

Premier Medical Clinic

315 East Ash Street
Perry, Florida 32347

Health History Form

Date: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ DOB: _____ Age: _____

Gender: Male / Female Marital Status: Single / Divorced / Widowed / Separated / Married

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Alternate #: (____) _____ - _____

Occupation: _____ Spouses Occupation: _____

Place of Employment: _____

Emergency Contact Info - Name: _____

Relationship: _____ Telephone Number: (____) _____ - _____

Who is Financially Responsible for your care? _____

Spouses Name: _____ Number of Children: _____

Insurance Type: Medicare / Medicaid / BCBS / Commercial / None / Other _____

Carrier Name: _____ Policy #: _____

Primary Insured Name: _____ DOB: _____

Social History

Highest level of Education Completed: _____ Race: _____

Do you currently smoke? Yes / No Have you smoked or used tobacco products in the past? Yes / No

If yes, what kind and how long: _____

Do you currently drink alcoholic beverages? Yes / No How many a day? _____ Week: _____ Month: _____

Religious Preference: _____

Hobbies: _____

Are you a student? Yes / No If yes, are you full or part time: _____

Do you have a Living Will or Advanced Directive? Yes / No (If yes, please give a copy to Admitting Clerk.)

Allergies (Check Yes/No as it applies to you and describe any reactions, if any to any of the following medications. Example: Rash, SOB)

Drug	Yes	No	Reaction	Drug	Yes	No	Reaction
Penicillin				Demerol			
Sulfa				Barbituates			
Asprin				Anesthetics			
Codeine				Other _____			

Notes: _____

Past Medical History

List all previous illnesses that required hospitalization including year (Exclude Surgeries).

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

List all previous surgeries and year.

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Accidents and Year (Describe injuries, if any.)

- 1. _____ 3. _____
- 2. _____ 4. _____

Please list all Physicians seen in last two years.

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Total # of Pregnancies: _____ Miscarriages: _____ Weight of largest child at delivery: _____ lbs _____ oz.

Age at Onset of Menses: _____ Duration of Menses: _____ Number of days between Menstruation: _____

Last Menstrual Cycle: _____ Last Pap Smear: _____ Last Mammogram: _____

Review of Symptoms (Circle the symptoms that apply to your current problem or any problems you have had in the past.)

- | | | |
|-----------------------------------|----------------------------------|-----------------------------------|
| Headaches | Vomiting Blood | Loose, Black Bowel Movements |
| Seizures/Fits | Numbness in Extremities | Weakness in Extremities |
| Difficulty with Balance | Dizziness | Fainting/Black-Outs |
| Strokes | Ringing in Ears | Difficulty with Hearing |
| Difficulty with Vision | Double Vision | Changes in Smell |
| Excessive sneezing | Chronic Sinus Infections | Difficulty breathing through Nose |
| Nose Bleeds | Voice Changes | Shortness of Breath at Night |
| Shortness of Breath while walking | Swelling in Ankles/Feet | Blood in Stool |
| Palpitations | Chest Pain/Tightness | Heart Murmur |
| Heart Attack | High Cholesterol | Swelling of Legs |
| Cough | Coughing up Blood | Wheezing |
| Diabetes | High Blood Pressure | Night sweats |
| Fever for > 5days | Nausea | Difficulty Swallowing |
| Vomiting | Diarrhea | Rash |
| Joint Pain/Swelling | Increase in Hair Growth | Loss of Hair |
| Nervousness | Hives | Excessive Sweating |
| Itching | Changes in skin appearance | Breast Discharge |
| Changes in Breast Tissue | Stomach Pain | Vaginal Discharge |
| Jaundice | Hemorrhoids | Excessive changes in weight |
| Loss of appetite | Frequent Urination | Urinary Retention |
| Pain during Urination | Blood in Urine | Changes in Urinary Pattern |
| Stomach Ulcers | Erectile/Ejaculation Dysfunction | Back Pain |
| Insomnia | Mood Swings | Depression |
| Mood Disorders | Changes in Memory | Asthma |

Family History

Please check all that apply:

Disorder	Father	Mother	Brother(s)	Sister(s)	Grandmother	Grandfather	Other
Goiter							
Cancer							
Tuberculosis							
Allergies							
Asthma							
Nervous Breakdown							
Suicide							
Epilepsy							
Migraines							
Arthritis							
Heart Attack							
Diabetes							
High Blood Pressure							
Gout							
Kidney Stones							
Bleeding Disorders							
Ulcers							

Medications (Please list all medications and doses you have taken in the past month. Bring Medication with you to your visit.)

- | | | |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

Consent to Use/Disclose Information for Treatment, Payment or Health Care Operations

I hereby authorize Premier Medical Clinic to use or disclose my protected health information for the purpose of treatment, payment, or healthcare operations as their terms are defined in federal HIPAA privacy rules.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my healthcare provider, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present and future physical or mental health conditions and identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand that I have the right to revoke this authorization at any time, but that such revocation must be given to Premier Medical Clinic in writing and that any revocation will be honored by Premier Medical Clinic, except to the extent that Premier Medical Clinic has already taken action by reliance on the original consent.

I understand that Premier Medical Clinic may refuse to treat me if I, or my authorized representative, fails to sign this Consent Form. (Except to the extent, by law, that Premier Medical Clinic is required to treat individuals.) I further understand that if I, or my authorized Representative sign this consent and later revoke this consent, Premier Medical Clinic has the right to refuse to provide further treatment to me as of the date of revocation. (Except to the extent, by law, that Premier Medical Clinic is required to treat individuals.)

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

(Power of Attorney or Judicial Order attached for Authorized Representative Signature)

Insurance Assignment Agreement

Premier Medical Clinic is pleased to accept your assignment on your insurance. However, it must be understood that insurance contracts are between you, the patient, and your insurance carrier. You are responsible for any amount not paid by your insurance carrier.

It is anticipated that your insurance carrier will pay within 30 days. If your insurance has not paid within 60 days, then you will be required to pay the balance due. Your insurance carrier will reimburse you, if and when it pays.

Premier Medical Clinic does not guarantee that your insurance will pay. We will make every attempt to obtain and submit the correct information, on your behalf. However, if for any reason, your insurance claim is denied, you are responsible for the full amount of your bill.

Premier Medical Clinic will NOT enter into a dispute with your insurance carrier over your claim; this is your responsibility and obligation.

By signing below, you acknowledge the above stated information and agree to all terms, as they are outlined.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

(Power of Attorney or Judicial Order attached for Authorized Representative Signature)

Acknowledgment of Notice of Privacy Practices

I, _____ acknowledge receipt of the currently effective Notice of Privacy Practices from Premier Medical Clinic this _____ day of _____, 20_____. I have reviewed the information and am aware of my rights as they are outlined in the document.

I understand that if I feel that my privacy protection rights have been violated, that I may submit a formal, written complaint to the Department of Health and Human Services, Office of Civil Rights, without fear of retaliation by Premier Medical Clinic.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

(Power of Attorney or Judicial Order attached for Authorized Representative Signature)

***We welcome you to the
Premier Medical Clinic Family
and look forward to serving you.***