zullo, MD

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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:** _____

Home Phone: _____ **Cellphone:** _____ **Email**: _____

Please circle preferred Communication: *Home Phone* *Cellphone* *Text*

Occupation:_____ **Employer Phone**:_____

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

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

Marital Status (*Please circle one*):

Single Married Divorced Widowed Other

Insurance Information

Primary Insurance Plan:_____
Policy Number:_____ Group Number (*if any*):_____
Claims Address: _____
Policy Holder Name & DOB (*if different from patient*):_____

Secondary Insurance Plan:_____
Policy Number:_____ Group Number (*if any*):_____
Claims Address: _____
Policy Holder Name & DOB (*if different from patient*):_____

Emergency Contact:_____ **Phone Number:**_____
Relationship: _____

Preferred Pharmacy Name: _____ **City:**_____

Name: _____ **DOB:** _____

Medical History Form

Allergies (*Please list all medication, food, & environmental allergies*):

_____
_____
_____

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

_____
_____
_____
_____

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

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

A-Fib
ADD / ADHD
Anxiety / Depression
Asthma
Blood / Clotting Disorder
Benign Prostatic Hyperplasia
Chicken Pox
Colon Polyps
Concussion
Congestive Heart Failure
Coronary Artery Disease
Crohn's Disease
Deep Vein Thrombosis
Dementia / Alzheimer's Disease
Diabetes, Type I
Diabetes, Type II
Emphysema / COPD
Epilepsy / Seizures
Erectile Dysfunction
Fibromyalgia
Gallbladder Disease
Gastroesophageal Reflux (GERD)
Glaucoma
Gonorrhea, Chlamydia, Herpes, Other STD
Headaches / Migraines
Hearing Loss
Heart Disease / Heart Attack
Hemorrhoids or Rectal Disease
Hepatitis A, B or C
Hernia
High Blood Pressure
High Cholesterol
Irritable Bowel Syndrome (IBS)
Kidney Stones / Kidney Disease
Lung Nodules
Lyme Disease
Mental Illness / PTSD
Osteoarthritis
Osteoporosis
Peptic Ulcers
Pneumonia
Psoriasis
Pulmonary Embolism
Rheumatic Fever
Rheumatoid Arthritis
Seasonal Allergies
Sleep Apnea
Stroke / TIA
Systemic Lupus Erythematosus
Thyroid Disease / Hypo or Hyper
Tuberculosis
Ulcerative Colitis
Other:
_____
_____
_____
_____

Have you ever been diagnosed with cancer? Yes No

*If yes please specify type of cancer and date of diagnosis:*_____

Surgical History (*Please list ALL past surgeries)*:_____

_____
_____

Do you use any Assistive Devices?

Cane Walker Wheelchair Hearing Aids Support Cane *(for seeing impaired)*

Do you see any specialist? *(If yes, please list their names and specialty)*

_____
_____
_____

Name: _____ **DOB:**_____

Family History:

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

*** If history of cancer or heart disease, please indicate age when diagnosed****

Cancer: _____
Type: _____
_____
Diabetes: _____
Thyroid Disease: _____
High Cholesterol: _____
High Blood Pressure: _____
Stroke: _____
Mental Illness: _____
Alcoholism: _____
Suicide: _____
Asthma: _____
Early Death (prior to 55 years old):_____
Heart Disease: _____

Tobacco:

Do you smoke? Yes: ____ Former: _____ Never: _____
If yes/former, how many packs per day? _____

Alcohol:

Do you drink alcohol? Yes: ____ Former: ____ Never: ____
If yes/former, how frequently? _____

Health Maintenance:

Date of last Physical Exam: _____
Date of last Colonoscopy: _____
Date of last Tetanus Vaccine: _____
Date of last Pneumovax Vaccine: _____

Other:

Do you use any illegal substances? *Yes* *No*
Were you ever treated for substance abuse problems? *Yes* *No*

Safety:

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

Women Only:

Age at menses 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

Review of Symptoms (*Please circle ALL that apply within the past 6 months*)**:**

Black Stool	Fever / Chills	Nose Bleeds	Trouble with Vision
Bloody Sputum / Vomit	Hair / Nail Problem	Numbness	Unexpected Weight Gain
Bruise Easily	Hearing Problems	Poor Appetite	Unexpected Weight Loss
Chest Pain	Heart Palpitations	Rectal Bleed	Urgent Urination
Cough (Unexplained)	Heartburn	Rectal Discomfort	Urination Problems
Diarrhea	Incontinence	Ringing of Ears	Voice Change
Difficulty Swallowing	Increased Thirst	Sexual Problems	Wheezing
Dizziness	Itching	Shortness of Breath	
Ear Pain / Discharge	Joint Pain	Skin Problems	
Excess Sweating	Muscle Aches / Weakness	Swollen Feet	
Fainting	Nausea	Throat Discomfort	
Fatigue	Nighttime Urination	Trouble Sleeping	

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.

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Financial, Cancellation, and Medication Refill Policy Information Form

I hereby authorize South County Medical Group to furnish information to insurance carriers 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 15 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:_____

SOUTH COUNTY MEDICAL GROUP

GENERAL CONSENT FOR TREATMENT

_____ Patient Name

_____/_____/_____ Date of Birth

Primary Care Wakefield 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 SCCHS 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 SCCHS 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 is signature is not patient _____

Photo ID verified by: _____

SOUTH COUNTY MEDICAL GROUP

For expert care, look no further.™

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

_____ _____ / / _____

Patient Name Date of Birth

I request that all communications from:

_____

(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

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Phone: 401-789-8543 Fax: 401-782-8766

Patient Name: _____

Date of Birth: _____ /_____ /_____ MRN: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I authorize South County Hospital Healthcare System (SCHHS) to obtain/disclose my health information specific to the following date or time period: _____ or ❑ All episodes of care

2. **❑ Obtain from:**

   Physician: _____
   Address: _____
   _____
   Phone: _____
   Fax: _____

   ❑ Release to:

   Primary Care Wakefield
   70 Kenyon Ave, Suite 211
   Wakefield, RI 02879
   Phone: 401-789-8543
   Fax: 401-782-8766

3. Purpose for which disclosure is to be made: _____

4. Information to be disclosed/exchanged:

   ❑ Discharge Summary ❑ Operative Report ❑ Progress Notes
   ❑ History and Physical Exam ❑ Pathology ❑ Laboratory Report
   ❑ Consultations ❑ Emergency Dept. Report ❑ Radiology Report
   ❑ Other: _____

   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

5. 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 SCHHS, it's 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.
6. I understand that SCHHS may receive compensation for the authorized use/disclosure of this information.
7. 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.
8. 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.
9. 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.
10. 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

Photo ID Verified:

Relationship to Patient if signature not patient:_____ By: _____

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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.southcountyhealth.org
- Click on the Patient Portals tab at the top of the page
- Scroll down and click on South County Medical Group Portal (Physicians Practices)
- 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