Travelers Rest Internal Medicine

6 South Poinsett Highway • Travelers Rest, SC 29690 • (864) 834-7834

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status (circle one): Single / Mar / Div / Sep / Wid

Birth Date: / /	Age:	Sex: ☐ Female ☐ Male	Parent's Name if Patient is a Minor:

Street Address:	Social Security No.:	Home Phone No.: ( )	Cell No: ( )

P. O. Box:	City:	State:	Zip Code:

Occupation:	Employer:	Employer Phone No.: ( )

Contact Preference: ☐ Phone ☐ Email ☐ Phone & Email ☐ Do Not Contact Email Address:	Preferred Language:	Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Declines ☐ Unreported	Race: ☐ Caucasian ☐ African American ☐ Asian ☐ American Indian ☐ Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Declines ☐ Unreported

Pharmacy: Location: Phone No:

GUARANTOR: INFORMATION

(Please give your insurance card and photo ID (Driver's License) to the receptionist.)

Person Responsible for Bill:	Birth Date: / /	Address (if different):	Home Phone No.: ( )
Occupation:	Employer:	Employer's Address:	Employer's Phone No.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No Is this related to: ☐ MVA ☐ WC ☐ Liability

Name of Insurance Company:

Subscriber's Name:	Subscriber's Soc. Sec. No.:	Birth Date: / /	Group No.:	Policy No.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's Name:	DOB: / /	Group No.:	Policy No.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to Patient:	Home Phone No.: ( )	Work Phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any services provided. I authorize the insurance company to release any information required to process my claims.

Patient/Guardian Signature *Date*

Health History Form

Name____________________

Reason for Visit____________

____

Surgeries__________________

____

Tobacco___________________

Alcohol ___________________

Drugs ____________________

Lives with_________________

Your occupation____________

Family History

Mother____________________

Father_____________________

Brother____________________

Sister_____________________

Date of Last:

Colonoscopy_______________

Mammogram_______________

PSA/Prostate Exam__________

Pap Smear_________________

Medical Allergies___________

Date:_______________

Pregnancy History

_______________Times

Are you Pregnant __yes ___no

Date of last Period__________

Current Medications & Dosage

1.____________________

2.____________________

3.____________________

4.____________________

5.____________________

6.____________________

7.____________________

8.____________________

9.____________________

10.___________________

11.___________________

12.___________________

Disability Reason__________

____

Pharmacy Location__________

Pharmacy Phone____________

Travelers Rest Internal Medicine

Dr. Scott Weikle, D.O.

Disclosure of Medical Information:

☐ **I DO NOT** want my information released to anyone other than myself.

Please list the individuals who we are authorized to discuss your care. Please note that we **can not** discuss any information with others, **INCLUDING** spouses or family members livings with you **UNLESS** they are listed below.

Name:____________________ Relationship to Patient:______________________

Name:____________________ Relationship to Patient:______________________

Name:____________________ Relationship to Patient:______________________

Confidential Communication and Messages:

Please list the phone number where you can be reached between 8am and 5pm, Monday through Thursday:

Primary #: ______________________

Secondary #:______________________

☐ **I DO NOT** authorize medical information regarding myself to be left on the above answering machine or voice mail.

☐ **I DO** authorize medical information regarding myself to be left on the above answering machine or voicemail.

Signatures:

I herby authorize the use or disclosure of the person health information as described above. **I understand that a copy of the privacy practices followed at Travelers Rest Internal Medicine is available to me upon request.**

Print Patient Name:____

Patient Date of Birth:_________________ Social Security #:__________________

Patient/POA Signature:____

Travelers Rest Internal Medicine

6 S. Poinsett Highway, Travelers Rest, South Carolina 864-834-7834

Patient Authorization for Practice to Release Protected Health Information to Third Parties

By signing this authorization, I authorize ______________________________ (Name of Previous Physician) and its designated staff members to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits ______________________________ (Name of Previous Physician)

Phone ____________________ Fax ____________________

To use or disclose to:
TRAVELERS REST INTERNAL MEDICINE, LLC
6 South Poinsett Highway
Travelers Rest, SC 29690
(864) 834-7834 Phone
(864) 834-7477 Fax

The following information for:
Name of Patient ______________________________ **Date of Birth** __________

- Complete Medical Record or only the following:
- One year Office Notes
- Three Years All Reports
- Lab Reports Only
- Radiology Reports Only
- Other ______________________________

This protected health information is being used or disclosed for the following purposes:

____

- Or, at the request of the individual.

This authorization will expire one year from today's date.
My physician will not condition my treatment, payment, enrollment in health plan or eligibility for benefits on whether I provide authorization for the requested disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Travelers Rest Internal Medicine, LLC has acted in reliance upon the authorization. My written revocation must be submitted to Travelers Rest Internal Medicine, LLC , 6 South Poinsett Highway, Travelers Rest, SC 29690.

______________________________ ____________________ __________
Signature of Patient or Legal Guardian — Relationship to Patient — Date

Print Name of Patient or Legal Guardian ______________________________

Travelers Rest Internal Medicine

6 S. Poinsett Hwy
Travelers Rest, SC
(864) 834-7834

Thank you for choosing Travelers Rest Internal Medicine. We appreciate you as our patient and look forward to providing you quality healthcare in the future.

Patient Name ______________________________ Today's Date ______________

How did you hear about us?

_____ **1.** My doctor **Dr.**_______________referred me.

_____ **2.** My **friend** ___________________ told me about you.

_____ **3.** My **family** told me about you.

_____ **4.** I found you on the **internet**.

_____ **5.** The **hospital** recommended you.

_____ **6.** You are a provider on my **Insurance**.

_____ **7.** I found you in the **Yellow Pages/Phonebook**.

_____ **8.** I received your **postcard**.

_____ **9.** Other______________________________________

The highest compliment our patients can give is the referral to their friends and family.