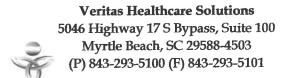
Patient Demographics



Personal	Date:	
Patient Name: _		
Patient Birthday:_		
Social Security Number (SSN):_		
Address:_		
_		
Home Phone Number:		
Work Phone Number:		
Medical Records		
Family Doctor:		
Referring Doctor:		
Financial		
Self Pay?	yes no	
Insurance Carrier:		
Policy Holder's Name: _		
Policy Number:		
Policy Holder's Phone Number:	×	

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Medical History

Name:				Date:
Date of Birth:				
Reason for appointn	nent:			
List all of your media	cal probl	ems:		
List all surgical proce	edures:			
				Health Habits
	Past	Present	Never	How long?/How much?
Tobacco	I ust	Tresent	14000	
Alcohol				
Drugs				
Are you pregnant? yes no Last menstrual period: Are you allergic to any medications? If so, please list them below.				
		Please I	ist all m	edications that you are taking.
			1	Family History
Relationship	Age	1		Heart Attack/Stroke/Cancer/Blood Clots, etc.
Mother				
Father				
Sisters				
Brothers				

Review of Systems



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Symptoms (circle all that apply)

General

decreased appetite
chills
fever
fatigue
night sweats
weight gain or loss

HEENT

headache
head injury
blurred vision
double vision
eye pain
glaucoma
vision disturbance
decreased hearing
earache
ringing in the ears
nose bleeds
facial numbness
hoarseness

Neurological

decreased memory difficulty speaking dizziness falls numbness seizures stroke T.I.A.

Neck swollen glands

Cardiovascular

high blood pressure
high cholesterol
chest pain
leg swelling
fainting
dizziness
history of bypass
history of stent
palpitations
rapid heart rate
slow heart rate
calf cramps
congestive heart failure
P.A.D.
aneurysm

Gastrointestinal

abdominal
black stool
bloody stool
change in bowel habits
constipation
diarrhea
difficulty swallowing
hemorrhoids
heartburn
gallstones
jaundice
hepatitis
nausea
acid reflux (G.E.R.D.)

Breasts breast mass history of breast cancer

Psychiatric

depression
disorientation
early awakening
frequent crying
hallucinations
panic attacks
suicidal thoughts
memory loss

Respiratory

chronic cough
snoring
pulmonary fibrosis
C.O.P.D.
asthma
shortness of breath

Skin

bruising
excessive swelling
hair loss
rash
skin ulcers

Hematology

anemia
hemophilia
blood clots
abnormal bleeding
easy bruising
enlarged lymph nodes
sickle cell disease

Genitourinary

prostate cancer
blood in urine
kidney stones
difficulty emptying
nocturia
bladder
painful urination
excessive menstrual bleeding
non-menstrual bleeding

Endocrine

cold intolerance
hot intolerance
excessive thirst
change in libido
thyroid problems
diabetes

Musculoskeletal

joint pain joint redness muscle cramps muscle weakness joint replacement

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Medication List

	Patient Name:				
	Patient Birthday:				
	Phone Number:				
	Pharmacy Name:				
Pharma	cy Phone Number:				
[NKDA ALLERGIE	ES:		THE PARTY OF THE P	
Date	Medication Name	Dosage	Instructions	Refills	Pain Mgmt
Juic					
		_			
			1	1	1

Financial Policy



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Our policy is that patients are responsible for the full payment of their accounts. Payment is collected at check in for amounts known to be due at the time services rendered. This may represent a co-payment, co-insurance or deductible amount.

Veritas Healthcare Solutions participates with many insurance carriers and their various plans. Please contact your insurance provider to verify participation. If your insurance company is one with which we have a participation agreement, you will be expected to pay your portion of the charge on the date of service, and we will file your claim. If you have a co-pay amount, it will be due at the time of service. We will allow a period of forty-five (45) days for the filing date for your carrier to process and pay your claim. If your claim has not been paid within that period, full payment, as well as any follow up with the insurance company becomes your responsibility.

If your insurance company is not our list of participating carriers, we will file your claim as a courtesy, but you will be responsible for any out-of-network fees or co-insurance amounts at the time of service.

If we refer you to a specialist or schedule procedures or test we will try to send you to a facility that participates with your insurance. Ultimately it is the responsibility you the patient to call the insurance company and confirm that the provider is in network and the procedure or test is authorized.

If you are not covered by an insurance plan, payment in full of all charges will be expected at the time of service. In the event your account becomes a bad debt and we discontinue providing services we will require the entire balance be paid as well as a reinstatement fee of one hundred dollars (\$100.00) prior to reinstating you as a patient.

I have read the financial policy, understand it and accept my responsibility.

date	patient name	patient signature



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Disclosure Agreement

HIPAA is the federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of healthcare information and help the healthcare industry control administrative costs.

You may choose to allow staff of Veritas Healthcare Solutions to share or discuss your personal healthcare information with others. Please name the eligible person(s) and sign below.

I,	· · · · · · · · · · · · · · · · · · ·
I,prin	nt patient name date of birth
ereby authorize the employees of	Veritas Healthcare Solutions to discuss my personal medical
ormation and treatment with;	
,	
Name:	Relationship:

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
NTowner	Palationchin
Name:	remuozinip.
the execut of an emergency I suther	rize the employees of Veritas Healthcare solutions to contact;
ne event of an emergency, I author	inze the employees of vertile results and the second of the employees of vertile results and the employees of the employees of vertile results and the employee
Name:	Phone Number:
Name:	Phone Number:
Name:	
my behalf.	
3	
	Date:
patient signa	ature

Privacy Practices



Notice of Privacy Practices and Patient Consent For Use and Disclosure or Protected Health Information

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain Patient Rights regarding my protected health information.

I understand that Veritas Healthcare Solutions may use or disclose my protected health information for treatment, payment or health care operations - which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Veritas Healthcare Solutions has a detailed document called 'The Notice of Privacy Practices'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read 'The Notice of Privacy Practices' before signing this agreement. If I ask, Veritas Healthcare Solutions will provide me with the most current version of 'The Notice of Privacy Practices'.

My signature below indicates that I have been given the chance to review such copy of 'The Notice of Privacy Practices'. My signature means that I agree to allow Veritas Healthcare Solutions to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Veritas Healthcare Solutions has taken action relying on this consent.

	I have read and understand the policy regarding privacy practices.				
date	patient name	patient signature			