SHORES MEDICAL CENTER

FAMILY PRACTICE

DEMOGRAPHICS

PATIENT NAME__________________________________ **DATE OF BIRTH**______________________

HOME ADDRESS____ **APT #**_____________

CITY____________________________________ **STATE**_____________ **ZIP CODE**_______________

HOME PHONE________________________________ **CELL PHONE**___________________________

EMAIL ADDRESS___________________________________ **SS #**______________________________

MARITAL STATUS: ____**MARRIED**

____**DIVORCED**

____**SINGLE**

____**WIDOW(ER)**

RACE: ____**AMERICAN INDIAN OR ALASKA NATIVE**

____**ASIAN**

____**BLACK OR AFRICAN AMERICAN**

____**WHITE**

____**NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**

____**OTHER**

ETHNICITY: ____**HISPANIC OR LATINO**

____**NON HISPANIC OR LATINO**

PRIMARY LANGUAGE____

EMPLOYER____ **PHONE#**_______________________

PRIMARY CARE PHYSICIAN______________________________ **PHONE #**_______________________

PHARMACY____PHONE #________________________

INSURANCE____

POLICY HOLDER___________________________________ DOB__________________________

PERSON TO NOTIFY IN CASE OF EMERGENCY____

RELATIONSHIP TO PATIENT__________________________PHONE #________________________

I, THE UNDERSIGNED, ASSIGN DIRECTLY SHORES MEDICAL CENTER ALL MEDICAL BENEFITS INCLUDING, BUT NOT LIMITED TO, MEDICARE, MEDICAID AND ANY OTHER COMMERICAL INSURANCE PAYMENTSPAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAIN BY INSURANCE. I ALSO AUTHORIZE THE RELEASE OF ALL NESESSARY INFORMATION TO SECURE PAYMENT OF MY BENEFITS ON ALL CLAIMS FILED ELECTRONICALLY OR MANUALLY BY THIS OFFICE.

SIGNATURE____DATE__________________________

REASON FOR TODAY'S VISIT ____

MEDICAL HISTORY INFORMATION

SYMPTOMS:		PAIN, WEAKNESS, OR NUMBNESS IN:	
CHEST PAIN	YES___ NO___	ARMS	YES___ NO___
SHORTNESS OF BREATH	YES___ NO___	BACK	YES___ NO___
HIGH BLOOD PRESSURE	YES___ NO___	FEET	YES___ NO___
IRREGULAR HEARTBEAT	YES___ NO___	HANDS	YES___ NO___
SWELLING OF ANKLES	YES___ NO___	HIPS	YES___ NO___
CHILLS	YES___ NO___	LEGS	YES___ NO___
DIZZINESS	YES___ NO___	NECK	YES___ NO___
SWEATS	YES___ NO___	SHOULDERS	YES___ NO___
BLURRED VISION	YES___ NO___		
LOSS OF WEIGHT	YES___ NO___		
GAIN OF WEIGHT	YES___ NO___		

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

AIDS	YES___ NO___	BLEEDING DISORDER	YES___ NO___
CANCER	YES___ NO___	DIABETES	YES___ NO___
EMPHYSEMA	YES___ NO___	HISTORY OF A STROKE	YES___ NO___
KIDNEY DISEASE	YES___ NO___	SCARLET FEVER	YES___ NO___
LIVER DISEASE	YES___ NO___	BLOOD DISORDER	YES___ NO___
RHEUMATIC FEVER	YES___ NO___	HIGH CHOLESTEROL	YES___ NO___

DO YOU HAVE ANY ALLERGIES? ____

HEALTH HABITS:

TOBACCO YES___ NO___ CAFFEINE YES___ NO___ ALCOHOL YES___ NO___

MEDICATIONS:

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________
7. ______________________ 8. ______________________

DO YOU HAVE A PACEMAKER OR DEFIBILLATOR? YES___ NO___

MAKE ______________________ IMPANT DATE ______________________

HAVE YOU EVER HAD A HEART ATTACK? YES___ NO___

BYPASS___________ CATHETERIZATION ___________ ANGIOPLASTY___________

DATE ______________________ WHERE______________________

WHEN WAS YOUR MOST RECENT BLOODWORK DONE?

DATE ______________________ WHERE______________________

HAVE YOU HAD ANY OF THE FOLLWING?

ECHOCARDIOGRAM___________ CAROTID ULTRASOUND___________

NUCLEAR STRESS TEST___________ TREADMILL STRESS TEST___________

DATE ______________________ WHERE______________________

Telephone: 386-767-9544 Fax: 386-756-0501
3512 SOUTH ATLANTIC AVENUE DAYTONA BEACH SHORES, FLORIDA 32118

PATIENT CONSENT FORM

DATE: ______________________

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS ESTABLISHED A "PRIVACY RULE" TO HELP ENSURE THAT PERSONAL HEALTH CARE INFORMATION IS PROTECTED. THE RULE ALLOWS FOR CERTAIN HEALTH CARE PROVIDERS TO OBTAIN THEIR PATIENTS CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION ABOUT THE PATIENT TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.

AS OUR PATIENT WE WANT YOU TO KNOW THAT WE RESPECT THE PRIVACY OF YOUR MEDICAL RECORDS AND WILL DO ALL WE CAN TO SECURE AND PROTECT THEM. WHEN IT IS APPROPRIATE AND NECESSARY, WE PROVIDE THE MINIMUM INFORMATION TO ONLY THOSE WE FEEL ARE IN NEED OF YOUR HEALTH INFORMATION. WE ALSO SUPPORT FULL ACCESS TO YOUR MEDICAL RECORD FILE HOUSED IN OUR OFFICE. THIS WILL BE DONE UNDER THE SUPERVISION OF A STAFF MEMBER.

WE MAY, FROM TIME TO TIME HAVE TO RELEASE THOSE RECORDS TO INDIRECT ENTITES FOR THINGS SUCH AS PAYMENT OR HEALTH CARE OPERATIONS. BY SIGNING THIS FORM YOU ARE GIVING US YOUR CONSENT FOR THESE DISCLOSURES.

YOU MAY REFUSE TO CONSENT TO THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION. THIS REFUSAL MUST BE IN WRITING. UNDER THE HIPPA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT) LAW, WE ALSO HAVE THE RIGHT TI REFUSE TO TREAT YOU IF YOU CHOOSE TO REFUSE TO DISCLOSE YOUR PERSONAL HEALTH INFORMATION. IF YOU CHOOSE TO GIVE YOUR CONSENT IN THIS DOCUMENT, YOU MAY REQUEST IN THE FUTURE TO REFUSE DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. HOWEVER, YOU MAY NOT REVOKE ACTIONS THAT HAVE ALREADY TAKEN PLACE WHICH RELIED ON THIS OR A PREVIOUSLY SIGNED CONSENT FORM. YOU ALSO HAVE THE RIGHT TO ALLOW US TO DISCUSS YOUR PERSONAL HEALTH INFORMATION WITH YOUR FAMILY MEMBERS, FRIENDS, AND CARE GIVERS. THIS MUST BE DONE IN WRITING. SPACE FOR THIS IS PROVIDED BELOW. IF YOU HAVE ANY QUESTIONS REGARDING OUR HIPPA COMPLIANCE PLEASE SPEAK TO OUR OFFICE MANAGER.

PRINT NAME: ____________________________ SIGNATURE: ______________________________

RELEASE PERSONAL HEALTH INFORMATION TO THE PERSONS LISTED.

NAME: __________________________________ RELATIONSHIP: ____________________________

NAME: __________________________________ RELATIONSHIP: ____________________________

NAME: __________________________________ RELATIONSHIP: ____________________________

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SHORES MEDICAL CENTER

FAMILY PRACTICE

GENERAL AUTHORIZATION

MEDICAL INFORMATION AUTHORIZATION

TO: ____ (NAME OF PHYSICIAN)

RE: ____ (NAME OF PATIENT)

YOU ARE HEARBY AUTHORIZED TO FURNISH ____________________ ANY OR ALL MEDICAL INFORMATION CONCERNING MY INJURIES, DISABILITIES, AND PHYSICAL CONDITION INCLUDING ALL MEDICAL RECORDS AND X-RAYS COVERING THE PERIOD FROM ____________, 20___ TO ____________, 20___. YOU ARE DIRECTED AND AUTHORIZED TO FURNISH COMPLETE MEDICAL RECORDS ON MY MEDICAL HISTORY, PAST, PRESENT AND FUTURE.

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AD THE ORIGINAL.

______________________________ ______________________

SIGNATURE OF PATIENT **DATE**

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WITNESS

NOT VALID IF PRESENTED MORE THAN 90 DAYS FROM DATE OF AUTHORIZATION. *NOT TO BE USED TO RELEASE DRUG AND ALCOHOL OR PSYCHIATRIC TREATMENT RECORD*