Great Plains Geriatrics, L.L.C.
118 Ponderosa Ave
Hill City, SD 57745
605-394-2118

NEW PATIENT FORM

Patient Name:____

Date of Birth:_____/_____/_________

Social Security #:_______ - _____ - ________

Community Name:____

Street Address:____

City:______________________________**State:**______ **Zip Code:**_____________

Phone:_______- _______- _________

Room #:____________

Emergency Contact/POA:______________________________________

Phone:_______-_______-_________

Relationship To Patient:______________________________________

Patient or POA Consent Signature:______________________________

Chronic Care Management (CCM) is defined as the non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more), significant chronic conditions. In addition to office visits and other face-to-face encounters (billed separately), these services include communication with the patient and other treating health professionals for care coordination (both electronically and by phone), medication management, and being accessible 24 hours a day to patients and any care providers (physicians or other clinical staff).

CCM Consent Signature:_______________________________________

INSURANCE INFORMATION

***PLEASE ATTACH A COPY OF CARDS**

Insurance Company:____

Policy ID #:____

Group #:____

Secondary Ins:____

/

SPECIALTY CARE PROVIDERS

Past Primary Care Provider:______________________________

Clinic:______________________________

Cardiology:______________________________

Neurology:______________________________

Urology:______________________________

Oncology:______________________________

Psychology:______________________________

Other:______________________________

ALLEGIES:

____

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MEDICATION LIST ***YOU MAY ALSO CHOSE TO ATTACH A MEDICATION LIST***

Please indicate the name of medication, dose and frequency taken.

Drug	Dose	Frequency
Drug	Dose	Frequency
Drug	Dose	Frequency
Drug	Dose	Frequency
Drug	Dose	Frequency
Drug	Dose	Frequency
Drug	Dose	Frequency
Drug	Dose	Frequency
Drug	Dose	Frequency

ADD ADDITIONAL PAGE IF NECESSARY

PAST MEDICAL HISTORY

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PLEASE INCLUDE THE FOLLOWING FORMS:

- **Insurance card copies**
- **POA medical paperwork (if applicable)**

WHEN COMPLETE: FAX TO 605-307-8999 OR EMAIL TO:
admissions@gpgcare.org