Great Plains Geriatrics, L.L.C.
118 Ponderosa Ave
Hill City, SD 57745
phone: 605-394-2118
fax:: 605-307-8999

NEW PATIENT FORM

Patient Name:_____

Date of Birth:_____/_____/_____

Social Security #:_____ - _____- _____

Community Name:_____

Street Address:_____

City:_____State:_____ Zip Code:_____

Phone: (xxx-xxx-xxxx) _____

Room #:_____

Emergency Contact/POA:_____

Phone: (xxx-xxx-xxxx) _____

Relationship To Patient:_____

Patient or POA Electronic Consent Signature:_____

Date:

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 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).

Electronic Signature:_____

INSURANCE INFORMATION

*PLEASE ATTACH A COPY OF CARDS

Insurance Company:_____

Policy ID #:_____

Group #:_____

Secondary Insurance _____

/

SPECIALTY CARE PROVIDERS

Past Primary Care Provider:_____

Clinic:_____

Cardiology:_____

Neurology _____

Urology:_____

Oncology:_____

Psychology:_____

Other:_____

ALLERGIES:

_____

_____

MEDICATION LIST **YOU MAY ALSO CHOOSE 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

_____

_____

_____

_____

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