



## Sewee Family Medicine

### Information Sheet

We would like to extend our warmest welcome and thank for entrusting your care to the physicians and staff at Sewee Family Medicine. Our goal is to provide you with excellent medical care in a professional, timely and friendly manner. To assist us in addressing your health care concerns an efficiently and accurately, we offer the following guidelines for your review.

- Office hours are Monday through Friday 8:30 AM – 5:00 PM. One of our physicians is available for weekend and after hour's emergencies and may be reached through the answering service at 884-2133.
- We request a 48 hour notice for medication refills. This allows us ample time to review your health record to ensure that your refill is accurately and appropriately complete.
- We strongly recommend an annual physical exam with Pap smear testing and complete gynecological evaluation for female patients over the age of 18 year, and a yearly physical with prostate screening for male patients over the age of 40 years.
- We will gladly file any insurance that can be submitted electronically. For us to accurately submit your claim we require documentation of valid and current insurance coverage and personal identification in the form of a driver's license and social security number. Without this information we will not be able to file your claim. As such, you will be required to update your patient profile and insurance information on your first visit of the calendar year. Notification of the office of any changes in patient information or insurance coverage thereafter will be the responsibility of the parent or guardian. The office will not re-file your claim to insurance if the above information is not present at the date of service. All insurance balance after 45 days of the date of service will become the patient's responsibility.
- Payment of all fees and co-pays are required at the time of service. All balances deemed applicable to your deductible by your insurance carrier for the calendar year are balances due to the office and will be billed accordingly.

By signing this document, you indicate that you have read the above information and agree to abide by these guidelines.

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Patient Signature

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Date

William S. Anderson, MD  
John A. Knepper, DO  
*Board Certified Family Physicians*



874 Whipple Road • Suite 100  
Mount Pleasant, SC 29464  
Phone 884-2133 • Fax 849-9466  
www.seweemed.com

## Sewee Family Medicine

### **Protected Health Information – Consent for Use and Disclosure**

With my consent, Sewee Family Medicine may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Sewee Family Medicine's posted Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Sewee Family Medicine reserves the right to revise this Notice of Privacy Practices at anytime.

With my consent, Sewee Family Medicine may call or mail my home or other designated location and leave message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory result among others.

I have the right to request that Sewee Family Medicine restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Sewee Family Medicine's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Sewee Family Medicine may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Print Name

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Date



## Sewee Family Medicine

### Important Policy Changes Effective – March 15, 2007

#### Please Read

1. Please check with your insurance carrier to verify coverage for annual physical examinations, laboratory testing and immunization coverage prior to your office visit.
2. If your insurance plan does not cover annual physical examinations or immunization or if there is a specific facility required for laboratory blood testing, please notify the staff promptly at the time of your office visit. Unless notified otherwise, the office will submit your laboratory studies to Laboratory Corporation of America (LabCorp). If the office is not informed of any of the above noted restrictions to the delivery of care, you will be responsible for the balance of any non-covered charges.
3. In order to assure accurate and appropriate dosing and refill of your medication, we request that you bring all of your prescription medication bottles with you to your office visit.
4. We are happy to provide you with the appropriate written prescriptions for your mail-order medication refills. All mail-order prescriptions will be written and ready for pick-up at 48 hours. It will be your responsibility to mail this prescription with payment to your pharmaceutical company. **THIS OFFICE WILL NO LONGER BE RESPONSIBLE FOR FAXING OR POSTING MAIL-ORDER PRESCRIPTIONS TO THE PHARMACY.**
5. Immunizations – Pediatric/Adolescent.  
If a patient's insurance does not cover 100% of the cost of vaccinations, then the patient (child/adolescent) is considered underinsured. Under these circumstances the patient (child/adolescent) can be considered eligible to receive all mandatory vaccinations through a governmental program named VAFAC. The parent or legal guardian is responsible for checking with their respective insurance carrier to confirm coverage of immunizations prior to the office visit.

**PLEASE SIGN STATING THAT YOU HAVE READ AND UNDERSTAND THE ABOVE POLICY CHANGES. THANK YOU**

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature



# Sewee Family Medicine

## Patient Registration Form (1)

**Date:** \_\_\_\_\_

**Doctor:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**First Name:** \_\_\_\_\_

**Gender:**     Male     Female

**MI:** \_\_\_\_\_

**Marital Status:**

**Mailing Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Single                       Married  
 Widowed                       Divorced  
 Separated                       Partner

**City:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

**State:** \_\_\_\_\_      **Zip:** \_\_\_\_\_

**Employer:**

**Name:** \_\_\_\_\_  
**Tel:** \_\_\_\_\_

**Telephone:**

**Home:** \_\_\_\_\_  
**Cell:** \_\_\_\_\_  
**Work:** \_\_\_\_\_  
**Ext:** \_\_\_\_\_

**Employment Status:**

Full-time                       N/A  
 Part-time                       Full-time  
 not employed                       Part-time  
 Self-employed  
 Retired  
 Active Military

### Billing Information:

**Responsible Party**

Self  
 Other (name, address, tel.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Emergency Contacts:

1) **Name:** \_\_\_\_\_  
**Tel:** \_\_\_\_\_

2) **Name:** \_\_\_\_\_  
**Tel:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

**Other family members who will be patients  
in this office (name and relationship)**

**Is this person a current patient in this office?**

Yes     No

\_\_\_\_\_  
\_\_\_\_\_



## Sewee Family Medicine

### Patient Registration Form (2)

**Insurance Information:** (Please provide **current insurance information**)

1. **Primary Insurance:** \_\_\_\_\_
  - Name of Insured: \_\_\_\_\_
  - Insured's Date of Birth: \_\_\_\_\_
  - Insured's SSN: \_\_\_\_\_
2. **Secondary Insurance:** \_\_\_\_\_

**Patient Information:**

1. **Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_
2. **Street Address:** (if different from mailing address)  
\_\_\_\_\_  
\_\_\_\_\_
3. **Telephone:** (H) \_\_\_\_\_ (W) \_\_\_\_\_  
(C) \_\_\_\_\_ **Email:** \_\_\_\_\_
  - May we leave a message at home?  Yes  No      At work?  Yes  No

**Employer:** (name and address) \_\_\_\_\_  
\_\_\_\_\_

**Pharmacy:** (name/location) \_\_\_\_\_  
Tel: \_\_\_\_\_

**Release of Medical Information:**

**NO**      I **do not** allow my provider to release billing data to my insurance carrier. I understand that my claims will be filed to insurance by my provider.

**YES**      I do permit provider to release medical billing data to my insurance carrier.

I request payment of authorized benefits be made to **SEWEE FAMILY MEDICINE** for any services provided to me by the physician. I authorize any holder of my medical information to release to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

William S. Anderson, MD  
John A. Knepper, DO  
*Board Certified Family Physicians*



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## Sewee Family Medicine

### Release/Discussion of Medical Information

Patient name: \_\_\_\_\_

D.O.B \_\_\_\_\_

SSN: \_\_\_\_\_

Date: \_\_\_\_\_

The release of my medical information and/or the discussion thereof may be shared with the following individual(s).

_____	_____	_____
Contact	Relationship	Telephone

_____	_____	_____
Contact	Relationship	Telephone

I hereby authorize the release or discussion of all medical information pertaining to the aforementioned individual, including but not limited to categories protected by state or federal law: (1) substance abuse treatment; (2) mental health treatment; and (3) HIV-AIDS-related treatment.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date:

William S. Anderson, MD  
John A. Knepper, DO  
Board Certified Family Physicians



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## Sewee Family Medicine

### MEDICAL RECORDS RELEASE

Obtain from \_\_\_\_\_ Release to \_\_\_\_\_

Dr.'s Name \_\_\_\_\_

Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

I hereby authorize the release of all medical information pertaining to the  
aforementioned, including but not limited to categories protected by state or federal law:  
(1) substance abuse treatment; (2) mental health treatment; and (3) HIV-AIDS-related  
treatment. I agree to pay the \$15.00 transfer fee prior to the release of my medical  
records.

\_\_\_\_\_  
Patient or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Paid \_\_\_\_\_ Cash / Check # \_\_\_\_\_ / Visa/MC Rec'd by \_\_\_\_\_



## Sewee Family Medicine

**Patient:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Family History

**Mother**

<input type="checkbox"/> Deceased	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Mental illness	<input type="checkbox"/> Cancer	<input type="checkbox"/> Healthy
<input type="checkbox"/> Other _____		

**Father**

<input type="checkbox"/> Deceased	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Mental illness	<input type="checkbox"/> Cancer	<input type="checkbox"/> Healthy
<input type="checkbox"/> Other _____		

**P Grandfather**

<input type="checkbox"/> Deceased	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Mental illness	<input type="checkbox"/> Cancer	<input type="checkbox"/> Healthy
<input type="checkbox"/> Other _____		

**P Grandmother**

<input type="checkbox"/> Deceased	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Mental illness	<input type="checkbox"/> Cancer	<input type="checkbox"/> Healthy
<input type="checkbox"/> Other _____		

**M Grandfather**

<input type="checkbox"/> Deceased	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Mental illness	<input type="checkbox"/> Cancer	<input type="checkbox"/> Healthy
<input type="checkbox"/> Other _____		

**M Grandmother**

<input type="checkbox"/> Deceased	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Mental illness	<input type="checkbox"/> Cancer	<input type="checkbox"/> Healthy
<input type="checkbox"/> Other _____		

**Siblings**

<input type="checkbox"/> Deceased	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Mental illness	<input type="checkbox"/> Cancer	<input type="checkbox"/> Healthy
<input type="checkbox"/> Other _____		

Siblings: \_\_\_\_\_

**Children**

<input type="checkbox"/> Deceased	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Mental illness	<input type="checkbox"/> Cancer	<input type="checkbox"/> Healthy
<input type="checkbox"/> Other _____		



## Sewee Family Medicine

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Medical History

#### Allergy/ENT

- Seasonal allergies  Yes  
Environmental allergies  Yes  
Sinusitis  Yes  
Recurrent ear infection  Yes  
Hearing deficit  Yes  
Food allergies  Yes  
Eczema  Yes  
Psoriasis  Yes  
Tinnitus  Yes

#### Cardiovascular

- HTN  Yes  
Heart disease  Yes  
Congestive heart failure  Yes  
Cardiomyopathy  Yes  
Atrial fibrillation  Yes  
Mitral valve prolapse  Yes  
Heart murmur  Yes  
DVT  Yes

#### Endocrinology

- Diabetes  Yes  
Hypercholesterolemia  Yes  
Hypothyroidism  Yes  
Grave's Disease  Yes

#### Eyes

- Glaucoma  Yes  
Cataracts  Yes  
Macular degeneration  Yes

#### Gastroenterology

- GERD  Yes  
Esophagitis  Yes  
Peptic ulcer disease  Yes  
H. pylori  Yes  
GI bleed  Yes  
Irritable bowel syndrome  Yes  
Colon polyp  Yes  
Crohn's Disease  Yes  
Colitis  Yes  
Diverticulosis  Yes  
Diverticulitis  Yes  
Cirrhosis/liver failure  Yes  
Pancreatitis  Yes

#### GYN/OB

- Abnormal pap smear  Yes  
HPV  Yes  
Endometriosis  Yes  
Post-menopausal  Yes  
Osteoporosis  Yes

#### Hematology/Oncology

- Iron deficiency anemia  Yes  
Thalassemia  Yes  
Breast cancer  Yes  
Colon cancer  Yes  
Leukemia  Yes  
Lymphoma  Yes  
Malignant melanoma  Yes  
Ovarian/Uterine cancer  Yes  
Prostate cancer  Yes



# Sewee Family Medicine

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Medical History

### Infectious Disease

- Hepatitis B  Yes
- Hepatitis C  Yes
- Meningitis, viral  Yes
- Blood transfusion  Yes
- Tattoo  Yes
- Chicken pox  Yes
- Shingles  Yes
- Mumps  Yes
- Measles  Yes
- Mononucleosis  Yes

### Neurology

- Neuropathy  Yes
- Migraine headache  Yes
- Dizziness/vertigo  Yes
- Seizures  Yes
- Stroke  Yes
- Alzheimer's dementia  Yes
- Tremor  Yes
- Restless Leg syndrome  Yes
- Speech/Language delay  Yes
- Cerebral palsy  Yes
- Multiple sclerosis  Yes

### Psychiatry

- Anxiety disorder  Yes
- Panic attacks  Yes
- Depression  Yes
- Bipolar affective disorder  Yes
- Schizophrenia  Yes
- ADHD/ADD  Yes

### Respiratory

- Asthma  Yes
- COPD  Yes
- Emphysema  Yes
- Sleep apnea  Yes
- Tuberculosis  Yes
- Pulmonary embolism  Yes

### Rheumatology/Musculoskeletal

- Osteoarthritis  Yes
- Rheumatoid arthritis  Yes
- Gout  Yes
- Degenerative disc disease  Yes
- Fibromyalgia  Yes

### Urology

- UTI/kidney infections  Yes
- Urinary incontinence  Yes
- Bedwetting  Yes
- Kidney stones  Yes
- Prostatitis  Yes
- Erectile dysfunction  Yes
- BPH  Yes
- Chronic Renal Insuff.  Yes

### Other Medical Problems:

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## Sewee Family Medicine

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Social History

**Occupation:** \_\_\_\_\_

**Occupational exposure:**       Yes       No      **Substance:** \_\_\_\_\_

Alcohol:	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> <2/day	<input type="radio"/> >2 /day	<input type="radio"/> social
Smoking:	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> <1ppd	<input type="radio"/> 1-2ppd	<input type="radio"/> >2ppd
Sexually active:	<input type="radio"/> Yes	<input type="radio"/> No			
Exercise:	<input type="radio"/> Yes	<input type="radio"/> No			
Caffeine:	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> <2 c/day	<input type="radio"/> >2c/day	
Lives With:	<input type="radio"/> Spouse	<input type="radio"/> Children	<input type="radio"/> parents	<input type="radio"/> alone	<input type="radio"/> partner
Passive Smoke Exp.	<input type="radio"/> Yes	<input type="radio"/> No			
Marital Status	<input type="radio"/> Single	<input type="radio"/> Married	<input type="radio"/> Widow	<input type="radio"/> Separated	<input type="radio"/> Divorced
Drug abuse/rehab	<input type="radio"/> Yes	<input type="radio"/> No	Dates: _____		

**Other:** \_\_\_\_\_

\_\_\_\_\_

**Allergies:** \_\_\_\_\_

\_\_\_\_\_

**Surgeries:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_