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PremierMED
Family & Sports Medicine

2940 Maguire Road STE 200
Ocoee, FL 34761-4752
(P) 407-581-9065
(F) 321-348-5827
(E) info@premierfsm.com

PATIENT INFORMATION

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

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

Street Address: _____

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

E-Mail Address: _____

INSURANCE INFORMATION

Primary Insurance: _____ **Circle One - HMO or PPO**

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

Policy Holder (Subscriber's Name): _____

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

Secondary Insurance: _____ **Circle One - HMO or 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 & EMERGENCY CONTACT

I agree that PremierMED| Family & Sport Medicine may disclose my medical information to me and the following individuals(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 #:** _____

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

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

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

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

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MEDICAL HISTORY 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. _____

Allergies/ Medication side effects: (Please list the agent/ medication and reaction)

_____

_____

_____

Current Medications: (Name, dosage, reason for use)

_____

_____

_____

Preferred Pharmacy: (Name, location, phone number)

_____

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

Paternal Mom: _____

Paternal Grandparents: Moms Mom: _____ Moms Dad: _____

Paternal Dad: _____

Paternal Grandparents: Dads Mom: _____ Dads Dad: _____

Siblings: _____

Past/ Current diagnoses: What medical conditions have you been diagnosed with?

_____

_____

_____

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

Do you see any Specialists? (Please list the name, specialty, and location.)

_____

_____

_____

Have you ever had a **Colonoscop**y? 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/ Dexa**: When? _____ Imaging Center? _____

Male:

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

Social History:

Do you use tobacco? YES NO Ever used tobacco? YES NO

How many per day? _____ How many years used? _____ Quit Date? _____ Method? _____

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

How many drinks per week? _____ How many years used?_____ Quit Date?_____ Method?_____

Surgical History: What surgeries have you had?

_____

_____

_____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____/_____/_____

Phone: _____ Email: _____

I authorize PremierMED Family & Sports Medicine to obtain 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 may be revoked in writing and otherwise expires five years from the date listed below. ***Note: If these records contain any information from previous providers, or information about cancer diagnosis, drug/alcohol abuse, sexually transmitted diseases, HIV/ AIDS, and mental health you are hereby authorizing disclosure of this information.***

Patient Signature: _____ Date: _____/_____/_____

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PATIENT POLICIES

(Patient copy)

-Appointments

Office visits are by appointments only. However, in the event that you develop sudden illness and require an appointment on the same day, we will do our best to accommodate you. Please understand that you may be seen by a different provider for that particular visit in order for us to care for you in a timely manner. Informing our reception staff beforehand about the nature of your appointment will ensure your appointment is equipped with enough time for your visit.

-Cancellations/ No shows

In the event that you need to cancel or reschedule your appointment, a 24 hour notice during business hours is required. If you are 10 minutes late, you will have to reschedule your appointment and will be considered a no show. *Appointments cancelled within the same day or marked as a no show will be charged a $50 fee.*

-After hours answering service

If you contact our office after business hours, an after hours answering service will be available. This service is only to assist you with acute (non-life threatening) urgent situations. ***Please note this is not for emergencies, call 911.*** Appointment cancellations, prescription refill requests, referral requests, and knowledge of test results are services NOT offered with the after hours answering service.

-Preventive care

Annual physical exams and Well woman exams are considered wellness visits. Complete physical exams are preventive visits that screen patients for common health conditions and include a head to toe assessment. A baseline reading of your lab results, blood pressure, temperature, pulse, respirations, weight, height, and other vital functions depending on your age and level of activity. We request all patients 21 and over to have labs drawn 7-10 days prior to their annual physical exam. ***Annual physical exams cannot be scheduled during the same visit as a new patient consultation, acute visit, or other requested appointments.***

-Hospital Admissions

If you are admitted to the emergency department and/ or the hospital, please make sure to inform the hospital admission staff of your primary care physician's name. Follow ups with your primary care physician is required 7-14 days after your hospitalization to help avoid readmissions and/ or complications.

-Surgical clearances

If you are an established patient scheduling an appointment for surgical clearance the following is required before we can schedule your appointment.
-Surgical clearance form
-Surgeon's name and office information
-Date of surgery

-Forms

Any documents (FMLA, STD, LTD, Parking permits, etc.) that need to be completed by a medical provider, we encourage that you schedule an appointment specifically for the completion of the document. This ensures that the document is completed accurately. If you're unable to schedule an appointment there is a $25 fee for the form completion and a 7-10 business days waiting period.

-Prescription refill requests

Please contact your local or mail order pharmacy to request a refill 1- 2 weeks prior to your refill date. Your pharmacy will then contact us by fax, please allow up to 3 business days for a response. DEA law states that all controlled substance medications require a 3 month follow up in office, we CANNOT submit a temporary refill.

-Referral/ Authorization for specialists

All referrals and prior authorizations to specialists or imaging centers require 48-72 hours for processing. For authorization procedures and/ or pharmacy approvals please contact your health insurance company for further information.

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