Florida Primary Care CLINICS
An Affiliate of Physician Partners of America

GENERAL PATIENT INFORMATION

Patient Last Name | First Name | Middle Initial | Date Of Birth

( ) | ( )

Home # | Cell #

Home Address | City | State | Zip Code

- - | Female Male | Single Married Divorced Widowed

Social Security # | Please Circle | Please Circle One

Employer Name

Primary Insurance Carrier | Policy ID Number | Group Number

HMO PPO POS Other:

(Type Of Insurance) Please Circle | Insurance Carrier Number

Secondary Insurance Carrier | Policy ID Number | Group Number

HMO PPO POS Other:

(Type Of Insurance) Please Circle | Insurance Carrier Number

Important: In case of emergency, who would we contact?

Name:	Relationship:
Address:	Home Phone#
Cell Phone#	Work Phone #

"I understand that I am financially responsible for all charges, whether or not paid by insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give my medical center (Florida Primary Care Clinic) consent to perform medical treatment"

Patient/Guardian Signature | Date

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Patient Medical History

Date of Last Physical Exam _____ Physician Name _____

Address: _____

PAST HISTORY (Personal and Allergies): Have you had any of the following illnesses?

	YES	NO		YES	NO		YES	NO		YES	NO
Anemia			Depression			Hay fever			Mumps		
Alcohol Overuse			Diabetes			Heart Attack or other heart disease			Nervous Breakdown		
Allergies (other than Medication)			Emphysema			Hepatitis			Rheumatic Fever		
Arthritis			Kidney Infection			High Blood Pressure			Sexually Transmitted Disease		
Asthma			Lung Infection			Jaundice			Sickle Cell Anemia		
Cancer			Gall Bladder Disease			Kidney Disease			Stomach Ulcer		
Chicken Pox			Gout			Measles			Thyroid Disease		
Colitis			Bladder Infection			Migraine Headache			Whooping Cough		

PERSONAL HABITS:

1. Have you ever smoked? ☐ YES ☐ NO
   a. If yes, are you a regular smoker? ☐ YES ☐ NO
      i. If NO, when did you quit? _____
2. Do you regularly drink alcohol? ☐ YES ☐ NO
   a. If yes, how often? _____
3. Have you ever used any of the following:

	YES	NO		YES	NO
Marijuana			Cocaine		
LSD			Speed		
Heroine			Other, Specify:		

OPERATIONS: List and indicate approximate year.

HOSPITALIZATIONS: (Other than operations) List reasons and approximate dates.

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Patient Medical History

SERIOUS INJURIES: List injuries and give approximate dates.

DIAGNOSTIC TESTS/EXAMS:

LAST TEST/EXAM	DATE	LOCATION/PROVIDER
EYE EXAM		
FOOT EXAM		
PAP SMEAR		
MAMMOGRAM		

IMMUNIZATIONS: Please give date

	YES	DATE	NO		YES	DATE	NO
Hepatitis B				Small Pox			
Flu				Tetanus			
Polio				Pneumococcal			
Typhoid				Chicken Pox			

FAMILY HISTORY:

	CHECK SEX	IF LIVING AGE:	IF LIVING HEALTH	IF DECEASED AGE AT DEATH	IF DECEASED CAUSE
Father					
Mother					
Brother/Sister	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F				
Husband/Wife					
Sons/Daughters	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F				

WOMEN ONLY:

NUMBER OF:

Date of last menstrual cycle?		Pregnancies:	Live Births:
Contraception Type		Miscarriages:	Abortions:

DATE OF LAST:

Pap Smear: (Abnormal): Y or N	Mammogram: (Abnormal): Y or N
Osteoporosis Scan:	Flushing/Menopausal Symptoms: Y or N

MEN ONLY: Date of Last:

Prostate Exam:	Last PSA (Prostate Blood Test)

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Patient Medical History

CHECK IF ANY BLOOD RELATIVE HAS OR HAD ANY OF THE FOLLOWING AND ENTER THEIR RELATIONSHIP:

	YES	NO	RELATIONSHIP TO YOU		YES	NO	RELATIONSHIP TO YOU
Arthritis				High Blood Pressure			
Asthma				Intestinal Polyps			
Bleeding Tendencies				Kidney Decease			
Cancer				Leukemia			
Colitis				Migraine			
Congenital Heart Decease				Nervous Breakdown			
Diabetes				Rheumatic Fever			
Emphysema				Sickle Cell Anemia			
Epilepsy				Stomach Ulcers			
Goiter				Stroke			
Gout				Suicide			
Hay Fever				Tuberculosis			
Eart Attack				Other, Specify:			

REVIEW OF SYSTEMS: Circle All That Apply:

General	Fever	Night Sweats	Unexplained Weight Loss	Fatigue	Unexplained Weight Gain
Skin	Rashes	Cancers	Change in Hair	Change in Skin	Change in nails
Eyes	Glasses	Contact Lenses	Pain	Changing Vision	Discharge
Ear, Nose, Throat	Ear Pain	Change in Hearing Sinus Trouble	Persistent Runny Nose	Sore Throat	Change in Voice
Heart	Chest Pain	Swelling Ankles	Heart Murmur		
Lungs	Cough	Short of Breath	Wheeze		
Gastrointestinal	Nausea	Blood in Stool	Change in Bowels	Ulcers	Heartburn
Genitourinary	Blood in Urine	Painful or Frequent Urination	Incontinence	STD's	
	Women:	Vaginal Discharge	Change in Menstrual Cycle	Change in Sexual Function	
	Men:	Testicular Pain	Decreased Urinary Stream	Penile Discharge	Change in Sexual Function
Orthopedic	Painful Joints	Muscle Weakness			
Neuro/Psych	Seizures	Anxiety Depression	Tremor	Paralysis	Frequent Headache
Allergy	Hives	Hay Fever			
Circulation	Leg Swelling	Blood Clots			

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Patient Medical History

MEDICATIONS:

CHECK	MEDICATION	CHECK	MEDICATION
	Asthma Wheezing Medicine		Sleeping Pills
	Aspirin, Buffering, Anacin, Tylenol, or Similar products		Thyroid Medicine
	Blood Pressure Pills		Stomach/Digestive Medicine
	Cortisone, Prednisone		Weight-Reducing Pills
	Cough Medicine		Blood Thinners or Coumadin
	Digitalis or heart Medicine		Dilantin or Seizure Medications
	Hormone		Water Pills or Diuretics
	Insulin or Diabetic Pills		Antibiotics
	Anemia Medications		Phenobarbital/Barbiturates
	Laxatives		Vitamins
	Others, Specify:		

LIST EACH MEDICATION/DOSAGE AND HOW OFTEN YOU TAKE IT, INCLUDING VITAMINS AND HERBAL SUPPLEMENTS

MEDICATION	DOSAGE	HOW OFTEN?	WHEN STARTED?

ARE YOU ALLERGIC TO ANY MEDICATION?

☐ YES ☐ NO

MEDICATION	REACTION

ADDITIONAL COMMENTS AND NOTES:

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

DOB:_____/_____/_____ Phone Number: _____

I authorize the release of my medical records to Florida Primary Care Clinics for review and continuation of my medical care. I authorize the following physician offices, clinics, legal offices, diagnostic centers, and medical providers to provide copies of my health records to:

Persons/organizations **receiving**: Florida Primary Care Clinics (location circled below)
(List all facilities, clinics, and offices from which information may be requested)

PHYSICIAN OFFICES (please list all physicians you have seen in the past two years)

Physician Name	Address	Phone Number

HOSPITAL/OTHER FACILITIES (surgeries/procedures, radiology reports, laboratory results)

Facility Name	Address	Phone Number

Restrictions: ____ there are NO restrictions to the information that can be released
____ the following information CAN NOT be released:

_____

DURATION: This Authorization will remain in effect: (please check selection):
____ from the date of this Authorization until ___/___/___
____ until the provider fulfill this Authorization request
____ until the following event occurs: _____

Date:____/____/_____Patient/Guardian Signature: _____

4726 N Habana Avenue, Suite 204
Tampa, FL 33614
Fax: (813) 878-6850
Office: (813) 426-8260

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PATIENT PERSONAL HEALTH INFORMATION CONSENT FORM

Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Florida Primary Care Clinics (FPCC) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

FPCC's *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that the FPCC reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices*, the revised *Notice* will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the FPCC is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the FPCC has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

_____ I request the following restrictions on the use and/or disclosure of my personal health information.

_____

_____

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed FPCC's Notice *of Privacy Practices* dated July 30, 2015.

Signature of Patient or Legal Representative,_____Date_____

Print Name of Patient or Legal Representative _____

Witness's Signature_____Date_____

Witness's Printed Name _____

*I request that changes to the *Notice of Privacy Practices* be sent to me at this address:

_____

_____

Florida Primary Care CLINICS

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NOTICE OF PRIVACY PRACTICES

Effective Date: 07/30/2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

YOUR PRIVATE HEALTH INFORMATION (PHI)

Each time you have contact with a healthcare provider for delivery of healthcare, a record of your contact/visit is prepared. This record, maintained in written, oral or electronic format, contains presenting signs/symptoms, results of examination and tests, diagnoses, treatment and future care. Your medical record is the physical property of the Florida Primary Care Clinics (FPCC), but you have certain rights to restrict some of the uses or disclosures of the information in your medical record. FPCC, however, has the right to use and disclose the information contained in your medical record in the process of providing treatment, receiving payment and performing other regular health operations such as:

- Documenting and describing the care you received for legal purposes
- Communicating with other healthcare providers who may be involved in your care
- Educating health care professionals
- Medical research
- Providing information for government and public health entities responsible for improving public health and welfare
- Evaluating and improving the care you receive and the outcomes achieved
- Billing and verification of services provided to you
- Conducting other routine healthcare operations such as quality improvement studies and assessing healthcare provider competence

Protecting your privacy and maintaining the security of your health information is one of the most important responsibilities of FPCC. FPCC is required by law to maintain privacy and confidentiality of your health information, provide you with this *Notice of Privacy Practices*, notify you of your rights to restrict use of this information, notify you if FPCC is unable to agree to a requested restriction, and allow you to review the Notice of Privacy Practices prior to granting consent and notifying you of changes/revisions to this Notice.

EXAMPLES OF DISCLOSURE OF YOUR PHI

• Healthcare delivery and treatment:

Information obtained from you by a physician, nurse or other healthcare professional is documented in your record and used for the assessment, evaluation, diagnosis and treatment of your medical condition(s). This information is provided

to other healthcare professionals, such as other physicians, specialists, physical therapists, hospital based providers and/or other healthcare providers following your treatment by FPCC.

- Billing and payment:
  Your PHI is utilized to justify the level of care delivered to you and the charges incurred for the services. This information generally accompanies the bill and is sent to our payers.

- Other healthcare operations:
  FPCC may disclose your PHI to other individuals and businesses in order for FPCC to perform its day-to-day operations. These other individuals and businesses include business associates such as vendors and/or contractors used for billing and claims management, medical research, disease management, and quality improvement initiatives, as well as management services organizations, laboratories, other free standing diagnostic facilities and legal counsel. FPCC requires all its business associates to agree to appropriately protect the confidentiality of your PHI.

- Reminders and Treatment:
  FPCC may contact you to provide you with information that we feel is useful or helpful to you, based on your PHI. For example, FPCC may contact you (or instruct a specialist physician to whom you have been referred to contact you) to schedule an appointment or as an appointment reminder, to suggest alternative treatments, or to provide you with information on treatments you are already receiving.

- Other Uses and Disclosures:
  FPCC may also utilize or disclose your PHI in order to communicate with or notify family members, relatives and others responsible for your health, and funeral directors. In addition, FPCC may disclose your PHI through other communications and reports required to be made by healthcare professionals such as the public health department, law enforcement, the Food and Drug Administration, organ procurement organizations, correctional institutions, and workers compensation, where applicable.

  Other uses and disclosures of PHI not permitted or required by law will be made only with your written authorization. You may revoke your authorization at any time provided that the revocation is in writing, except to the extent that FPCC has already taken action in reliance on your prior authorization.

YOUR RIGHTS CONCERNING PHI

Except as otherwise provided by law, you have the right to:

- Receive a paper copy of this *Notice of Privacy Practices* if you have agreed to receive it electronically

- Receive confidential communications of PHI if a request is submitted to FPCC in writing
- Inspect and copy PHI or records about you in a designated record set as long as the PHI is maintained in the record set
- Ask FPCC to amend PHI or records about you in a designated record set as long as the PHI or record is maintained in the record set (FPCC is not required to change the information if it deems it to be accurate);
- Receive an accounting of disclosures of PHI (a list of the disclosures made by FPCC about you for reasons other than treatment, payment or health care operations)
- Request that FPCC restrict uses or disclosures of your PHI. Though the FPCC is not required to agree to a restriction, to the extent that it does agree with your request, FPCC may not use or disclose the protected PHI in violation of the restriction unless the information is needed to provide emergency treatment, or is otherwise permitted or required by law.

FPCC is required by law to abide by the terms of this *Notice of Privacy Practices*, allow you to review this *Notice* prior to granting consent, and notify you of changes/revisions to this *Notice*. If you believe your privacy rights have been violated, you may submit a written complaint to FPCC or the Secretary of Health and Human Services describing in detail the manner in which you feel your privacy rights have been violated. FPCC will not retaliate against you in any way for filing a complaint with FPCC, or with the Secretary.

This *Notice of Privacy Practices* is effective as of July 30, 2015. For further information regarding PHI, please contact Ian Weitz, Privacy Officer of FPCC, at (813) 549-2134.