PATIENT HISTORY FORM

First Care Medical Centers, P.A. 12995 S. Cleveland Ave., #184, Fort Myers, FL 33907

Full Name: ____ **Date of Birth:** ________________ **Age:** _________

Smoker: ( ) No ( ) Yes ( ) Occasional *Number of Packs Per Day:* ______________

Allergies: Medications ( ) Seasonal ( ) **Substance Use:** (Mark "A" for alcohol, "D" for non-prescription drug use).
(Please list below)
____
____ *Amount Per Week*: ________________
____

Past Surgery/Operations: ( ) Tonsils/Adenoids ( ) Appendix ( ) Gallbladder ( ) Hemorrhoids
( ) Hernia-Inguinal (Right or Left) ( ) Umbilical ( ) Ventral ( ) Hysterectomy ( ) Other

Past Hospitalizations: ____

Past Illnesses:
( ) Asthma ( ) Hiatal Hernia ( ) Cardiovascular
( ) Anemia ( ) Pneumonia ( ) Hypertension
( ) Kidney Stones ( ) Fractures ( ) Diabetes
( ) Hepatitis ( ) Seizures ( ) Musculoskeletal
( ) Other: ____

Family History of:
( ) Diabetes ( ) Asthma ( ) Hypertension ( ) Seizure Disorder
( ) Elevated Blood Fats (Triglyceride/ Cholesterol) ( ) Heart Problems, Cardiovascular
( ) Other: ____

Any Known Diagnosis: ____

Current Medications: ____

Advance Directives: ( ) **Living Will** ( ) **Health Care Surrogate**
Please Note: You should notify your provider of any advance directives you may have, and a copy must be housed in your permanent medical record.*

Patient/Guardian Signature: _____________________________ **Date:** _________________________

Reviewed by: ____ **Date:** _________________________

Patient Information Sheet

First Care Medical Centers, P.A. 12995 S. Cleveland Ave., Ste. 184, Fort Myers, FL 33907

Last Name: ________________________________ First Name: ________________________________ MI: ________

DOB: _________ Sex: Male ___ Female ___ S.S.#: ___________________ Driver's License#: ___________________

Local Address: ____

City: _____________________________ State: ______ Zip Code: ______________

Home Phone: (____) ________________ Cell #:(____) ________________ Emergency #: (____) _________________

Employer Name: ___________________________ Employer Address: ______________________________________

City: ____________________________ State: ______ Zip Code: ______________ Work#: (____) ________________

Medical Information May Be Disclosed To: ____

Test results may be left on answering machine: (circle one) yes no

Emergency Contact: _________________________________ Relationship: __________________________________

Marital Status: ____________________________ Spouse's Name: ____

Northern Address: ____ City: ________________________________

State: ___________________ Zip Code: __________________ Home#: (____) ________________

Referred by: (circle one) Friend Doctor Employer Signs Direct Mail Referral Service Internet

Other: ________________________

Advanced Directives: (circle any that apply) Living Will DNR Health Care Surrogate

Insurance Information:

Name of Insurance Company: ____________________________________ Effective Date: _____________________

Name of Supplement (for Medicare): _______________________________ Effective Date: _____________________

I understand my signature authorizes payment to be made, and authorizes release of medical information necessary to pay a claim. I item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer of agency shown, In Medicare assigned cases, the physician of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, co-insurance, and non-covered services. Co-insurance, and the deductible, are based upon the charge determination of the Medicare carrier.

I hereby consent to the examination, treatment, and payment, and procedures, which may be performed during this, and subsequent visits, including emergency treatment deemed necessary by the First Care Medical Centers, P.A. staff. I authorize payment directly to First Care of my insurance benefits herein specified, and otherwise payable to me, but not to exceed the balance due of the center's regular charges. I understand that failure to make payment in full, or failure to make financial arrangements for payment may result in my account being placed with a collection agency, and I will be charged interest, collection fees, and/or attorney fees.

Patient/ Guardian Signature: ____ Date: __________________

INSURANCE INFORMATION

Primary Insurance ___________________________ Group # ______________

Policy ID# _________________________ Insurance Phone # ______________

Insurance Address ____

Policyholder Name ____

Policyholder Date of Birth ______________Relationship to Patient_________

If Auto Insurance Claim Number ______________ Date of Accident________

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Secondary Insurance _________________________ Group # ______________

Policy ID# _________________________ Insurance Phone # ______________

Insurance Address ____

Policyholder Name ____

Policyholder Date of Birth ______________Relationship to Patient_________

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Individual we may contact for questions regarding this information:

_________________________________ Contact Number _________________

FIRST CARE MEDICAL CENTERS, P. A.
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, First Care Medical Centers, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to First Care Medical Centers' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. First Care Medical Centers reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to First Care Medical Centers, Privacy Officer at 12995 S. Cleveland Ave., Ste. 184, Fort Myers, FL 33907.

With my consent, First Care Medical Centers may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, First Care Medical Centers may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment cards and patient statements as long as they are marked Personal and Confidential.

With my consent First Care Medical Centers may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that First Care Medical Centers restrict how it uses or discloses my PHI to carry out TPO. However, 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 First Care Medical Centers' use and disclosure of 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, First Care Medical Centers may decline to provide treatment to me.

______________________________	______________________________
Signature of Patient or Legal Guardian	**Relationship to Patient**
______________________________	______________________________
Patient's Name	**Date**
______________________________	
Print Name of Patient or Legal Guardian	