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
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: __________________________
**Medical History Form**

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

________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

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

________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

**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
- 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
- Sleep Apnea
- Stroke / TIA
- Systemic Lupus Erythematosus
- Thyroid Disease / Hypo or Hyper
- Tuberculosis
- Ulcerative Colitis
- Other: ____________________________
- Other: ____________________________
- 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**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Relative</th>
<th>Side</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer:</td>
<td></td>
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<tr>
<td>Stroke:</td>
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<td>Mental Illness:</td>
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<td>Alcoholism:</td>
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<tr>
<td>Suicide:</td>
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<tr>
<td>Asthma:</td>
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<tr>
<td>Early Death (prior to 55 years old):</td>
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<tr>
<td>Heart Disease:</td>
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</tbody>
</table>

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

Health Maintenance:
Date of last Physical Exam: _______________________
Date of last Colonoscopy: _______________________
Date of last Tetanus Vaccine: _______________________
Date of last Pneumovax Vaccine: _______________________

Women Only:
Age at menstes 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:
Date of last PAP: _______________________
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):

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Stool</td>
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<tr>
<td>Bloody Sputum / Vomit</td>
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<tr>
<td>Bruise Easily</td>
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<tr>
<td>Chest Pain</td>
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<tr>
<td>Cough (Unexplained)</td>
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<tr>
<td>Diarrhea</td>
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<td>Difficulty Swallowing</td>
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<tr>
<td>Dizziness</td>
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<tr>
<td>Ear Pain / Discharge</td>
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<tr>
<td>Excess Sweating</td>
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<tr>
<td>Fainting</td>
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<tr>
<td>Fatigue</td>
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<tr>
<td>Fever / Chills</td>
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<tr>
<td>Hair / Nail Problem</td>
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<tr>
<td>Hearing Problems</td>
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<tr>
<td>Heart Palpitations</td>
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<tr>
<td>Heartburn</td>
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<tr>
<td>Incontinence</td>
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<tr>
<td>Increased Thirst</td>
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<tr>
<td>Itching</td>
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<tr>
<td>Joint Pain</td>
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<tr>
<td>Muscle Aches / Weakness</td>
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<tr>
<td>Nausea</td>
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<tr>
<td>Nighttime Urination</td>
<td></td>
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<tr>
<td>Nose Bleeds</td>
<td></td>
<td></td>
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<tr>
<td>Numbness</td>
<td></td>
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<tr>
<td>Poor Appetite</td>
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<tr>
<td>Rectal Bleed</td>
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<tr>
<td>Rectal Discomfort</td>
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<tr>
<td>Ringing of Ears</td>
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<tr>
<td>Sexual Problems</td>
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<tr>
<td>Shortness of Breath</td>
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<tr>
<td>Skin Problems</td>
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<tr>
<td>Slimness</td>
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<tr>
<td>Skin Problems</td>
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<tr>
<td>Skin Problems</td>
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<tr>
<td>Spine Problems</td>
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<tr>
<td>Sport Problems</td>
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<tr>
<td>Swollen Feets</td>
<td></td>
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<tr>
<td>Throat Discomfort</td>
<td></td>
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<tr>
<td>Trouble Sleeping</td>
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<tr>
<td>Trouble with Vision</td>
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<tr>
<td>Unexpected Weight Gain</td>
<td></td>
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<tr>
<td>Unexpected Weight Loss</td>
<td></td>
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</tr>
<tr>
<td>Voice Change</td>
<td></td>
<td></td>
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<tr>
<td>Wheezing</td>
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</tbody>
</table>

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.
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:__________________
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: __________________________
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 ___________________________
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: [ ] Release to:

   Physician: _____________________________
   Address: ______________________________
   Phone: ________________________________
   Fax: _________________________________

   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, its 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

   Relationship to Patient if signature not patient: ____________________________________________ By: __________________

   Photo ID Verified: ________________________________________________________________

   By: __________________
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](http://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*