SUNSET PRIMARY CARE

PATIENT INFORMATION

Name: _____ Chart#: _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell: _____ Work: _____

SSN: _____ Birth Date: _____ Age: _____ Sex: □ M □ F

Employer: _____ Position: _____

Driver's License #/State: _____ Email: _____

Medical Insurance Company: _____ ID#: _____

Policy Holder Name: _____ Policy Holder Date Of Birth: _____

Emergency Contact/Relation: _____ Phone: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Life Partner □ Separated □ Unknown

Ethnic Origin: □ American Indian □ Asian □ Black □ Hispanic □ White □ Other

How did you hear about us? Internet / Facebook Ad / Referral / Other:_____

PERSONAL INJURY PATIENTS ONLY:

Date of Accident/Injury: _____ Type of Injury: _____

Law Office: _____ LAWYER: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

List any previous treating hospitals, Providers, their address and phone number:

1. _____
2. _____
3. _____

Release Information_____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for any amount not covered by my insurance. I request that payment of authorized Medicare benefits be made to my physician.

Signature of Patient/Representative:_____ Date:_____

Medical History

Please be as accurate as you can with all history information

SUNSET PRIMARY CARE

Name: _____ **DOB:** _____ **Date:** _____

Pharmacy Name/Location: _____ **Pharmacy Phone#:** _____

Medical History:

CVA Hypertension Diabetes Hyperlipidemia Myocardial Infarction UTI

Asthma COPD ADHD/ADD DVT Cancer Hypothyroid Hyperthyroid

Migraines Depression Anxiety Seizures TB Glaucoma Cataracts

Arthritis Alzheimer's Glaucoma Reflux disease Low Testosterone

Other _____

Family History:

CVA Hypertension Diabetes Hyperlipidemia Myocardial Infarction

Asthma COPD DVT Cancer Hypothyroid Hyperthyroid Cancer Migraines

Depression Anxiety Seizures

Other _____

Surgical History: _____

_____

Social History: Married _____ Single _____ Divorced _____ Widowed _____ Life Partnership _____

Tobacco/Vape _____ How Much _____ How many years _____ Date quit _____

Alcohol _____ Recreational Drug Use _____

Employment: _____ **Job Title:** _____

Drug Allergies: _____

Medications: _____

_____

_____

_____

Signature: _____ **Date:** _____

ONLY COMPLETE FIRST BOX AND SIGNATURE

SUNSET PRIMARY CARE

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I Hereby Authorize Sunset Primary Care to Use or Disclose my Protected Health Information as Described Below. I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Patient Name: _____
First Middle Last

Address: _____ City, State, and Zip Code: _____

Social Security Number: _____ Date of Birth: _____ Phone: _____

Name of Person/facility Authorized to **RELEASE** the information: _____

Address: _____ Phone Number: _____

City, State, and Zip Code: _____ Fax Number: _____

Name of Person/facility Authorized to **RECEIVE** the Information: Sunset Primary Care .

Address: 2379 Augusta Road City, State, and Zip Code: West Columbia, SC 29169 .

Phone Number: 803.794.8776 . Fax Number: 803.794.4342 .

Purpose of Disclosure: CONTINUATION OF CARE *Dates of Treatment*: _____

Information to be Used/Disclosed – Please check those that apply:

History and Physical __	Discharge Summary __	Operative Report __	Other (specify) _____
Progress Notes __	Laboratory Report __	Radiology Report __	Immunization Record __
Billing Summary __	Consultation Report __	Pathology Report __	Entire Medical Record X.

I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, communicable diseases including HIV/AIDS this information will be included as part of my medical record to the above-named person/facility.

Sunset Primary Care may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization.

This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative, provided that the cancellation is made in writing except to the extent that:

1. **The facility has already acted on your request prior to receiving the request to cancel the authorization; or**
2. **If the authorization was given to release records to your insurance company in order to obtain insurance coverage.**

This authorization will automatically expire in 90 days unless otherwise stated. Expiration Date: _____

_____ _____

Signature of Patient or Legally Qualified Representative **Date**

_____

Relationship of Legally Qualified Representative

SUNSET PRIMARY CARE

Authorization for Release of Information

Patient Name: _____

DOB: _____ **SSN:** _____ **Chart #**_____

Sunset Primary Care is authorized to release protected health information concerning the above named patient to the entities noted below. The purpose is to inform the patient or designee of health matters, as per the patient instructions.

Entity to receive information: Check each person/entity that you approve To receive information:	Description of information to be released: check each item that can be given to person or entity on left in the same section
o Voice Mail-Home _____ o Voice mail- cell _____ o Voice mail- Ofc _____	o Results of lab test/xrays o Change in Medication o Other _____
o Spouse (provide name) _____ o Parent/guardian (provide name) _____	o Family billing information o Financial matters o Medical information as follows: _____
o Information to employer _____ o Information to school Official _____	o Appointment Information o Absent information o Other: _____

Rights of Patient:

I understand that I have the right to revoke the authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the Notice of Privacy Practices previously provided me, by sending written notification of Privacy officer. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this information may be subject to re-disclosure by the recipient and may longer be protected by federal state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature: _____ Date: _____

SUNSET PRIMARY CARE

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

My signature acknowledges my receipt of the Notice of Privacy Practices from Sunset Primary Care.

_____ _____

Signature of Patient or Designee Date

SUNSET PRIMARY CARE

URINE DRUG SCREEN CONSENT

I hereby consent to allow Sunset Primary Care to take a specimen of my urine and submit it for testing service for a compliance drug screen.

I understand that positive test results, refusal to be tested or any attempt to affect the test results or test sample will result in no controlled substance medication being prescribed to me by Sunset Primary Care.

I agree to hold harmless and release from all claims and its agents (including the above-named facility) from any liability arising in whole or part out of the collection of specimens, testing and the appropriate use of the information from such testing.

Name: _____

Signature: _____

Date: _____