(o) 435-383-6120 (f) 435-557-8003
Office@SentryMedicalCare.com

NAME OF PATIENT: _____

Date of Birth: _____/_____/_____ Community/Facility Name: _____

SELECTION OF PRIMARY CARE PHYSICIAN AND MEDICAL CONSENT

I hereby request medical care and treatment by Atlas Medical Utah DBA Sentry Medical (Sentry), its Primary Care Providers and available Specialists. I designate Sentry as my only Primary Care Providers and request that they monitor and assist with all aspects of my health care, and I agree to provide Sentry with a detailed medical history.

CHRONIC CARE MANAGEMENT (CCM)

I agree to allow Sentry to provide me with Chronic Care Management (CCM), Home Health and Hospice Care Plan Oversight services and to be designated as my only CCM provider. Services include: 24/7 phone access to clinical staff, consultation, and guidance in managing my chronic conditions, reviewing my medications, help with scheduling specialist visits and tests that my provider ordered, receiving a plan of care with personal health goals, sharing e-records and coordination of care with other providers, and working closely with my home health and hospice. I understand that this is an insurance covered benefit and Sentry may bill my insurance for CCM and depending on my insurance, I may be responsible for a co-pay. I can refuse these available services by opting out of my CCM benefit at the end of any month by notifying Sentry in writing.

FINANCIAL RESPONSIBILITY

I authorize Sentry to bill my insurance and for my insurance company to make direct payments to Sentry. I accept full financial responsibility for payment of insurance mandated charges such as Deductibles, Copays, and Coinsurance. I am aware that the only bills I will receive from Sentry will be for Deductibles, Copays, and Coinsurance; Sentry will not bill me personally for any services denied by my insurance. I understand that it is my responsibility to continuously provide up-to-date Insurance information or select a cash payment plan with Sentry.

NOTICE OF PRIVACY PRACTICES

Sentry participates in Government Health Information Exchange (HIE) programs to which I can opt out at any time. Sentry may disclose my health information when required to do so by law. Medical information is considered private and confidential; however, I am aware, that in accordance with HIPPA Law, my information may be shared or disclosed verbally, electronically, and on paper as needed to others who are involved in my care and as needed for medical billing and/or care coordination. Additionally, I understand that Sentry may need to contact me or my designee directly regarding my care. To improve care coordination, I give my permission for Sentry to leave phone messages regarding my medical care/account information. I understand that this consent will remain valid until updated or revoked.

Voicemail: Text Message: Email:

RELEASE OF MEDICAL RECORDS

I authorize the prompt release of my complete health record from all past and present healthcare providers to Sentry; this authorization for release of information covers all past and present medical records, unless otherwise specified, which may include records relating to communicable diseases and treatment of alcohol or drug abuse

HOSPICE CARE

I understand that if I request Hospice or Home Health Services Sentry will remain as Primary Care Provider and act as my Attending Physician (GV), unless otherwise notified in writing.

TRANSFER OF CARE

I understand, that if I am receiving In-Home Provider Services that Sentry may or may not remain as my Primary Care Provider if I change care facilities or move from my current address. Sentry also reserves the legal right to terminate services, at any time, without cause, upon (30) days prior notice. I understand that if I desire a change in provider for any reason that prompt written notification be sent to Sentry. Furthermore, I understand that Sentry may change my assigned Provider to any of Sentry's Associate Providers at any time without prior notice.

My Signature below certifies that I have read, understand, and consent to all the terms and conditions listed above.

_____

Signature of patient or Legal POA Date

Sentry MEDICAL

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Office@SentryMedicalCare.com

Sentry Medical Location: ☐ Brigham City ☐ Cache Valley ☐ Weber County. ☐ Salt Lake

PATIENT REGISTRATION

First Name: _____ Last Name: _____ (MI): _____

DOB: _____ / _____ / _____ Sex: M / F Patient Personal Cell: _____

Preferred Language: _____ Race: _____ Ethnicity: ☐ Non-Hispanic ☐Hispanic

Social Security Number: Medicare Number:

PLACE OF RESIDENCE

Community/Facility Name: _____ Move-in Date: _____ / _____ / _____ Room# _____

Home/Community/Facility Address:

PAST PRIMARY CARE PROVIDER AND CURRENT SPECIALISTS

Primary Care Provider Name/Info: _____ Phone #: _____

Specialist: _____ Specialty: _____ Phone #: _____

Specialist: _____ Specialty: _____ Phone #: _____

☐ I AM ON Hospice (Hospice Company: _____)

☐I AM ON Home Health (PT/OT/Skilled Nursing) (Home Health Company:

DESIGNEE INFORMATION *(Please fax verification of active POA/FPOA to our office)*

☐I DO have a Medical Power of Attorney (MPOA) ☐I DO NOT have a Medical Power of Attorney (MPOA)

MPOA or Primary Contact: _____ Relation to Patient: _____

MPOA Primary Phone #: _____ MPOA Email Address: _____

MPOA Mailing Address: _____ City: _____ State: ____ Zip: _____

☐ I DO have a Guarantor or Financial POA (FPOA) ☐ I DO NOT have a Guarantor or Financial POA (FPOA)

FPOA or Primary Contact: _____ Relation to Patient: _____

FPOA Primary Phone #: _____ FPOA Email Address: _____

FPOA Mailing Address: City: State: Zip:

(Without accurate insurance information we will be unable to bill your insurance and we will have to bill you directly)

PRIMARY INSURANCE (Medicare, Medicare/Medicaid Advantage, Commercial Plan) (Part B, Part C)

Insurance Provider and Plan Name: _____

Member ID# _____

SECONDARY INSURANCE (Medicare Supplement Plan, Medicaid, or "Medigap" Plan) (Part F, G, K, L, M, N, Etc)

Insurance Provider and Plan Name: _____

Member ID#

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PATIENT MEDICAL HISTORY

Patient Name: _____ DOB ____ / ____ / _____ Height: _____(Inches) / Weight: _____(lbs)

ADVANCED DIRECTIVES

(Check all that apply / Fax verification of advanced directives to our office)

☐ Living Will ☐ Advanced Directive. ☐ DNR (Do Not Resuscitate). ☐ DNI (Do Not Intubate) ☐ DNH (Do Not Hospitalize)

ALLERGIES AND ALLERGIES TO MEDICATIONS

(include reaction if known i.e. rash, trouble breathing, etc):

_____

_____

SOCIAL HISTORY

Former Profession(s): _____

Current smoker YES NO Year started _____ Year Quit _____ Pack/s per day: _____

Tobacco use YES NO Type: _____ (chew, pipe, cigar, etc)

Alcohol Use: YES NO Type: _____ Drinks per week _____

History of Illicit Drug use:

FAMILY HISTORY

Mother Living Deceased known health issues: _____

Father Living Deceased known health issues: _____

Other family members known health issues (*state relation and health issues*):

_____

SURGICAL HISTORY

Heart Bypass/CABG Date _____ Cardiac (Heart) Stent Date _____

Heart Valve Replacement Date _____ Pacemaker Date _____

Defibrillator/ICD Placement Date _____ Tonsillectomy Date _____

Appendix Removal Date _____ Gall Bladder Removal Date _____

Hysterectomy Date _____ Cataract removal - Date _____ L / R / Both

Knee Replacement Date _____ L / R / Both Hip Replacement - Date _____ L / R / Both

Other Surgical History_____

HOSPITALIZATION HISTORY

(Please list any hospitalizations in the past 12 months, Hospital name and reason)

_____

_____

_____

_____

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DETAILED MEDICAL HISTORY BY SYSTEM

Patient Name: _____ DOB ____ / ____ / _____

Eyes and Ears:
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Blindness (R, L, or both eyes): _____
- ☐ Hearing loss
- ☐ Other: _____

Heart:
- ☐ High Blood Pressure
- ☐ Heart Attack – (Year if known): _____
- ☐ Heart Failure
- ☐ Aortic Stenosis
- ☐ Heart Valve Problems
- ☐ Angina
- ☐ High Cholesterol
- ☐ Atrial Fibrillation (A-fib)
- ☐ Irregular Heart Beats
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Edema (swelling)
- ☐ Other: _____

Kidney and Urinary Tract:
- ☐ Recurrent bladder infections (UTI)
- ☐ Chronic Kidney disease
- ☐ Enlarged prostate
- ☐ Prostate Cancer
- ☐ Urinary incontinence
- ☐ Kidney stones
- ☐ Bladder Cancer
- ☐ Other: _____

Endocrine:
- ☐ Underactive Thyroid
- ☐ Overactive Thyroid
- ☐ Diabetes Type 1 (juvenile onset)
- ☐ Diabetes Type 2 (adult onset)
- ☐ Other: _____

Musculoskeletal:
- ☐ Arthritis
- ☐ Chronic back pain
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other:_____

Psychological:
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Other: _____

Lungs:
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Bronchitis
- ☐ Frequent or recurrent Pneumonia
- ☐ Sleep Apnea
- ☐ Pulmonary Embolism (blood clot in lung)
- ☐ Lung Cancer
- ☐ Other: _____

Gastrointestinal:
- ☐ Reflux/GERD/Heartburn
- ☐ Ulcers
- ☐ Irritable Bowel Disease
- ☐ Liver Disease/Cirrhosis
- ☐ Hepatitis
- ☐ Gallbladder Disease
- ☐ Colon Polyps
- ☐ Diverticulosis/Diverticulitis
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Hernia
- ☐ Colon Cancer
- ☐ Other: _____

Neurologic:
- ☐ Dementia (Type if known): _____
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Seizure disorder/Epilepsy
- ☐ Neuropathy
- ☐ Migraines
- ☐ TIA (mini-stroke)
- ☐ Multiple Sclerosis
- ☐ Tremors
- ☐ Other: _____

Vascular:
- ☐ DVT (blood clot in arms or legs)
- ☐ Aneurysm
- ☐ Peripheral Vascular Disease (Poor circulation)
- ☐ Other: _____

Other Health conditions:
- ☐ Anemia
- ☐ Eczema
- ☐ Psoriasis
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Breast Cancer
- ☐ Skin Cancer
- ☐ Other Cancer: _____