Ocala Family Medical Center, Inc.

How did you hear about us?	☐ Family ☐ Friend ☐ Phone Book ☐ Signs ☐ Internet ☐ Other:

PATIENT INFORMATION FORM

Last Name:	First Name:	Initial:	PT#
Primary Mailing Address:			
Alternate Mailing Address:			
Reside here **FROM** (Month)	**TO** (Month)		
Gender: / Gender Identity:	Sexual Orientation	Date of Birth:	
Employer or School:	Employment Status:	Mobile#:	
SSN#	Marital:	Home#:	
Race:	Ethnicity:	Work#:	
Language:	Email:		

CONTACT INFORMATION – MUST BE COMPLETED

☐ Consent to leave message with detailed information

☐ Consent to leave message with call back number, extension and name only

I wish to be contacted in the following manner:
(apply number 1-4 indicating preferred number and indicate preferred method of contact)

_____ Home: ☐	_____ Work: ☐	_____ Mobile: ☐	_____ ☐ Patient Portal
☐ Voice	☐ E-Mail	☐ Text	☐ Don't Contact

HIPAA consent to release Protected Health Information (PHI) to the following person(s)
THIS FORM REPLACES ALL PRIOR FORMS
(i.e. pick up your prescriptions, release medical records, discuss billing/clinical information)

Name:	Relationship:
Name:	Relationship:

HIPAA consent to release Protected Health Information (PHI) to Patient Registries
(i.e. Specialists, Hospitals, Insurance Carrier Registries, Immunization Registries, Cancer Registries)

Consent to submit PHI to patient registries ☐ Yes ☐ No

Emergency Contact Information / Living Will

Name of Emergency Contact:	Phone:	Relationship:

Do you have a living will? YES ☐ NO ☐ If yes, copy provided: YES ☐ NO ☐

Primary Insurance

Name:	Member ID:	Effective Date:

Secondary Insurance

Name:	Member ID:	Effective Date:

Preferred Pharmacies

Name:	Address:	Phone:
Name:	Address:	Phone:

I understand and agree*: I authorize treatment and will be responsible for the payment of all charges incurred on behalf of myself or family member.*

Please be prepared to pay the copay/deductible for today's visit

I authorize payment of medical benefits to: OCALA FAMILY MEDICAL CENTER, INC.

Signature: _____ Date: _____

Revised: 09/01/2023

Patient Name_____DOB_____Sex_____Age_____Date_____

MEDICAL HISTORY

Have you had any of the following?
If yes, please check the box.

- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Enlarged Prostate
- ☐ Cancer Type_____
- ☐ Chicken Pox
- ☐ Gallbladder Disease
- ☐ Kidney Disease
  Type_____
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Glaucoma
- ☐ Gout
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Liver Disease Type_____
- ☐ Measles
- ☐ Mental Illness Type_____
- ☐ Migraines
- ☐ Mumps
- ☐ Heart Attack When?_____
- ☐ Osteoporosis
- ☐ Peptic Ulcer(s)
- ☐ Polio
- ☐ Lung Disease Type_____
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizure
- ☐ Stroke When?_____
- ☐ Phlebitis
- ☐ Thyroid issues Explain_____
- ☐ Transfusion When?_____
- ☐ Tuberculosis
- ☐ Varicose Veins
- ☐ Sexually Transmitted Infection
  Type_____
- ☐ OTHER _____

ALLERGIES

_____

_____

_____

SOCIAL HISTORY

Alcohol Use? ☐ yes ☐ no
Type _____
# of drinks per day _____
# of time per week _____
Tobacco Use? Current ☐ yes
Never Smoked ☐ yes
Former Tobacco User / Quit Date _____
Type _____
Amount per day _____
# of years used _____
Cups of Caffeine per day: _____
Any Illegal Drug Use: _____
Any Physical Disabilities:_____

SURGERIES/OPERATIONS:

Have you had surgery on any of the following areas?

	Date of Surgery
☐ Adenoids	
☐ Appendix	
☐ Back	
☐ Breast	
☐ Cataract	
☐ C-Section	
☐ Gallbladder	
☐ Colon	
☐ Gastric Bypass	
☐ Hernia Repair	
☐ Hysterectomy	
☐ Total ☐ Partial	
☐ Joint Replacement	
☐ Thyroid	
☐ Tonsils	
☐ Tubal Ligation	
☐ Spleen	
☐ Vasectomy	
☐ Other (please explain)	

_____

IMMUNIZATIONS

	Date Received
Tetanus	
Influenza	
Pneumonia	

FAMILY HISTORY

Has any blood relative had any of the following?

	Relationship
☐ Alcoholism	
☐ Anemia	
☐ Arthritis	
☐ Asthma	
☐ Bleeding Problems	
☐ Cancer	
☐ Heart Failure	
☐ Colon Problems	
☐ COPD	
☐ Diabetes	
☐ Early Death	
☐ Gout	
☐ Heart Disease	
☐ High Cholesterol	
☐ High Blood Pressure	
☐ Kidney Disorder	
☐ Leukemia	
☐ Liver Disorder	
☐ Mental Illness	
☐ Migraines	
☐ Obesity	
☐ Osteoporosis	
☐ Seizure(s)	
☐ Stroke	
☐ Substance Abuse	
☐ Suicide	
☐ Thyroid Disorder	
☐ Tuberculosis	
☐ Other (please explain)	

_____

GYN - OB

Started menstruating at age: _____
Last normal menstrual period date:
_____
Prior menstrual period: _____
Sexually Active? ☐ YES ☐ NO
Number of pregnancies _____
Number of miscarriages _____
Number of abortions _____
Number of births _____
Multiple births _____
Date of last pap smear _____
Date of last mammogram _____
Do you use contraception ☐ yes ☐ no
Pelvic inflammatory disease/pelvic pain ☐ yes ☐ no
Sexually transmitted disease ☐ yes ☐ no
Abnormal pap smears ☐ yes ☐ no

CURRENT MEDICATION	DOSAGE (Ex: 250 mg)	INSTRUCTIONS (Ex: 1 daily, 3 daily, as needed)

MISSED APPOINTMENTS

UNLESS CANCELED AT LEAST 24 HOURS IN ADVANCE, OUR POLICY IS TO CHARGE FOR LATE ARRIVALS IF WE CANNOT WORK YOU IN, MISSED APPOINTMENTS AND APPOINTMENTS CANCELED LESS THAN 24 HOURS IN ADVANCE. PLEASE VISIT OUR WEBSITE FOR MORE INFORMATION ON OUR NO SHOW POLICY.

MINOR PATIENTS

THE ADULT ACCOMPANYING A MINOR AND THE PARENTS (OR GUARDIANS) OF THE MINOR ARE RESPONSIBLE FOR FULL PAYMENT OF SERVICES RENDERED. NON-EMERGENCY TREATMENT WILL BE DENIED TO UNACCOMPANIED MINORS UNLESS CHARGES HAVE BEEN PRE-AUTHORIZED TO AN APPROVED CREDIT PLAN, VISA/MASTERCARD, OR PAYMENT BY CASH OR CHECK AT TIME OF SERVICE.

CONSENT TO TREAT/AUTHORIZATION

I HEREBY GIVE OCALA FAMILY MEDICAL CENTER, INC. CONSENT TO PROVIDE WHATEVER TREATMENT DEEMED NECESSARY TO THE PATIENT FOR WHOM I AM RESPONSIBLE. I UNDERSTAND THAT MY REFUSAL OF SUCH TREATMENT MUST BE VERIFIED BY MY SIGNATURE.

PAYMENT OPTIONS / PERSCRIPTIONS

OCALA FAMILY MEDICAL CENTER UNDERSTANDS THE FINANCIAL BURDEN THAT MEDICAL BILLS CAN BE. AS A RESULT, WE OFFER SEVERAL PAYMENT OPTIONS. PAYMENT PLANS ARE PRESENTED ON A GOOD FAITH BASIS THAT YOU, THE PATIENT, ARE MAKING EVERY EFFORT TO PAY YOUR MEDICAL BILLS IN A TIMELY FASHION WITHOUT INTERRUPTION OF CARE.

ALL PAYMENT ARRANGEMENTS MUST BE CURRENT IN ORDER TO PICK UP YOUR PRESCRIPTION

*** PAYMENT AGREEMENTS MARE FOR *PAST DUE* SERVICES. ALL CO-PAYS ARE DUE AT TIME OF SERVICE. ***

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS AND OTHER INFORMATION, AS REQUIRED FOR PAYMENT OF BENEFITS PAYABLE BY INSURANCE, OR THIRD PARTY SOURCES, IN CONNECTION WITH TREATMENT OF _____ (PATIENT'S NAME). I FURTHER AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO OCALA FAMILY MEDICAL CENTER, INC. OF ANY BENEFITS PAYABLE WHICH ARE OTHERWISE PAYABLE TO ME.

GUARDIAN OF A MINOR COMPLETE BOX BELOW

I, _____, BEING THE LEGAL GUARDIAN OF: _____
(PATIENT'S NAME) HEREBY AUTHORIZE THE MEDICAL TREATMENT OF SAID PATIENT BY THE STAFF OF OCALA FAMILY MEDICAL CENTER, INC.

In the event that I am not available, I authorize the release of medical and/or financial records for information to:

_____

I HAVE READ AND FULLY UNDERSTAND THE CONTENT OF ALL PAGES OF THIS PATIENT INFORMATION AND MEDICAL RELEASE FORM. I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO IT.

_____	_____	_____
SIGNATURE OF PATIENT	SIGNATURE OF PERSON RESPONSIBLE (WHERE APPLICABLE)	DATE
_____	_____	_____
PRINT NAME OF PATIENT	PRINT NAME OF RESPONSIBLE PERSON	

METHOD OF PAYMENT: CASH _____ CHECK _____ CREDIT CARD _____ INSURANCE _____

NOTE: MINIMUM CHECK RETURN FEE OF $25

Revised: 04/28/2025

2230 SW 19th Avenue Road
Ocala, FL 34471
Phone: (352) 237-4133
Fax: (352) 873-4581

Patient Consent for Use and Disclosure of Protected Health Information (PHI)

I, _____, understand that as part of my healthcare, Ocala Family Medical Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that I have the following rights and privileges:

- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or healthcare operations.
- If I elect to not allow an Ocala Family Medical Center staff member to have access to my records I must notify Ocala Family Medical Center in writing. The request will be addressed by a member of the management team and/or the privacy officer. I will be contacted if additional information is required.

I understand that Ocala Family Medical Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164-506 of the Code of Federal Regulations.

I further understand that Ocala Family Medical Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164-520 of the Code of Federal Regulations. Should Ocala Family Medical Center change their notice, they will send a copy of any revised notice to the address I have provided.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information (PHI) to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I authorize my health care provider to use an automated telephone system and/or email and to use my name, address, and phone number; the name of my scheduled treating physician; and the time and place of my scheduled appointment(s), for limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information (PHI) regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine.

I fully understand and accept the terms of this consent.

_____	_____
Signature of Patient or Legal Guardian	Patient's Name
_____	_____
Print Name of Patient or Legal Guardian	Date

NOTIFICATION OF ALTERNATE SUPPLIERS OF DIAGNOSTIC IMAGING SERVICES

Dear Valued Patient:

During your office visit your provider may recommend that you seek certain diagnostic imaging services (i.e., CT or MRI) as part of your course of treatment.

Pursuant to Section 6003 of the Patient Protection and Affordable Care Act, Ocala Family Medical Center is hereby providing notice to you that you may obtain diagnostic imaging services from another provider other than Ocala Family Medical Center if you so choose.

The Following is a list of suppliers that provide such diagnostic imaging services within a twenty-five-mile (25mile) radius of this location:

- AdventHealth Ocala, 1500 S.W. 1st Avenue, Ocala, Fl 34471
  352.351.7200
- Ocala Regional Medical Center, 1431 SW 1st Avenue, Ocala, Fl 34471
  352.401.1000
- West Marion Community Hospital, 4600 SW 46th Court, Ocala, Fl 34474
  352.291.3000
- Timberridge Imaging Center, 9521 SW HWY 200, Ocala, Fl 34481
  352.671.4300
- Advanced Imaging, 8150 SW HWY 200, Ocala, Fl 34481
  352.854.2020

If you elect not to use one of the aforementioned alternate suppliers, Ocala Family Medical Center will be pleased to provide your diagnostic imaging services here at this location.

Please acknowledge your receipt of this notification by signing below.

_____
Signature

_____
Printed Name

_____
Date

Name: _____ DOB: _____ Date: _____

Medical History Form

Primary Doctor/Clinic: _____ Referred by your doctor? Yes / No

Reason for today's visit: _____

Do you have any concerns that you would like addressed? Yes / No If yes, _____

ALLERGIES: _____

MEDICATIONS: _____

Skin Conditions and Social History	Yes	No
Have you had skin cancer	☐	☐
Melanoma	☐	☐
Basal Cell Carcinoma	☐	☐
Squamous Cell Carcinoma	☐	☐
Have you had abnormal / dysplastic moles	☐	☐
Have you had pre-cancerous Actinic Keratoses	☐	☐
List any other skin conditions you have: (Ex: Eczema, Psoriasis, Acne, Rosacea, Vitiligo) _____		
Do you use sunscreen? SPF # _____	☐	☐
Do you use tanning booths?	☐	☐
Have you had blistering sunburns?	☐	☐
Do you heal with thick (keloid) scars?	☐	☐
Do you bleed / bruise easily?	☐	☐
Do you react to bandages or adhesive?	☐	☐
Do you need antibiotics for the dentist?	☐	☐
Have you had staph infections / MRSA?	☐	☐
Do you work outdoors?	☐	☐
Do you smoke? # cigarettes/day _____	☐	☐
Do you drink alcohol? # drinks / day _____	☐	☐
Do you take aspirin? Blood thinners?	☐	☐
Are you allergic to local anesthesia?	☐	☐

Past Surgeries	Yes	No
Pacemaker / Defibrillator	☐	☐
Joint Replacement Site: _____	☐	☐
Heart Valve Replacement	☐	☐
Organ Transplant Type: _____	☐	☐
Tubal Ligation	☐	☐
List Other Surgeries: _____		

FAMILY Medical Problems	Yes	No
Skin Cancer	☐	☐
Melanoma	☐	☐
Basal Cell Carcinoma	☐	☐
Squamous Cell Carcinoma	☐	☐
Abnormal Moles	☐	☐
Eczema	☐	☐
Asthma	☐	☐
Seasonal Allergies	☐	☐
Psoriasis	☐	☐
Autoimmune Disease	☐	☐
(Lupus, Rheumatoid Arthritis, MS, Crohn's, Colitis, Thyroid) _____		

ROS: Circle any Symptoms you currently have					
General	Fatigue	Weight Loss			
Immune	Fever	Night Sweats	Frequent Infections		
Eye	Dryness	Blurry Vision	Irritation		
Heart	Chest Pain	Ankle Swelling	Palpitations		
Lungs	Cough	Shortness of Breath			
GI	Nausea	Vomiting	Diarrhea		
Joint	Stiffness	Pain	Cramping		
Neuro	Numbness	Tingling	Headache	Weakness	
Endocrine	Heat/Cold Intolerance	Excessive Thirst			
Psych	Depression	Anxiety			
Heme	Easy Bleeding	Bruising	Swollen Nodes		
Skin	Itch	Burning	Redness	Discoloration	Scale
Females					
Pregnant		Nursing	Irregular Periods		
Planning Pregnancy Soon		Birth Control Pills			

PMH: Circle your Medical Problems				
Cancer	Breast	Prostate	Colon	
Immune	HIV	Immune Deficiency		
Eyes	Glaucoma	Cataract	Rosacea	
Nose	Seasonal Allergies	Chronic Rhinitis		
Heart	High Blood Pressure	Heart Attack		
	High Cholesterol	Atrial Fibrillation		
	Heart Valve Problems	Clotting Disorder		
Lungs	COPD	Asthma	Tuberculosis	
GI	Acid Reflux	Colitis	Irritable Bowel	
	Hepatitis B	Hepatitis C		
Joint	Arthritis	Joint Replacement		
Brain	Stroke	Seizures	Migraines	Headaches
Endocrine	Thyroid	Diabetes	Polycystic Ovary	
Psych	Depression	Anxiety	Attention Deficit	
Other				

_____ _____

Patient's Signature Date

_____ _____

Provider's Signature Date

Ocala Family Medical Center
2230 SW 19th Avenue Road
Ocala, FL 34471
(352) 237-4133

Dear Patient:

Welcome to Ocala Family Medical Center, Inc. Our goal is to improve your quality of life. It is our policy to charge for missed appointments at the rate of:

Primary Care:

New Patient Appointment: $50.00

Follow Up Appointment: $50.00

Physical Therapy

Initial Evaluation: $100.00

Follow Up Appointment: $75.00

Specialist

New Patient Appointment: $100.00

Follow Up Appointment: $75.00

Missed Procedures: $100.00

Radiology

CT Appointment: $100.00

MRI Appointment: $100.00

Nuclear Appointment: $100.00

Ultrasound Appointment: $100.00

Please help us to serve you better by keeping your scheduled appointments. If you are unable to keep an appointment, please call (352) 237-4133 to reschedule your appointment at least 24-hours in advance.

Sincerely,
The Staff of Ocala Family Medical Center

I have read and understand the above no show policy.

Print Name	Date of Birth
Signature	Date

Effective: 02/02/2024