SOUTH COUNTY MEDICAL GROUP

Primary Care Westerly

268 Post Road, Suite 203, Westerly, RI 02891
Phone: (401) 604-2530 Fax: (401) 604-2560

John C. Beauchamp, MD Robert E. Fox, MD Patricia Martino, NP Russell J. Berscheid, 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 six important medical forms, which we ask that you complete and return to us prior to your appointment either by dropping off, faxing or mailing. Once we receive this paperwork we will call you to schedule your appointment.

Checklist for your appointment:

Forms to return prior to scheduling your appointment:

- ☐ Patient Information and Insurance Form
- ☐ Medical History Form (2 pages)
- ☐ Signed Policy Information Form
- ☐ Authorization for Release of Protected Health Information form (2 pages)
- ☐ Consent for Treatment and Confidential Communication forms (2 pages)

Day of your appointment:

- ☐ Please bring your current medical card(s). I*f 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) 604-2530.** 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,
John C. Beauchamp, MD
Robert E. Fox, MD
Patricia Martino, NP
Russell J. Berscheid, MD

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Patient Information and Insurance Form

First Name:_____ **MI:**_____ **Last Name:**_____
Maiden Name _____

Preferred Name:_____ **DOB**:_____ **Sex:** Male / Female

Street Address:_____

City: _____ **State**:_____ **Zip:**_____ **Email**:_____

Home Phone: _____ **Cellphone:** _____ **Work Phone:**_____
Please circle preferred Communication: *Home Phone Cellphone Work Phone Email*
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:**_____
Preferred Pharmacy Name:_____ **City:**_____

Name:_____ **DOB:**_____

Medical History Form

Allergies (*Please list ALL 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*):

Anemia
Anxiety
Bleeding / Clotting Disorder
Blood Transfusion
Cancer
Chicken Pox
Chron's Disease
Concussion
Depression
Diabetes, Type I
Diabetes, Type II
Emphysema / COPD
Epilepsy / Seizures
Fibromyalgia
Gallbladder Disease
Gastroesophageal Reflux (GERD)
Glaucoma
Gonorrhea, Chlamydia, Herpes, Other STD
Headaches
Hemorrhoids or Rectal Disease
Hepatitis
High Blood Pressure
Irritable Bowel Syndrome (IBS)
Kidney Stones / Nephritis / Kidney Disease
Lyme Disease
Macular Degeneration
Mental Illness
Migraine
Osteoarthritis
Osteoporosis
Peptic Ulcers
Pneumonia
Psoriasis
Rheumatic Fever
Rheumatoid Arthritis
Seasonal Allergies
Stroke
Systemic Lupus Erythematosus
Thyroid Disease / Hypothyroid or Hyperthyroid
Tuberculosis
Ulcerative Colitis
Other:_____
_____
_____
_____

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

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:_____ No:_____
If yes, how many packs per day? _____
Have you ever been a smoker? Yes:_____ No:_____

Alcohol

Do you drink alcohol? Yes:____ No:_____
*If yes, how frequently?*_____

Other:

Do you use any illegal substances? Yes:_____ No:_____
Were you ever treated for a substance abuse problem?
Yes:_____ No:_____

Women Only:

Age at meses 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

Safety:

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

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

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

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 Westerly 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 if signature is not patient _____

Photo ID verified by: _____

SOUTH COUNTY MEDICAL GROUP
PRIMARY CARE
Family & Internal Medicine

Patient Name: _____

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

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I request that all communication from:

Primary Care Westerly

Check off preference(s)

- ☐ For **written** communications:
  - Address to: _____
    _____
    _____
  - Secure Email: _____
- ☐ For **oral** communications:
  - Best number to call: (_____) _____
  - May we leave a detailed message: Yes No

Who may we discuss your medical condition with in necessary (not including your physician)?

Name:_____

Relationship to patient: _____ Medical Durable Power of Attorney: Yes No
*Please present document

Phone number: (_____) _____ Form Provided: Yes No

Name:_____

Relationship to patient: _____ Medical Durable Power of Attorney: Yes No
*Please present document

Phone number: (_____) _____ Form Provided: Yes No

_____ _____

Patient Signature Date

SOUTH COUNTY MEDICAL GROUP
PRIMARY CARE
Family & Internal Medicine

Patient Name: _____

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

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I authorize South County Medical Group to obtain / release / exchange my health information specific to the following date or time period: _____

Physician:_____

2. **OBTAIN FROM:**

_____

_____

Phone: _____

Fax: _____

RELEASE TO:

Primary Care Westerly

268 Post Road, Westerly RI 02891

Phone: (401) 604-2530

Fax: (401) 604-2560

3. Patients may elect to have copies of their medical record provided electronically. Please check ☐ to indicate your wish to have your medical records provided in an electronic format.
Email address:_____

4. Purpose for which disclosure is being made:_____

5. Information to be disclosed / exchanged:

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultations
- ☐ Medications
- ☐ Operative Report
- ☐ Pathology
- ☐ Emergency Department
- ☐ Office Notes
- ☐ Progress Notes
- ☐ Laboratory
- ☐ Radiology
- ☐ Other_____
  _____
  _____
  _____

I understand this may include health information relating to (check if applicable):

- ☐ HIV (Human Immunodeficiency Virus) infection
- ☐ Treatment for alcohol and/or drug abuse
- ☐ Behavioral Health
- ☐ Genetic Testing

6. 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 regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release SCMG, its employees and contractors from all liability arising from the disclosure of my health information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

**** Please continue to the second page and complete the authorization ****

SOUTH COUNTY MEDICAL GROUP
PRIMARY CARE
Family & Internal Medicine

Patient Name: _____

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

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Page 2: Authorization

7. I understand that SCMG may receive compensation for the authorized use / disclosure of this information.

8. 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 this information, knowing that previously disclosed information would not be subject to my revoke request.

9. 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.

10. I understand that this authorization shall be retained as a part of my protected health information in accordance with applicable SCMG policy. I have received a copy of this authorization.

11. This authorization expires on _____ or ninety days from the date of this authorization was signed. I further understand that I may revoke this authorization in writing at any time except to the extent that action has been taken on it.

_____ ____/____/_____ _____ ____/____/_____

Patient or Legal Representative Date Witness Signature Date

Relationship to patient if signature not patient: _____

Photo ID verified by: _____ Receipt date / time: _____ / _____

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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 Patient Portals and scroll down to: South County Medical Group Portal (Physician Practices)
- Click on Create a new 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