Black Creek Medical Consultants
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BLACK CREEK MEDICAL CONSULTANTS
SINUS & ALLERGY DIVISION
EAR, NOSE & THROAT DIVISION
SLEEP MEDICINE DIVISION
AGING & AESTHETICS DIVISION

New Patient Form

Please read carefully, PRINT , and complete in full

Patient Name: _____ DOB: _____

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? _____

Please list any person that health information may be released to on your behalf in any form such as: phone, fax, in person, in writing, etc. Please list name, relationship, and phone number.

Name:	Relationship:	Phone Number:

Medical History & Review of Symptoms

Preferred Pharmacy		
Name:	Location:	Phone Number:

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)

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)

Review of Symptoms

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:**		Snoring
	Nosebleeds		Thyroid Issues		Insomnia
	Nasal Stuffiness		Weight Gain / Loss		Lack of Sleep
	Sinus Pressure		Mood Swings		Reduced Productivity
	Sneezing		Heavy Menstrual Cycle		
	Allergies				**Other:** *Please List*
	Postnasal Drainage				
	Runny Nose				

Social History

****Please Indication below by checking boxes of Consumption****

	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)* _____

Surgical History

List ANY surgeries you have had and the year the surgery took place:

Type of Surgery	Year Done:	Type of Surgery	Year Done:

Please check boxes if ANY of the following has been complete 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 judgement, 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 the 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
Privacy Officer
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.

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: _____

Printed Name of Representative and Relationship: _____

Date: _____

Use of Electronic Health Record & 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 uses both EHR & 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 and to enroll me in their E-Prescribing system. 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: _____