2020

# Adult Health History

Name: ___________________________________ DOB: __________________________

Employer: _________________________ Highest Level of Education: ______________

Reason for Visit: __________________________________

Surgeries

| Surgery | Year | Reason for Surgery |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Past Medical and Family History

(Please check if you or any BLOOD relative have these conditions. Please name SPECIFIC relatives- Example: maternal grandmother)

| Condition | You | Relative | Condition | You | Relative |
|---|---|---|---|---|---|
| Diabetes | | | Psoriasis/Eczema | | |
| Hypertension | | | Bowel Issues | | |
| High Cholesterol | | | Kidney/Bladder Problem | | |
| Coronary Artery Disease | | | Kidney Disease | | |
| Stroke/TIA | | | Arthritis | | |
| Cardiac Arrhythmia | | | Recent Weight Loss | | |
| Heart Attack | | | Migraine Headaches | | |
| Heart Disease | | | Epilepsy/Seizures | | |
| Sleep Apnea | | | Head Trauma | | |
| COPD/Emphysema | | | Eye Disease | | |
| Asthma | | | Pulmonary Embolism | | |
| Chronic Pain | | | Heartburn/Reflux | | |
| Gout | | | Liver Disease/Hepatitis | | |

Name: ___________________________________ DOB: __________________________

## PAST MEDICAL AND FAMILY HISTORY

(Please check if you or any BLOOD relative have these conditions. Please name SPECIFIC relatives- Example: maternal grandmother)

| Condition | You | Relative | Condition | You | Relative |
|---|---|---|---|---|---|
| Obesity | | | Parkinson's Disease | | |
| Thyroid Disease | | | Lupus | | |
| Insomnia | | | Cancer<br>Type: | | |
| Depression | | | | | |
| Anxiety | | | | | |
| Osteoporosis | | | | | |
| Anemia | | | | | |

Please list any other illness that you have been diagnosed with:

______________________________________________________________________________

______________________________________________________________________________

FAMILY HISTORY

Mother: □ Alive □ Deceased Age at Death _____ Cause of Death ________________

Father: □ Alive □ Deceased Age at Death _____ Cause of Death _________________

SOCIAL HISTORY

Do you drink caffeine? □ Yes □ No Tobacco Use? □ Yes □ No □Quit: __________

Tobacco: PPD: _____________________ Years of Use:________________________

Recreational Drug Use? □ Yes □ No □Quit: ________

Alcohol use? □Yes □No □Quit: ______ Frequency:_________ Average daily: ______

Last Time You Had:

Eye Exam:_______ Colonoscopy: ________ Stool Blood Test: _______ Dental Exam:________

Flu Vaccine: _______ Tetanus Shot: ______ Pneumonia Shot: ______ Shingles Shot: ________

Name: ___________________________________ DOB: __________________________

## Medications

| Medication | Dose & Frequency | Reason |
| --- | --- | --- |
| | | |
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## Allergies

| Medication | Reaction Type |
| --- | --- |
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| | |
| | |
| | |

Pharmacy I want my medication sent to: _________________________________________________________

Name: ___________________________________ DOB: __________________________

WOMEN ONLY

Date of last period: ______/______/______ Regular: ☐ Y ☐ N Spotting: ☐ Y ☐ N

Birth Control: ☐ Y ☐ N Name/Type: _____________________________

Number of Pregnancies:__________ Number of Births: ______________

Number of Abortions: ___________ Number of Miscarriages: _________

Number of C- sections ___________

Date of Last

Pap: ______________ ☐ Normal ☐ Abnormal

Breast Exam: ______________ ☐ Normal ☐ Abnormal

Mammogram: _____________ ☐ Normal ☐ Abnormal

Bone Density: ______________ ☐ Normal ☐ Abnormal

Additional Comments:

______________________________________________________________________________________________

______________________________________________________________________________________________

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# Patient Information

Name:_______________________________________________________________
Last First M.I.

Address:______________________________________________________________
Street City State Zip

DOB: _____/_____/______ Sex: M/F_____ Employer: ______________________________

SSN:_________________________________ Email: _________________________________

Cell Phone:___________________________ Home Phone: ____________________________

Optional: Race: ______________ Ethnicity: ____________ Language: __________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner

## Emergency Contact

Name:______________________________ Relation to Patient: ________________________

Cell Phone:___________________________ Home Phone: ____________________________

Name:______________________________ Relation to Patient: ________________________

Cell Phone:___________________________ Home Phone: ____________________________

## Insurance Information

Insurance Company: ____________________________________________________________

Policy Number: ____________________________ Group Number: _____________________

Policy Holder: ___________________________________ DOB: __________________________

Secondary Insurance Company: ___________________________________________________

Policy Number: ____________________________ Group Number: _____________________

Policy Holder: ___________________________________ DOB: __________________________

# Patient Financial Responsibility

All patients or guardians are responsibly for 100% of the charges incurred for treatment at Primary Care Physicians of Gainesville.

- The patient or guardian who signs the financial policy statement is the responsible party.
- Established patients who have health insurance benefits that have been verified will be expected to pay that portion of the charges not covered under their policy as well as any applicable co-payments under the terms of their policy.
- Patients who have health insurance benefits that have been verified will be responsible for all charges, paid in full on the day of the service, until their policy out of pocket has been met.
- Primary Care Physicians of Gainesville is not responsible for incorrect information given by your insurance company.
- Patient who have health insurance benefits that have not been verifies will be responsible for any portion of the charge that are not covered, as well as any applicable co-payments under the terms of their policy.
- Having an active health insurance policy in no way negates a patient’s responsibility for payment of their medical charges, if these charges are denied or not covered by the patient’s insurance carrier.
- Patients may pay their bills by cash, check or credit card.
- Patients who fail to pay their outstanding balance within 90 days of the service being provided may be turned over to a collection agency. The patient will still be responsible for the charges as well as all collection agency costs and fees, including reasonable attorney fees.

We have developed these financial policies in an effort to keep you medical costs down. Printing and mailing statements is an extremely time consuming and expensive undertaking. We ask that you adhere to these policies as part of your financial responsibility. Our staff will assist you in any way that we can. If you have questions regarding our fees or your insurance coverage and filing of your insurance claims please ask to speak with one of the members of our billing and insurance department.

I agree to be financially responsible for any and all related charges, if they are not covered by my insurance policy.

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AUTHORIZATION TO RELEASE MY MEDICAL CARE

I ____________________________ give Primary Care Physicians of Gainesville permission to discuss my medical care and account information with the following person(s):

| Name of authorized person | Relation | Phone |
|---|---|---|
| Name of authorized person | Relation | Phone |
| Name of authorized person | Relation | Phone |
| Name of authorized person | Relation | Phone |

You may leave detailed messages regarding my healthcare (not including lab results) on my:

☐Cell Phone ☐ Home Phone ☐ Neither

You may leave messages regarding my lab results on my:

☐Cell Phone ☐ Home Phone ☐ Neither

**Cell Phone:**_________________________ **Home Phone:** _________________________

________________________________________ ________________________
Signature of Patient Date

________________________________________
Printed Name of Patient

Elizabeth Sanders, DO    Abigail Eley, DNP, ARNP

PRIMARY CARE
PHYSICIANS
of Gainesville

Springhill Professional Park, 3780 NW 83rd Street • Gainesville, Florida 32606
Phone: 352-377-2022 • Fax: 352-377-9113 • www.pcpgnv.com
Hours: Monday - Friday 8-5

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.**

Primary Care Physicians is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practice with respect to protected health information. Primary Care Physicians is required by law to abide by the terms of this Notice.

**HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:**

The following describes how Primary Care Physicians may use your protected health information for treatments, payment or health care operations.

**Treatment:**

Primary Care Physicians may use health information about you to provide you with health care treatment or services. Primary Care Physicians may disclose information about you to doctors, nurses, or other essential personnel who are involved in your care.

**Payment:**

Primary Care Physicians may use and disclose health information about you to receive payment for services provide to you. Under Florida law we must obtain your written consent in order to submit claims for services provided to you. Failure to sign may force us to decline you as a new patient or discontinue you as an active patient.

**Health Care Operations:**

Primary Care Physicians may use and disclose health information about you for operational purposes related to our office. We may also and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointments and Reminders
Treatment Information
Disclosure to Department of Health and Human
Services
Family and Friends
Notification
Disaster Relief
Health Oversight Activities
Abuse or Neglect
Judicial and Administrative Proceedings
Law Enforcement
Specialized Government Functions
Coroners, Medical Examiner’s and Funerals Directors
Organ Donation
Research
Public Health Activities
Public Safety
Worker’s Compensation
Business Associates

**MINIMUM NECESSARY INCIDENTAL DISCLOSURES AND SUPER CONFIDENTIAL INFORMATION**

Our staff will not use or disclose your medical information unless it is necessary to perform their jobs. We will follow both state and federal laws related to the use and disclosure of super-confidential information such as HIV/AIDS, alcohol/substance abuse and mental health records.

**AUTHORIZATIONS AND CONSENTS:**

We will not use or disclose your medical information for any other purpose other than treatment, payment or health care operations without your written authorization. Once given, you make revoke your authorization in writing at any time. This consent is required under Florida law in order for our office to submit claims and other information needed to receive for services rendered to you or your family.

**YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:**

- You may ask us to restrict certain uses and disclosures for your medical information. We are not required to agree to your request, but if we do we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific reasons. If we deny requests, we will provide you with a written explanation for the denial and information regarding further right you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by Primary Care Physicians during the last 6 years. Except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
- You have the right to complaint to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please require at the Registration desk (you will be directed to our Privacy Officer).
- To file a complaint with the U.S. Department of Health and Human Services you must submit your complaint in writing, within 180 days of the alleged violation to:

  Region I.V, Office for Civil Rights
  U.S. Department of Health and Human Services
  Atlanta Federal Center, Suite 3B70
  61 Forsyth Street, S.W.
  Atlanta, GA 30303-8909
  Phone: 404-562-7886
  Fax: 404-562-7881

**For the full version of Primary Care Physician's privacy policy, view our website at www.pcpgnv.com**

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PRIVACY POLICY, FINANCIAL RESPONSIBILITY AND CONSENT FOR TREATMENT

I, ___________________________________, hereby authorize Primary Care Physicians of Gainesville to administer examinations, immunizations, treatments, and view my prescription history from an external source as deemed medically necessary in the exercise of their professional judgement. Additionally, by signing this form I acknowledge that I have received a copy of the Privacy Policies and Financial Responsibility Policy for Primary Care Physicians of Gainesville.

_______________________________________ ________________________

Printed Patient Name Date of Birth

_______________________________________ ________________________

Patient Signature Date

_______________________________________ ________________________

Witness Signature Date

Primary Care Physicians

3780 NW 83rd Street
Gainesville, FL 32606
Phone: 352-377-2022
Fax: 352-377-9113 or 352-377-9574

# Records Release

**Patient Name: ________________________________________** **DOB: ______________________**

| TO BE FILLED OUT BY OFFICE STAFF ONLY | |
|---|---|
| Previous Physician/Office Name: | |
| Specialty: | |
| Phone: | Fax: |
| City: | State: |

I hereby authorize and release the custodian of my/my dependent's medical records to Primary Care Physicians of Gainesville, including physical examination reports, laboratory reports, immunizations, diagnostic imaging reports, reports including HIV/AIDS, STD records, mental health records, and substance abuse reports. ____________________

**Patient Initials**

**Release to: Primary Care Physicians of Gainesville** ☐ Elizabeth Sanders, DO ☐ Abigail Eley, DNP, ARNP

3780 NW 83rd Street, Gainesville, FL 32606 Fax: 352-377-9113 or 352-377-9574

***If records exceed 15 pages we request that they be mailed.* *No computer disk records.***

-I understand that all medical, surgical, psychiatric and psychological information is confidential and that the patient records are the property of Primary Care Physicians of Gainesville and its related corporate entities. I will not hold Primary Care Physicians of Gainesville, its employees, staff or representatives responsible for any damage, mental or physical, which may be caused by the release of patient records and the information contained therein.
-I understand that my authorization for release may be revoked at any time by written request to Primary Care Physicians of Gainesville, but may not be revoked to include the release allowed by this document. Also, if this authorization is permission for Primary Care Physicians of Gainesville to disclose information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest your coverage.
-I understand that the person or organization that receives the information because of this authorization may disclose this information to other people or organizations without my knowledge or consent. Therefore, I hereby release Primary Care Physicians of Gainesville, its employees, its staff, and representatives from all liability relating to or arising out of this release of information contained Primary Care Physicians of Gainesville records.
-I understand I can refuse to sign this authorization and I do not need to sign this authorization to receive treatment services from Primary Care Physicians of Gainesville. However, if the only purpose for providing the service is to obtain in formation in order to release information to myself or a third party, then I understand that I might sign the authorization in order to receive the service.

This authorization will expire in twelve (12) months following the date of signature, unless otherwise specified. Expiration Date or Circumstance: ____________________________________

**Patient Signature: ______________________________________________** **Date: _________________**

Relationship to Patient if Not Self: ________________________________________

Witness: ______________________________________________________________

Requested By: ________________________________________________________ Date: ________________