Tidelands Health

Patient Information

Last Name		**Primary Care Provider**
First Name	**Middle Initial**	**Referring Provider**
Previous Name		**Date of Birth (mm/dd/yyyy)**
Address Line 1		**Gender:** □ Male □ Female □ Other
Address Line 2		**Marital Status:** □ Single □ Divorced □ Married □ Widowed
City		**Social Security Number**
State	**Zip**	**Employer Name**
Home Phone Number	**Cell Phone Number**	**Employee Status:** □ Employed □ Retired □ Disabled □ Unemployed
Work Phone Number	**Ext.**	**Student Status:** □ Full-time Student □ Part-time Student □ Not a Student
Emergency Contact Name	**Relation**	**Emergency Contact Phone Number**

Responsible Party or Guarantor (If under 18 years of age.)

Last Name		**Relation**		
First Name		**Address**		
Home Phone Number	**Cell Phone Number**	**City**	**State**	**Zip**

Advanced Directive Planning (A document explaining healthcare wishes if you were very sick and could not talk.)

Do you have an Advanced Directive?
□ Living Will □ Medical Power of Attorney □ DNR □ I do not have an Advanced Directive. □ I would like more information.

Additional Information

Email	**Do you want to participate in the Patient Portal?** □ Yes □ No **(The patient portal is a way to communicate electronically with your provider.)**
Race: □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Pacific Islander □ Black or African American □ White □ Hispanic □ Other □ Refuse to Report	**Ethnicity:** □ Hispanic or Latino □ Not Hispanic or Latino □ Refuse to report

Employer Information

Employer Address	**City**	**State**	**Zip**

Pharmacy Information

Local Pharmacy Name	**Pharmacy Telephone Number**	**Pharmacy Location**
Mail Order Pharmacy Name		**Mail Order Pharmacy Telephone Number**

Patient Name
Last Name: _____ First Name: _____ Middle Initial: _____Date of Birth: ____ / ____ / ____

Primary Reason for Visit:

_____

_____

Wellness and Health Maintenance Information (Please fill in the month and year.)

Date of Last Pap Test	____ / ____	**Date of Last Lung Cancer Screening CT**	____ / ____
Date of Last Mammogram	____ / ____	**Date of Last Hepatitis C Screen**	____ / ____
Date of Last DEXA Bone Density Scan	____ / ____	**Date of Last Flu Vaccine**	____ / ____
Date of Last Aortic Aneurysm Screening	____ / ____	**Date of Last Pneumovax (Old Pneumonia) Vaccine**	____ / ____
Date of Last Colonoscopy	____ / ____	**Date of Last Prevnar (New Pneumonia) Vaccine**	____ / ____
Date of Last Wellness Physical	____ / ____	**Date of Last Shingles Vaccine**	____ / ____
Date of Last Eye Exam	____ / ____	**Date of Last Tetanus Vaccine**	____ / ____

Current Medications (Including prescribed herbs, vitamins, and/or over the counter medications. If more space is needed, please use the additional medication form provided.)

Medication Name	Dosage	How often taken (ex. Once a day)

Medical History (Circle any of the following medical problems you have had in your life.)

Anxiety
Anemia
Arthritis
Asthma
Bipolar Disorder
Bleeding Disorder
Blood Clots
Cancer (type) _____
COPD/Emphysema
Chronic Pain
(where)_____
Depression
Degenerative Joint Disease
Diabetes Mellitus
Drug/Alcohol Addiction
Female Problems
Gallbladder Disease
Heart Attack
Heart Disease
Heart Rhythm Problem
Hepatitis (type) _____
High Blood Pressure
High Cholesterol
HIV/AIDS
Irritable Bowel Syndrome
Kidney Disease
Liver Disease
Lupus
Lung Problems
Male Problems
Overactive Bladder
Parkinson's Disease
Rheumatic Fever
Rheumatoid Arthritis
Seizure Disorder
Schizophrenia
Stroke
Sickle Cell
Thyroid Disease
Tuberculosis
Ulcers

Other:

_____

_____

_____

Allergies	Allergic Reaction

Past Operations/Surgeries	Date

Hospitalizations (Other than Operations/Surgeries.)

Reason for Hospitalization	Date

Family Health History (Please fill out the following.)

Family Members	Diabetes (yes / no)	Heart Disease (yes / no)	Cancer (Type)	Other Medical Issues
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Brother(s)				
Sister(s)				
Children				

Social History

Do you drink alcohol? □ **Yes** □ **No**	**How often do you drink?**	**How many drinks?**	**Do you use recreational/illegal drugs?** □ **Yes** □ **No**
Do you smoke? □ **Yes** □ **No**	**How many packs per day?**	**How many years have you smoked?**	**Are you a former smoker?** □ **Yes** □ **No** **Years quit?**
Do you chew tobacco? □ **Yes** □ **No**	**How many years?** **Years quit?**	**Do you vape?** □ **Yes** □ **No**	**Have you worked with asbestos or other hazardous materials?** □ **Yes** □ **No**

Please list all current medical providers and medical supply companies you have used in the past year.

Medical Providers	Medical Supply Company

Review of Systems (Please circle any of the following symptoms that you have had in the last two weeks.)

General: weakness, fatigue, weight loss, trouble sleeping, fever, chills, night sweats

Skin: rash, dryness, itching of your skin, wounds

Breast: breast lumps, breast pain, or breast discharge

Hematologic: easy bruising or bleeding, enlarged lymph nodes, swollen glands

Neurologic: headaches, dizziness, blurry vision, numbness, tingling

Eyes/Ears: red eyes, discharge from eyes, eye pain, eye itchiness, ringing of the ears, ear pain, difficulty hearing, ear discharge, red ears

Nose: nasal itching, runny nose, nosebleed, sinus pain

Mouth: change in taste, loss of smell, difficulty swallowing, sore throats, hoarseness

Neck: neck pain, neck swelling, lumps in neck

Pulmonary: coughing, wheezing, excessive phlegm/mucous production

Cardiovascular: chest pain, chest tightness, shortness of breath, palpitations, cold hands or feet

Gastrointestinal: stomach pain, vomiting, diarrhea, constipation, blood in your stool, loss of appetite

Endocrine: excessive thirst, increased urination, increased appetite, fatigue

Genitourinary: difficulty urinating, burning during urination, frequent urination, blood in your urine, dark colored urine, sexually transmitted disease, sexual problems, rash on genitals, vaginal discharge, painful periods

Musculoskeletal: joint pain, joint stiffness, muscle pain, weakness, decreased range of motion in joint, joint swelling

Mood: disturbing or unusual thoughts, seeing visions of things that are not there, hearing voices, mood swings, anxiety, crying spells, thoughts of harming myself, thoughts of harming others

Other: _____

TIDELANDS HEALTH
GENERAL CONSENT TO TREATMENT

Consent for Diagnosis and Treatment. I hereby request and consent to medical care given to me or my minor child at Georgetown Memorial Hospital, Waccamaw Community Hospital, Georgetown Physician Services, LLC d/b/a Tidelands Health Group, Tidelands Health ASC, LLC, or Tidelands Health Market Common, LLC (collectively, "Tidelands Health"), which may include routine diagnostic procedures and treatment the physician(s) or other practitioners involved in my/my child's care consider necessary. I understand I have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. I further acknowledge that no guarantees have been made to me regarding the outcome of any medical, surgical, diagnostic or therapeutic treatment or test. To protect myself/my child and others, I consent to have blood drawn and tested for infectious diseases, including but not limited to HIV/AIDS and hepatitis. I understand that some physicians and other practitioners provide their services as independent contractors to Tidelands Health, are not employees or agents of Tidelands Health, and that Tidelands Health is not liable for their acts or omissions.

Patient's Certification, Assignment of Insurance Benefits, and Guaranty of Payment. I certify that the information I have given in applying for payment under Medicare, Medicaid, or any other government or insurance benefits is correct. I authorize payment of hospital insurance, government or other third party benefits directly to Tidelands Health. I also authorize payment of surgical and/ or medical benefits directly to all treating, consulting, and supervisory physicians and entities. As a courtesy, Tidelands Health will file my insurance when this assignment of benefits has been signed.

- I understand that any charges Tidelands Health quotes to me prior to the provision of medical treatment are only an estimate. These charges are based on the insurance benefits given to Tidelands Health by my insurance company and are subject to change due to my medical condition and any further testing or treatment that may be necessary.
charges are based on the insurance benefits given to Tidelands Health by my insurance company and are subject to change due to my medical condition and any further testing or treatment that may be necessary.

- I understand that I am financially responsible for, agree to pay, and guarantee payment in full of all charges for services provided to me by Tidelands Health, independent physicians, or other independent health care professionals involved in providing treatment or consultation to me at Tidelands Health, even if such services are not covered by insurance. I understand that payment of estimated charges is due at the time of a non-emergent service unless previous arrangements have been made, and that my bill for any unpaid amounts will be sent to my address on file unless I request my bill to be sent to a different address. Any unpaid accounts of 90 days or more are subject to collection activity. If I have any such unpaid accounts, I understand that I will have to pay cash at the time of service for all future non-emergency services until my unpaid accounts are resolved. If I am uninsured or am having difficulty paying my bill, I understand Tidelands Health has a financial assistance program that may help me. I understand that I will be required to provide financial information to determine my eligibility for this program, and that I can get more information on this program by calling the patient financial services department at 843-520-8880 Option 2.
- I authorize Tidelands Health and any independent practitioner(s) that have provided services to me at Tidelands Health to act as attorney-in-fact (act with authority from me) for the limited purposes of: (1) collecting benefits from any responsible third party through whatever means necessary; and (2) endorsing benefit checks made payable to me and/or Tidelands Health, any of the individual entities named above, or such independent practitioner(s). If collection efforts are needed to obtain payment from me for the services and supplies provided, I agree to pay the costs of such collection efforts, including litigation or arbitration costs and reasonable attorneys' fees.
- I authorize payment of any refund of any overpaid insurance benefits to be made to the appropriate payor in accordance with my insurance policy conditions or any applicable benefit provisions. If any refund is due to me, I authorize the application of any refund to any amount that I am personally legally obligated to pay for services provided by Tidelands Health. I understand that any remaining credit due after payment of these outstanding amounts will be refunded to me.

Responsibility for Personal Valuables. If I bring money or other valuables during an inpatient hospital visit and do not give these items to an authorized hospital employee for safekeeping, or if I bring these items to an outpatient appointment or procedure, I release Tidelands Health from any responsibility or liability for the loss of or damage to any such items.

Automated Appointment Reminders. By supplying my home phone number/mobile phone number/email address, I acknowledge that Tidelands Health or a third-party automated outreach and messaging system may notify me of a pending appointment, missed appointment, wellness exam, lab results, or deliver any other health care message by call, email, or text message.
- To service my Tidelands Health account or collect any amounts I may owe, I consent for Tidelands Health or a third party acting on its behalf to call or text me at any phone number associated with my account, including through pre-recorded/automated voice and text messages. I understand that my cell phone carrier could charge me for these text messages and that I will be offered an easy way to opt out of these automated calls or text messages.

Use and Release of Medical Information. I acknowledge that Tidelands Health, licensed physicians and other health care professionals involved in my care at Tidelands Health may use and release my medical information obtained during this visit for purposes of treatment, payment, and health care operations and otherwise as stated in the Tidelands Health Notice of Privacy Practices.

I understand that this consent will automatically expire in one year. I also understand that I may revoke or discontinue my consent at any time by notifying Tidelands Health in writing, except to the extent actions have already been taken based upon my consent. I understand and agree to the above releases, consents, authorizations, and assignments of benefits:

Signature: _____ Date: _____ Time: _____
(Patient or legal guardian/authorized representative, if patient unable to sign)

Printed Name: _____ Relationship, if not Patient: _____

Acknowledgment of Receipt of Tidelands Health Notice of Privacy Practices. If I am a first-time patient, I certify that I have received a copy of the Tidelands Health Notice of Privacy Practices. If I am a returning patient, I certify that I have been offered a copy of the Tidelands Health Notice of Privacy Practices.

Signature: _____ Date: _____ Time: _____

FOR EMERGENCY DEPARTMENT USE ONLY

Release from Responsibility for Refusal to Consent to Transfer

I, _____, certify that I have been examined at a Tidelands Health hospital and that I have refused to consent to a transfer to another facility against the advice of my attending physician and the hospital administration. I acknowledge that I have been fully informed of the risks involved in not consenting to such a transfer, and I hereby release the attending physician and the hospital from all responsibility for any ill effects that may result from my decision not to consent.

_____	_____	_____	_____
(*Signature of Patient/Legal Representative)*	*(Relationship)*	*(Witness)*	*(Date & Time)*

Request for Transfer

I, _____, certify that I have been examined at a Tidelands Health hospital, and I have requested a transfer from this hospital to _____. I acknowledge that I have been fully informed of the risks involved in the transfer and that I have given my consent to the transfer. I hereby release the attending physician and the hospital from all responsibility for any ill effects that may result from the transfer.

_____	_____	_____	_____
(*Signature of Patient/Legal Representative)*	*(Relationship)*	*(Witness)*	*(Date & Time)*

Release at Own Risk

I, _____, acknowledge and agree that I am being discharged from a Tidelands Health hospital against the advice of the attending physician and the hospital's administration. I acknowledge that I have been informed of the risks involved, and I hereby release the attending physician and his or her medical practice associates, partners, assistants, or designees and the hospital and any of its personnel from all responsibility for any ill effects that may result from my decision to be discharged.

_____	_____	_____	_____
(*Signature of Patient/Legal Representative)*	*(Relationship)*	*(Witness)*	*(Date & Time)*

Patient Request for Confidential Communications

Patient Name: _____ Patient Date of Birth: _____

This is a request for confidential communications of my protected health information (PHI). When the doctor, nurse or other members of your office want to contact me, please use the following guidelines. I understand that you will do your best to adhere to the following requests.

Please check all that apply to this request:
_____ Please do not phone me at home. Use the following alternative phone number to contact me: _____
_____ Please do not phone me at work. Use the following alternative number to contact me: _____
_____ Please do not contact me by email.
_____Other request(s) (describe in detail): _____
_____
_____ When contacting me by phone it is OK to leave messages and discuss my health information with:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

_____ (Please initial) I understand that the physician or provider to whom I am making this request will make reasonable efforts to accommodate this request. I further understand that in some emergency situations, my PHI may be released. I authorize my medication from the Pharmacy Database to be released to Tidelands Health.

Additional Medication Form

Medication Name	Dosage	How often taken (ex. Once a day)