The Medicine Shoppe
1304 Mount Rushmore Rd
Rapid City, SD 57701

Screening Questionnaire for Remote Patient Monitoring

I. Patient Information:					
Patient Name:		Medicare #:			
Address:		Medication Allergies:			
Phone:	DOB:	City:	State:	Zip:	
Primary Doctor:		Age:	Gender: Male	Female	
Primary Doctor Phone Number:		Primary Language:			
		Patient email:			

II. Health History Questionnaire: (Please answer all questions)	**Yes**	**No**	**Don't Know**
1. Has the patient been treated for Hypertension?			
2. Has the patient been treated for Diabetes?			
3. Has the patient been treated for congestive heart failure?			
4. Patient has Medicare Part B coverage? (please provide a copy of the Medicare (red/white/blue) card.			
5. Does the Patient have a Medicare Supplement Policy? (Please provide a copy of the Supplemental Insurance Card)			

6. Patent prefers to be called at the following time of day _____Morning _____Afternoon

III. Signatures:

Form Completed by: _____ Relationship to Patient: _____

Patient Signature:_____ Date _____

IV: Administrator Use

Notes:

Medicine Shoppe
Personnel Name: _____ **Signature:** _____

Date: _____