PATIENT INFORMATION SHEET

Last Name:_____ **First Name**:_____ **Middle**:_____

Gender: M F SSN: _____-_____-_____ **Marital Status**:_____ **D.O.B**:_____

Race: Decline American Indian/Alaska Native Asian African American/Black Hawaiian White Other:_____

Ethnic Group: Decline Hispanic/Latino Not Hispanic/Latino **Language**:_____

Florida Address:_____ **Zip**:_____**City**:_____

Home Phone: ( )_____-_____ **Cell** : ( )_____-_____ **Work** : ( )_____-_____

Email Adress:_____@_____.com

Alter. Address:_____**Zip**:_____**City**:_____ **State**:____

Emergency Contact:_____ Phone:( )_____ - _____

Pharmacy Name:_____ Phone: ( )_____- _____

I authorize Premier Medical Associates to release to any insurance company/Medicare or its carriers any information needed to process and pay my claims. I permit a copy of this to be used for that purpose and to request payment of medical insurance and medical benefits to be made directly to Premier Medical Associates. I understand that it is mandatory to inform the healthcare provider of any other party who may be responsible for paying any deductible amount, co pay, or any percentage fees not paid by the insurance company of third party within a reasonable time which is not to exceed 60 days. I also authorize payment of my insurance/ Medicare benefits to be paid directly to Premier Medical Associates for my treatment. I also understand that it is my responsibility to pay any unpaid amounts not paid by the insurance company/Medicare.

Insurance regulations suggest that we inform you in advance of we believe a service may not be covered or fully reimbursed by your insurance. In the doctors professional judgment certain services are needed in order to give high quality healthcare and to help provide a diagnosis, but some services may not be reimbursed by them. These services may include but are not limited to an EKG, lipid profile, protime, biopsy, etc. We will only perform these services when required and the results will help us to provide you with optimum care. Patient Agreement: I certify that I have read and fully understand the above information. I understand that I will be responsible for payment of any medically necessary services should they be denied by my insurance.

I understand that I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. An Advance Directive refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply: Our office requires a copy of such documents.

□ I have not executed an Advance Directive □I have executed an Advance Directive

□Living Will □Durable Medical Power of Attorney □Do Not Resuscitate (DNR)

□Designation of health care surrogate form Designated/Guardian;_____

_____ _____

Signature of Patient Date

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Premier Medical Associates to use and disclose protected health information (FM) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Premier Medical Associates describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Premier Medical Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Premier Medical Associates.

With this consent, Premier Medical Associates may call my home or other alternative location and leave a 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 calls pertaining to my clinical care, including laboratory test results, among others.
With this consent, Premier Medical Associates may mail to my home or other alternative location any items that assist the practice in carry out TPO, such as appointment reminder cards and patient statements.

With this consent, Premier Medical Associates may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment cards and patient statements. I have the right to request that Premier Medical Associates restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Premier Medical Associates to use and disclose 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, or later revoke it, Premier Medical Associates may decline to provide treatment to me.

_____ _____

Signature of patient or Legal Guardian Date

_____ □_____

Print Patient Name Check box and print name if signing as Legal Guardian

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

I authorize Premier medical Associates to use and disclose the protected health information described below

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. _____ to _____.

OR

b. □ all past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the **exception** of the following information:

□ Mental health records

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

X_____

Signature of patient or personal representative

X_____

Printed name of patient or personal representative and his or her relationship to patient

_____

Date

MEDICAL INFORMATION RELEASE FORM

Patient Name:_____ D.O.B_____

□ I authorize the release of information including diagnosis, records, examination rendered to me along with claims information regarding my medical care to the following individuals:

□ Spouse: (name)_____

□Child(ren): (name)_____

_____

_____

□Other:_____

This release will remain effective until terminated by me in writing. In addition, messages regarding my healthcare can:

□be left on any one of my message machines using the numbers I have provided

□not be left on any message machine, rather a message to return the provider's call needs to be left

_____ _____

Signature Date

OFFICAL USE ONLY→: ***WEIGHT:_____ HEIGHT:____'____" TEMP:_____ BP:_____/_____ PULSE:_____ O2:_____***

YOUR NAME: _____ DATE OF BIRTH___/___/ 19_____ Gender:_____
DRUG ALLERGIES: Penicillin Sulfa Macrolides Cephalosporin Tetracyclines NSAIDS
OTHER:_____

♦ WHAT BRINGS YOU TO THE OFFICE TODAY ♦

♦ YOUR PAST MEDICAL HISTORY ♦

Condition	*Year Began*	*Condition*	*Year Began*
❑ Diabetes		❑ Hypertension	
❑ Renal Disease (Kidney Disease)		❑ High Cholesterol	
❑ COPD, Bronchitis, Emphysema or Asthma		❑ Hypothyroidism (low thyroid)	
❑ Coronary Artery Disease/ Heart attack		❑ Depression or Anxiety	
❑ CHF(Heart Failure)		❑ GERD or peptic ulcers	
❑ Pacemaker/ Defibrillator		❑ Cirrhosis or Hepatitis	
❑ A-Fib or Mechanical Valve(type):		❑ Rheumatoid Arthritis	
❑ PVD, PAD, or DVT		❑ Gout or Osteoarthritis	
❑ Stable chest pain (using Nitro)		❑ Erectile Dysfunction or BPH	
❑ Stroke or TIA		❑ Sleep Apnea	
❑ Seizure, Parkinson Disease, Epilepsy		❑ Cataracts or Glaucoma	
❑ Dementia or Alzheimer Disease		❑ Cancer:	
❑ History of STD's		❑ Other:	
❑ Other:		❑ Other:	

♦ **Review of Systems** ♦

Please review the following symptoms and ***circle*** *those items that are* ***a problem for you in the past 3-6 months***

Vision problems	Wheezing	Loud Snoring	Spinning/ Vertigo	Diarrhea
Hearing problems	Cough / Coughing blood	Breast Lumps/ discharge	Memory Loss	Constipation
Sinus trouble	Shortness of breath	Testicle Lump	Balance problems	Rectal bleeding
Hay fever	TB exposure	Frequent Urination	Trouble swallowing	Dark Colored Stool
Nosebleeds	Palpitations	Incontinence	Excessive hunger	Hives
Sore throat	Chest pain / discomfort	Blood in Urine	Excessive thirst	Rash
Hoarseness	Dizziness	Kidney stones	Heat /Cold intolerance	
Lumps in neck	Leg Swelling	Anemia	Excessive Sweating	**Pls List Others Below:**
Tooth problems	Poor Circulation	Easy bruising	High blood sugar readings	
Earache/ Discharge	Cold / Burning Feet	Joint pain / stiffness	Low blood sugar readings	
Runny Nose/Congestion	Discomfort in legs when walking	Tremor	Nausea	
Fever / Chills	Weakness	Fainting	Vomiting	
Weight loss / gain	Difficulty sleeping	Weakness	Decrease/ Increased Appetite	
Sweats / Fatigue	Increased daytime sleepiness	Hallucinations	Abdominal Pain	
Anxiety/Depression	Falling asleep watching T.V	Headaches	Heartburn	

☐ ***Place an "X" in the box to the left if you have none of the above.***

♦ Family Health History ♦

*Please list below the health history of your **blood** (genetic) first degree relatives*

Relative	*Living or Deceased*	*Current age or age at death*	*Cause of Death*	*Health Problems*
Father:				
Mother:				
Brother(s):				
Sister(s):				
Mother's Father				
Mother's Mother				
Father's Father				
Father's Mother				
Child(ren)				
Other:				
I was adopted □				

♦ Hospitalizations within the PAST ONE (1) YEAR♦

Hospitalization Reason	*Month / Yr*	*Name of Hospital*	

♦ Past Surgical Procedures ♦

Operation Type	*Month / Yr*	*Operation Type*	*Month / Yr*
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

♦ Serious Injuries or Fractures ♦

Type of injury or fracture	*Month / Yr*	*Type of injury or fracture*	*Month/ Yr*

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		*Month/Yr*		*Month/Yr*
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Bone Density(DEXA)		ECHO	
Hepatitis B Vaccine		Colonoscopy		Heart Stress Test	
Shingles Vaccine		Endoscopy (EDG)		PSA	
Other:		Chest X-Ray		Other:	

♦ Medications, Vitamins and Herbal Supplements ♦

Medication Name	*Strength (Mg)*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*

♦ Social, Educational and Work History ♦

Marital Status: SINGLE/ MARRIED/ DIVORCED /WIDOWED	In what type of residence do you live (i.e., apartment, house, assisted living, nursing home)?	
Work Status (circle one): Employed/ Unemployed / Retired/ Disabled/ Student	**Current/ Prior occupation:**	
Do you drink alcohol? Yes / No / Not anymore / Never	**What type of alcohol?**	**No. of drinks per day?**
I am a social drinker: Yes No	**I am a recovering alcoholic:**	**I quit drinking(date):**
Are you a current smoker? Yes No	**What do you smoke:** Cigarettes / Cigars/ Pipe	**If you smoke, how much per day?**
Former smoker? Yes No	**If so, what year did you quit:**	**# of years you smoked:** **Pks per day:**
Do you use smokeless tobacco: Yes No	**Do you use illicit substances:** Yes No	**cocaine/marijuana/ other:**
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?

ADL'S: I can do/ know the following:

BATHE MYSELF □YES □NO	CLEAN MY HOUSE □ YES □ NO	CONTROL MY BLADDER □ YES □ NO	CONTROL MY BOWEL □YES □ NO
COOK/PREPARE MEALS □YES □NO	CONVERSATE MEANINGFULLY □YES □ NO	DRESS MYSELF □YES □ NO	OPERATE MOTOR VEHICLE □YES □NO
FEED MYSELF □YES □NO	FIND MY WAY HOME □YES □NO	LIVE INDEPENDENTLY □YES □ NO	RECOGNIZE FAMILIAR FACES □ YES □NO
REMEMBER MY NAME □YES □NO	KNOW WHERE I LIVE □YES □NO	KNOW THE CURRENT DATE □YES □NO	**I use public transportation:** □YES □ NO

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, Cardiology etc)

Type of Doctor	*Name of Doctor*	*Phone number:*
Cardiologist		
Dermatologist		
E/N/T		
Gastroenterologist		
Nephrologist		
Oncologist		
Ophthalmologist		
Orthopedist		
Psychiatrist/ Psychologist		
Pulmonologist		
Rheumatologist		
Urologist		
Last Primary Care:		
Other:		
Other:		