

Premier MED
Family & Sports Medicine



2940 Maguire Road STE 200
Ocoee, FL 34761-4752
Ph. 407-581-9065
Fax. 321-348-5827

NEW PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** ____/____/____

Home Phone#: _____ **Cell Phone#:** _____

Leave a detailed message **OR** Leave a call back number

How did you hear about us? Google Facebook Friend Other _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

E-Mail Address: _____

(This will only be used for correspondence regarding your health records, insurance, and general office information.)

I hereby acknowledge that I have read or received a copy of the patient Notice of Privacy Practices.

Patient Signature: _____

(Parent or Guardian if the patient is under age 18)

Insurance Information:

Primary insurance: _____ **Check One:** EPO HMO PPO

Policy/Member ID #: _____ **Group #:** _____

Policy Holder (Subscriber's Name): _____

Policy Holder DOB: ____/____/____ **Relation:** _____

Secondary Insurance: _____ **Check One :** EPO HMO PPO

Policy/Member ID #: _____ **Group #:** _____

Policy Holder (Subscriber's Name): _____

Signature: _____ **Date:** ____/____/____

I understand that my insurance is not a guarantee of payment and I am responsible for any remaining amount my insurance may not during any office visit. I am also responsible for updating my provider with my most recent insurance information.

Consent For Disclosure and Emergency Contact:

I agree that PremierMED| Family & Sport Medicine may disclose my medical information to me and the following individual(s) in the event I am not physically present, including disclosures by telephone, voice mail, facsimile, e- mail or regular mail. I agree to let certain individual(s) participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for PremierMED| Family & Sport Medicine and or staff to disclose my personal medical information to the following individual(s):

Name: _____ **Relationship:** _____ **Phone #:** _____

Name: _____ **Relationship:** _____ **Phone #:** _____

(Parent or Guardian list yourself or other adults authorized)

Patient Signature: _____ **Date:** ____/____/____

I understand that this consent may be revoked by me at any time by written notice to PremierMED| Family & Sports Medicine.



NEW PATIENT HEALTH HISTORY INTAKE FORM

Name: _____ **Date of Birth:** _____

Reason for visit: What brings you in today? (Top 3 Medical concerns or problems to discuss today)

1. _____
2. _____
3. _____

Medication or Food Allergies: (What happens?)

Current Medications: (Name, dose, instructions)

Preferred Pharmacy: (Name, location, zip code)

Family History: (Major Medical Conditions- Diabetes, Heart Disease, Cancer, etc.) (Please indicate if they are alive (A) or deceased (D))

Your Mom: _____

Grandparents: Moms Mom _____ Moms Dad: _____

Your Dad: _____

Grandparents: Dads Mom: _____ Dads Dad: _____

Siblings: _____

Personal Medical History: What medical conditions have you been diagnosed with?



Do you see any Specialists? (Name and Specialty, Inc. OBGYN, Dermatology, etc.)

Have you ever had a **Colonoscopy**? YES NO What year? Name of doctor?

When was your last **Annual Physical Exam**? Who did you see?

Female:

Last **Pap Smear**: When? _____ Doctor's Name? _____

Last **Mammogram**: When? _____ Imaging Center? _____

Male:

Have you had your **Prostate checked**? YES NO When was the last time? _____

Social History:

Do you smoke? YES NO Ever been a smoker? YES NO

How many per day? _____ How many years did you smoke? _____ Quit Date? _____

Do you drink any alcohol: YES NO (Never) BEER WINE LIQUOR

How drinks per week? _____

Surgical History: What surgeries have you had?

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****NO CD MEDICAL RECORDS****

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **DOB:** ____/____/____

Phone: _____ **Email:** _____

I authorize PremierMED Family & Sports Medicine to obtain from the following:

Progress Notes Radiology Reports Pathology Reports

Dates: _____ to _____ All Diagnostic Results All Medical Records

Please release my health information from the following providers/facilities:

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

The information may be used for the following purposes:

Continued Treatment Insurance Personal use

Disability Legal Other: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by Federal Privacy Laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. This consent form maybe revoked in writing and otherwise expires five years from the date listed below.

Patient Signature: _____ **Date:** ____/____/____

**Note: If these records contain any information from previous providers, or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted diseases, you are hereby authorizing disclosure of this information,*

****This form expires one year from the signed date****