

### New Patient History Form:

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Briefly describe what problem brings you to the doctor: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous primary care doctor: \_\_\_\_\_  
Any major specialists you see: \_\_\_\_\_

**List all of your medications (dose, frequency, and over-the-counter medication)**

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**Medication Allergies with reaction**

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |

**Medical Problems (in your own words):**

\_\_\_\_\_

\_\_\_\_\_

For example (you can circle) : Diabetes, Thyroid, Seizures, TB, Cancer (type), psychiatric problems, high blood pressure, lung disease, kidney stones, bleeding problems, heart disease, liver function, kidney disease, urine infections, arthritis, skin problems

Past Gynecological History: Last menstrual period \_\_\_\_\_ Last PAP smear \_\_\_\_\_

Immunizations: Last tetanus: \_\_\_\_\_ Flu shot: \_\_\_\_\_ Pneumonia shot: \_\_\_\_\_

**Past Surgeries: (date)**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Social History:**

single  married  divorced  widowed

Any children? \_\_\_\_\_

Do you or have you ever...

Used Tobacco? Yes No How much? \_\_\_\_\_ How long? \_\_\_\_\_

Drink Alcohol? Yes No How much? \_\_\_\_\_

Used illegal drugs? Yes No What type? \_\_\_\_\_

**Family Medical History:**

- |            |           |   |
|------------|-----------|---|
| 1. Father  | Age _____ | Living <input type="checkbox"/> Deceased <input type="checkbox"/> |
| 2. Mother  | Age _____ | Living <input type="checkbox"/> Deceased <input type="checkbox"/> |
| 3. Brother | Age _____ | Living <input type="checkbox"/> Deceased <input type="checkbox"/> |
| 4. Brother | Age _____ | Living <input type="checkbox"/> Deceased <input type="checkbox"/> |
| 5. Sister  | Age _____ | Living <input type="checkbox"/> Deceased <input type="checkbox"/> |
| 6. Sister  | Age _____ | Living <input type="checkbox"/> Deceased <input type="checkbox"/> |

**Disease or cause of death:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Any children with diseases?  
\_\_\_\_\_  
\_\_\_\_\_

Review Of Systems:

Do You Now Or Have You Recently Had Problems With Any Of The Following?

(Please Circle Your Answer)

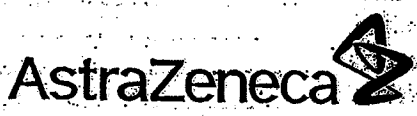
<b>G/U System:</b>	Pain Or Burning With Urination Getting Up At Night To Urinate Abnormal Vaginal Bleeding	Kidney Stone Leaking Of Urine Sexual Problem	Frequency Urgency Menstrual Probs.	Slow Or Small Stream Poor Bladder Emptying	Blood In The Urine Recurrent Urine Inf
<b>General:</b>	Change In Weight	Fever			
<b>Skin:</b>	Lumps Or Nodules	Breast Lump	Rashes	Sores	Other Skin Problem
<b>Eyes:</b>	Glaucoma	Cataracts	Glasses	Other Eye Problems	
<b>ENT:</b>	Trouble Swallowing	Nose Bleeds	Dentures	Sinus Problems	Earaches
<b>Heme/Lymph:</b>	Swollen Nodes Or Glands	Bleeding Problems	Anemia	Other Blood Disorders	
<b>C/V:</b>	Irregular Heart Beat Pain In Legs With Exertion Other Heart/Blood Vessel Problems	Heart Failure Chest Pain	Angina Phlebitis	Heart Valve Problem Swelling In Legs	Heart Murmur Blood Clots
<b>Respiratory:</b>	Shortness Of Breath	Wheezing	Cough	Asthma	Other Lung Problem
<b>G/I:</b>	Gall Bladder Problems Poor Appetite Constipation	Blood In Stool Hiatal Hernia Vomiting	Diarrhea Ulcer Nausea	Dark Tarry Stools Indigestion Hernia	Intestinal Bleeding Hemorrhoids
<b>Neuro:</b>	Loss Of Consciousness Numbness	Headaches Weakness	Strokes	Dizziness	Paralysis
<b>Psych:</b>	Other Psychological Problem	Depression	Anxiety		
<b>Musculoskeletal:</b>	Joint Replacement Surgery	Broken Bones	Gout	Arthritis	Bone Or Joint Pain
<b>Endocrine:</b>	Heat Or Cold Intolerance Skin Pigmentation Changes	Hot Flashes	Flushing	Abnormally Thirsty	Changes In Body H

Do You Have Any Other Problem You Want To Discuss With The Doctor?      Yes     No

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Physician's Signature

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# MUSC

CAROLINA FAMILY CARE

WEST ASHLEY •  
INTERSTATE 526  
INTERNAL MEDICINE

2125 CHARLIE HALL BLVD.  
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CHARLESTON, SC 29414  
(843) 876-3151  
FAX (843) 573-1537

Jeffrey G. Schultze, M.D.  
Antonio M. Hernandez, M.D.

## Patient Information

Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Last Name	First	M.I.	Birthdate	Age	Gender
Address	City	State	Zip	( )	Home Phone
Soc.Sec.#	Employer	Address	( )	( )	Work Phone
Birthplace	Marital Status	( )	( )	( )	Cell Phone
Emergency Contact	Home Phone	Bus. Phone	( )	( )	Cell Phone

I, \_\_\_\_\_, do hereby authorize a representative from Carolina Family Care to speak with the following person(s) regarding my health care. Please note that without your authorization, we are not allowed by law, in most circumstances, to discuss any information about your health care.

Name	Phone number	Medical Care	Appointments	Acct.
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you give the above representative authorized access regarding the following information?

*I do* *I do not* (circle one) authorize release of information to the above named individual(s) related to AIDS (acquired immunodeficiency syndrome) HIV (Human Immunodeficiency syndrome), sexually transmitted disease, psychiatric care/assessment and treatment for alcohol or drug abuse. **Cross out any topics you do not want information released.**

_____	_____
Patient Signature	Date
_____	_____
Witness	Date

# MUSC ORGANIZED HEALTHCARE ARRANGEMENT CAROLINA FAMILY CARE

## Consent for Medical Treatment:

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Carolina Family Care and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations. I/we have read or have/had read to read to me this consent and understand agree to its contents.

\_\_\_\_\_  
Initials

## Authorization for Release of Information and Assignment of Insurance Benefits:

My physician is authorized to release any medical information required in the processing of applications or submission of information for financial coverage, including information referring to psychiatric care, drug and alcohol abuse, sexual assault, or tests for infectious diseases including AIDS/HIV for services provided during this admission. I/we also agree to the release of medical or other information about me to government regulatory agencies (federal or state) as required by law. For Medicare/Medicaid beneficiaries - I/we have provided all necessary information for proper assignment of Medicare/Medicaid benefits.

\_\_\_\_\_  
Initials

## Agreement of Financial Responsibility:

I/we guarantee payment of all charges associated with services received from Carolina Family Care (CFC) or other related medical organizations, including University Medical Associates (UMA), Medical University Hospital Authority (MUHA), or any other related organization on behalf of the named patient. I/we agree to assign any insurance benefits or other funding to Carolina Family Care. I understand it is my responsibility to verify participation status of the physician with my health plan prior to the patients's visit and to obtain all authorization as required by my health plan prior to the patient's visit.

\_\_\_\_\_  
Initials

## H.I.P.A.A. ( Health Insurance Portability and Accountability Act ) Notification:

I acknowledge my receipt of a copy of the MUSC Organized Health Care Arrangements Notice of Privacy Practices.

\_\_\_\_\_  
Initials

## Agreement of Financial Responsibility for Non-Covered Services (Not applicable for all patients):

By signing and dating this form, I am indicating that I have been informed by Carolina Family Care or other related organization that the services the patient will receive today may not be covered because of the reason indicated below.

(Patient to initial the appropriate section if applicable.)

\_\_\_\_\_ CFC/the rendering physician is not a contracted/credentialed provider for your health plan. You will be responsible for any amounts not covered by your insurance plan.

\_\_\_\_\_ Your insurance carrier/primary care physician has not provided a referral/authorization for today's service. You will be responsible for any amounts not covered by your insurance plan.

\_\_\_\_\_ Your condition may be considered pre-existing based on the length of your coverage under your insurance plan. You may be responsible for the entire cost of the service.

\_\_\_\_\_ Your service may not be considered medically necessary by your insurance plan. You may be responsible for the entire cost of the service.

\_\_\_\_\_ Other reason: \_\_\_\_\_

I understand that the consent for medical treatment, authorization for release of information, assignment of insurance benefits, and agreement of financial responsibility will be valid for one year from the date of signature and can only be revoked upon written notice. By signing below, I/we acknowledge that this consent form has been read in full and explained as necessary.

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Signature of Patient ( Parent or Legal Guardian )

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Guarantor ( if different from the patient )