Black Creek Medical Consultants
Dr. Orville Dyce MD, Dr. Leroy Robinson MD & Andrea Trader NP
149 E. Carolina Ave Hartsville, SC 29550
Phone: 843-383-5312 Fax: 843-800-4536// 843-800-7223

# New Patient Form

**Please read carefully, PRINT , and complete in full**

Patient Name: _____ DOB: _____ SSN: _____

Parent / Guardian Name (If Applicable) : _____

Phone Number: _____ Secondary: _____

*** Does This Phone Accept Voicemails? (Please Circle) **YES or NO** ***

Email Address: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Occupation (Indicate if Student): _____ Employer: _____

Please Indicate (Circle any that apply): Married Single Divorced Separated Widowed

## INSURANCE INFORMATION

Primary Insurance Policy Company: _____ Policy #: _____

*****(PLEASE GIVE INSURANCE CARD AND IDENTIFICATION TO FRONT DESK)*****

Insurance Policy Holder Name: _____ Policy Holder SSN: _____

Insurance Policy Holder DOB: _____

Are there **ANY OTHER** insurance policies that cover the Patient? (Please Circle): **YES or NO**

Is this visit related to a Workers Compensation Case? **YES or NO**

## Primary Care / Referring Physician Information

Primary Physician: _____ Address / Phone #: _____

Has a referral been sent over on my behalf for this visit and / or my medical records? (Please Circle) **YES or NO**

When was the last time you were seen by Physician listed above? _____

## Preferred Pharmacy

Pharmacy: _____ Address / Phone #: _____

## Current Medications

| Are you Currently on any Blood Thinners? If so, please check box below | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Aspirin | | Plavix | | Coumadin | | Other: |

| Please check any medications you are either allergic to or that you cannot take: | | | | | |
|---|---|---|---|---|---|
| | Anesthetics | | Aspirin | | Barbiturates |
| | Codeine | | Demerol | | Penicillin |
| | Morphine | | Sulfa | | Anticonvulsants |
| | Other: | | | | |

| Please List all *CURRENT* Medications below. This includes Over the Counter , Vitamins, Herbal Supplements, etc. | | |
|---|---|---|
| **Name of Medication:** | **Dose:** | **Frequency (How Often Taken)** |
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## Family History

| *Please CHECK any medical history that YOU or your FAMILY may have or have had* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS / HIV | | Self | | Mother | | Father | | Grandparent (Maternal / Paternal) |
| Arthritis | | Self | | Mother | | Father | | Grandparent (Maternal / Paternal) |
| Blood Disorder | | Self | | Mother | | Father | | Grandparent (Maternal / Paternal) |
| Cancer (Type & Area) _____ | | Self | | Mother | | Father | | Grandparent (Maternal / Paternal) |
| Diabetes | | Self | | Mother | | Father | | Grandparent (Maternal / Paternal) |
| High Cholesterol | | Self | | Mother | | Father | | Grandparent (Maternal / Paternal) |
| High Blood Pressure | | Self | | Mother | | Father | | Grandparent (Maternal / Paternal) |
| Heart Disease | | Self | | Mother | | Father | | Grandparent (Maternal / Paternal) |
| Kidney Disease | | Self | | Mother | | Father | | Grandparent (Maternal / Paternal) |
| Lung Disease | | Self | | Mother | | Father | | Grandparent (Maternal / Paternal) |
| Neurological (seizures, etc.) | | Self | | Mother | | Father | | Grandparent (Maternal / Paternal) |
| Stomach (ulcer, reflux, etc.) | | Self | | Mother | | Father | | Grandparent (Maternal / Paternal) |
| Stroke | | Self | | Mother | | Father | | Grandparent (Maternal / Paternal) |

## Social History

| **Please CHECK if you use any of the following** | | | | | |
|---|---|---|---|---|---|
| | Tobacco Use | | CBD | | Crack |
| | Smokeless Tobacco | | Marijuana | | Other: *Please List* |
| | Electronic Vape | | Cocaine | | |
| | Cigar / Pipe | | Heroine | | |

**** If you checked ANY of the boxes above , please continue to next section below****

| **Frequency:** *(How Often)* | **Duration:** *(How Long)* |
|---|---|
| _____ | _____ |

## Review of Symptoms for Dr. Dyce or Andrea Trader, NP

Please CHECK any of the following symptoms you are experiencing

| | **Eyes:** | | **Throat:** | | **Skin / Allergies:** |
|---|---|---|---|---|---|
| | Itchy Eyes | | Sore Throat | | Hives |
| | Watery Eyes | | Trouble Eating | | Breakouts |
| | | | Mouth / Throat Pain | | Skin Rashes |
| | **Ears:** | | Hoarseness | | Skin Itching |
| | Popping in Ears | | Knot Feeling in Throat | | Bleeding Patches / Growths |
| | Decreased Hearing | | Trouble Swallowing | | Eczema |
| | Drainage | | Reflux | | Skin Cancers |
| | Ear Pain | | Sour Taste in Mouth | | Throat / Lip Swelling |
| | Itching in Ears | | Cough | | |
| | Ringing in Ears | | Shortness of Breath | | **Sleep:** |
| | Ear Fullness | | Wheezing | | Restless Sleeping |
| | Dizziness / Vertigo | | Nausea | | Trouble Falling Asleep |
| | Headaches | | Choking Sensation (foods / Liquids) | | Nocturnal Awakenings |
| | | | | | Fatigue / Tiredness |
| | **Nose:** | | **Thyroid or Hormone:** | | Snoring |
| | Nosebleeds | | Weight Gain / Loss | | Insomnia |
| | Nasal Stuffiness | | Mood Swings | | Lack of Sleep |
| | Sinus Pressure | | Heavy Menstrual Cycle | | Reduced Productivity |
| | Sneezing | | Dry Skin | | |
| | Allergies | | Fatigue | | **Other:** *Please List* |
| | Postnasal Drainage | | Decreased interest in sex | | |
| | Runny Nose | | Hair Thinning | | |
| | | | Cold Hands or Feet | | |

| | Review of Symptoms for Dr. Robinson | | | |
|---|---|---|---|---|
| | Please ANSWER any of the following questions below | | | |
| | | | | |
| | **Menstrual & Reproductive History:** | | | |
| | What was the date of your last menstrual period? | | | |
| | Are your cycles regular? | YES // NO | How many days do they last? | |
| | Do you experience heavy bleeding? | YES // NO | | |
| | Do you experience bleeding between periods? | YES // NO | | |
| | Do you experience pain during menstruation? | YES // NO | | |
| | How many times have you been pregnant? | | How many of those were deliveries? | |
| | **Pelvic and Sexual Health:** | | | |
| | Do you experience pelvic pain? | YES // NO | Is it associated with nausea/fever? | YES // NO |
| | Is there pain during sexual intercourse? | YES // NO | Do you have discomfort when wearing tight fitting clothes or a swimsuit? | YES // NO |
| | Have you noticed any abnormal vaginal discharge, itching or odor? | YES // NO | | |
| | Are you using any method of contraception? | YES // NO | Are you happy with it? | YES // NO |
| | Are you experiencing any urinary frequency, urgency, or burning? | YES // NO | | |
| | Have you noticed any leakage of urine (incontinence)? | YES // NO | | |
| | Have you noticed any breast lumps? | YES // NO | Breast Tenderness? | YES // NO |
| | Have you noticed any discharge from the breasts? | YES // NO | | |
| | **Menopause and Hormonal Health:** | | | |
| | Are you experiencing any hot flashes, vaginal dryness, or mood changes? | YES // NO | | |
| | Have you noticed any unexplained changes in weight, fatigue, or skin conditions? | YES // NO | | |
| | What is the date of your last PAP smear? | | | |
| | What is the date of your last HPV test? | | | |
| | What was the date of your last mammogram? | | | |
| | What was the date of your last bone density scan? | | | |

## Surgical History

| List ANY surgeries you have had and the year the surgery took place: | | |
|---|---|---|
| Type of Surgery | Year Done: | Year Done: |
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## Diagnostic Studies

| **Please check boxes if ANY of the following has been completed prior to this visit:** | | |
|---|---|---|
| | | ***If ANY of the boxes have been checked, indicate WHEN & WHERE study was completed*** |
| | Lab Work | |
| | CT Scans | |
| | MRI | |
| | X-Ray | |
| | Ultrasound | |
| | Hearing Test | |
| | | |

**Height: _____ Weight: _____**

***Once all information has been filled out, continue for Signing***

## Consent for Treatment & Release Medical Information & Privacy Statement

I do voluntarily consent to the rendering of such care as the physician(s) or any provider(s) of Black Creek Medical Consultants, LLC in their judgment, deem necessary for my health & wellbeing. This consent shall include medical examination, diagnostic testing, and minor procedures. This consent shall cover the carrying out of provider orders by the office personnel. I acknowledge that neither the physician nor staff have made any guarantee or assurance as to the results that may be obtained.

I authorize any holder of medical information about me to release any/all relevant information about me to Black Creek Medical Consultants and/or their provider(s). I also authorize the people listed below to receive information about me.

Name / Relation / Phone Number: _____

Name / Relation / Phone Number: _____

I also acknowledge that I may review a copy of Black Creek Medical Consultants HIPPA Notice of Privacy Practices explaining this office's obligations concerning the use & disclosure of my protected health information, how they will use & disclose my protected health information, and my privacy rights regarding my protected health information. I understand that if I have questions or complaints that I may contact the Privacy Officer of the practice at :

Black Creek Medical Consultants
149 E. Carolina Ave
Hartsville, SC 29550
843-383-5312

By signing below, I acknowledge the statements above and consent to this facility, its providers, and staff use of my medical information for the permitted purposes of treatment, payment, and healthcare operations.
*By signing below, I acknowledge the statements above.*

Signature of Patient (Representative): _____

Printed Name of Patient: _____

Printed Name of Representative and Relationship: _____

Date: _____

## Assignment of Benefits, Guarantee of Payment & Precertification

In consideration of services rendered to me, I agree to be financially responsible and to pay charges for all services ordered or rendered by Black Creek Medical Consultants. I understand that I am responsible for full disclosure of any/all insurance policies that cover my medical care and that these policies must be updated on every visit to this facility. I understand that Black Creek Medical Consultants will file it with my insurance company(s) as a courtesy, but that any balance due because of treatment is my responsibility. I further understand that if I fail to make payment, my account will be sent to a collection agency, attorney, or local magistrate.

I understand that Black Creek Medical Consultants will seek relevant and required precertification and preauthorization from my listed insurance(s) on my behalf. I also understand that even if these requirements are met, if my insurance deems that they will not cover or pay for the related visits/procedure, I am financially responsible to Black Creek Medical Consultants for the cost of care.

I understand that from time to time, my insurance company will request from me "coordination of benefits" or "confirmation of other insurance" and that I fill these forms out in a timely fashion, as related to visits at Black Creek Medical Consultants.

I understand that any/all estimates that Black Creek Medical Consultants and its staff provide me as related to the cost of care and the application of my health care benefits to my treatment are a courtesy ONLY. In no way is Black Creek Medical Consultants responsible for how your insurance company chooses to process claims or the benefits that affect you. It is my responsibility to understand my insurance and my healthcare benefits as it applied to my treatment at Black Creek Medical Consultants. I also understand that, irrespective of my estimate, I am responsible for the cost of treatment at Black Creek Medical Consultants.

*By signing below, I acknowledge the statements above.*

Signature of Patient (Representative): _____

Printed Name of Patient: _____

Name of Representative/Relationship: _____

Date: _____ _____

## Use of Electronic Health Record, Artificial Intelligence & E- Prescribing Technology

I understand that the use of an HER helps providers better manage care for patients and provide better health care by providing accurate, up-to-date, and complete information about patients at the point of care. They also enable quick access to patient records for more coordinated, efficient care. E-Prescribing is defined as a physician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. Black Creek Medical Consultants utilizes AI-assisted documentation tools to improve the accuracy and efficiency of your medical record. All AI tools are vetted for HIPAA compliance, and your data remains protected. Your participation is voluntary, and you may request that AI not be used during your visit. Final responsibility for the accuracy of your medical record rests with your provider. Black Creek Medical Consultants uses EHR, AI & E-Prescribing technologies in their facilities to maintain my health information. I consent to *Black Creek Medical Consultants* to create a chart/profile for the maintenance of my health record, to enroll me in their E-Prescribing system, and that AI may be used to document my visit. I have had a chance to ask questions and all my questions have been answered to my satisfaction.

*By signing below, I acknowledge the statements above.*

Signature of Patient (Representative): _____

Printed Name of Patient: _____

Printed Name of Representative and Relationship: _____

Date: _____