

Ocala Family Medical Center, Inc.

How did you hear about us?		<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Phone Book <input type="checkbox"/> Signs <input type="checkbox"/> Internet <input type="checkbox"/> Other:	
PATIENT INFORMATION FORM			
Last Name:		First Name:	
Primary Mailing Address:		Initial: PT#	
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			
<input type="checkbox"/> Consent to leave message with detailed information <input type="checkbox"/> 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: <input type="checkbox"/>	_____ Work: <input type="checkbox"/>	_____ Mobile: <input type="checkbox"/>	_____ <input type="checkbox"/> Patient Portal
<input type="checkbox"/> Voice	<input type="checkbox"/> E-Mail	<input type="checkbox"/> Text	<input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No			
Emergency Contact Information / Living Will			
Name of Emergency Contact:		Phone:	Relationship:
Do you have a living will? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, copy provided: YES <input type="checkbox"/> NO <input type="checkbox"/>			
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: _____

Patient Name _____ DOB _____ Sex _____ Age _____ Date _____

MEDICAL HISTORY	SOCIAL HISTORY	FAMILY HISTORY
<p>Have you had any of the following? If yes, please check the box.</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bleeding Disorder</p> <p><input type="checkbox"/> Enlarged Prostate</p> <p><input type="checkbox"/> Cancer Type _____</p> <p><input type="checkbox"/> Chicken Pox</p> <p><input type="checkbox"/> Gallbladder Disease</p> <p><input type="checkbox"/> Kidney Disease</p> <p>Type _____</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Diverticulosis</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Hiatal Hernia</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Liver Disease Type _____</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Mental Illness Type _____</p> <p><input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Heart Attack When? _____</p> <p><input type="checkbox"/> Osteoporosis</p> <p><input type="checkbox"/> Peptic Ulcer(s)</p> <p><input type="checkbox"/> Polio</p> <p><input type="checkbox"/> Lung Disease Type _____</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Scarlet Fever</p> <p><input type="checkbox"/> Seizure</p> <p><input type="checkbox"/> Stroke When? _____</p> <p><input type="checkbox"/> Phlebitis</p> <p><input type="checkbox"/> Thyroid issues Explain _____</p> <p><input type="checkbox"/> Transfusion When? _____</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Varicose Veins</p> <p><input type="checkbox"/> Sexually Transmitted Infection</p> <p style="padding-left: 20px;">Type _____</p> <p><input type="checkbox"/> OTHER _____</p> <p style="text-align: center;">ALLERGIES</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Alcohol Use? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Type _____</p> <p># of drinks per day _____</p> <p># of time per week _____</p> <p>Tobacco Use? Current <input type="checkbox"/> yes</p> <p>Never Smoked <input type="checkbox"/> yes</p> <p>Former Tobacco User / Quit Date _____</p> <p>Type _____</p> <p>Amount per day _____</p> <p># of years used _____</p> <p>Cups of Caffeine per day: _____</p> <p>Any Illegal Drug Use: _____</p> <p>Any Physical Disabilities: _____</p> <p style="text-align: center;">SURGERIES/OPERATIONS:</p> <p>Have you had surgery on any of the following areas?</p> <p style="text-align: right;"><u>Date of Surgery</u></p> <p><input type="checkbox"/> Adenoids _____</p> <p><input type="checkbox"/> Appendix _____</p> <p><input type="checkbox"/> Back _____</p> <p><input type="checkbox"/> Breast _____</p> <p><input type="checkbox"/> Cataract _____</p> <p><input type="checkbox"/> C-Section _____</p> <p><input type="checkbox"/> Gallbladder _____</p> <p><input type="checkbox"/> Colon _____</p> <p><input type="checkbox"/> Gastric Bypass _____</p> <p><input type="checkbox"/> Hernia Repair _____</p> <p><input type="checkbox"/> Hysterectomy _____</p> <p style="padding-left: 20px;"><input type="checkbox"/> Total <input type="checkbox"/> Partial</p> <p><input type="checkbox"/> Joint Replacement _____</p> <p><input type="checkbox"/> Thyroid _____</p> <p><input type="checkbox"/> Tonsils _____</p> <p><input type="checkbox"/> Tubal Ligation _____</p> <p><input type="checkbox"/> Spleen _____</p> <p><input type="checkbox"/> Vasectomy _____</p> <p><input type="checkbox"/> Other (please explain) _____</p> <p style="text-align: center;">IMMUNIZATIONS</p> <p style="text-align: right;"><u>Date Received</u></p> <p>Tetanus _____</p> <p>Influenza _____</p> <p>Pneumonia _____</p> <p>_____</p>	<p>Has any blood relative had any of the following?</p> <p style="text-align: right;"><u>Relationship</u></p> <p><input type="checkbox"/> Alcoholism _____</p> <p><input type="checkbox"/> Anemia _____</p> <p><input type="checkbox"/> Arthritis _____</p> <p><input type="checkbox"/> Asthma _____</p> <p><input type="checkbox"/> Bleeding Problems _____</p> <p><input type="checkbox"/> Cancer _____</p> <p><input type="checkbox"/> Heart Failure _____</p> <p><input type="checkbox"/> Colon Problems _____</p> <p><input type="checkbox"/> COPD _____</p> <p><input type="checkbox"/> Diabetes _____</p> <p><input type="checkbox"/> Early Death _____</p> <p><input type="checkbox"/> Gout _____</p> <p><input type="checkbox"/> Heart Disease _____</p> <p><input type="checkbox"/> High Cholesterol _____</p> <p><input type="checkbox"/> High Blood Pressure _____</p> <p><input type="checkbox"/> Kidney Disorder _____</p> <p><input type="checkbox"/> Leukemia _____</p> <p><input type="checkbox"/> Liver Disorder _____</p> <p><input type="checkbox"/> Mental Illness _____</p> <p><input type="checkbox"/> Migraines _____</p> <p><input type="checkbox"/> Obesity _____</p> <p><input type="checkbox"/> Osteoporosis _____</p> <p><input type="checkbox"/> Seizure(s) _____</p> <p><input type="checkbox"/> Stroke _____</p> <p><input type="checkbox"/> Substance Abuse _____</p> <p><input type="checkbox"/> Suicide _____</p> <p><input type="checkbox"/> Thyroid Disorder _____</p> <p><input type="checkbox"/> Tuberculosis _____</p> <p><input type="checkbox"/> Other (please explain) _____</p> <p style="text-align: center;">GYN - OB</p> <p>Started menstruating at age: _____</p> <p>Last normal menstrual period date: _____</p> <p>Prior menstrual period: _____</p> <p>Sexually Active? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Number of pregnancies _____</p> <p>Number of miscarriages _____</p> <p>Number of abortions _____</p> <p>Number of births _____</p> <p>Multiple births _____</p> <p>Date of last pap smear _____</p> <p>Date of last mammogram _____</p> <p>Do you use contraception <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Pelvic inflammatory disease/pelvic pain <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Sexually transmitted disease <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Abnormal pap smears <input type="checkbox"/> yes <input type="checkbox"/> no</p>
CURRENT MEDICATION	DOSAGE (Ex: 250 mg)	INSTRUCTIONS (Ex: 1 daily, 3 daily, as needed)

Patient Name: _____ Date: _____ DOB _____

Have you recently experienced any of the following? Check “yes” or “no.” If unsure, leave blank.

GENERAL

- Weight Change yes no
- Chills yes no
- Fever yes no
- Night Sweats yes no
- Feeling Tired or Poorly yes no
- Generalized pain yes no
- Generalized swelling (edema) yes no
- Body Aches yes no

HEAD

- Headache yes no
- Facial Pain yes no
- Sinus Pain yes no
- Sinus Pressure yes no

NECK

- Neck Pain yes no
- Neck Stiffness yes no
- Lump or swelling in neck yes no
- Swollen glands in neck yes no

EYE

- Eyesight/Vision problems yes no
- Sensitivity to light yes no
- Eye Pain yes no
- Itching of the eyes yes no
- Dry Eyes yes no
- Watering/Discharge of eyes yes no

EARS, NOSE, & THROAT

- Earache/Ear pain yes no
- Hearing Loss yes no
- Ringing in the ears yes no
- Ears feel full or plugged yes no
- Discharge from the ears yes no
- Nasal Discharge yes no
- Nosebleeds yes no
- Post-nasal drainage yes no
- Itching of the nose yes no
- Hoarseness yes no
- Choking yes no
- Sore Throat yes no
- Teeth problems yes no
- Pain of the jaw yes no
- Sore gums yes no

CARDIOVASCULAR

- Chest pain or pressure yes no
- Vein problems yes no
- Palpitations yes no
- Cold/bluish hands or feet yes no
- Swelling of ankles yes no

GASTROINTESTINAL

- Change in Appetite yes no
- Difficulty Swallowing yes no
- Heartburn yes no
- Nausea yes no
- Vomiting yes no
- Abdominal pain yes no
- Diarrhea yes no
- Constipation yes no
- Bloating yes no

PULMONARY

- Shortness of breath yes no
- Cough yes no
- Blood in phlegm/sputum yes no
- Chest Congestion yes no
- Wheezing yes no
- Difficulty breathing while lying yes no

GENITOURINARY

- Painful urination yes no
- Pain in flank yes no
- Blood in urine yes no
- Dribbling or incontinence of urine yes no

SKIN

- Itchy skin yes no
- Dry skin yes no
- Changes in skin yes no
- Changes in nails yes no

MUSCULOSKELETAL

- Joint Pain yes no
- Joint Stiffness yes no
- Muscle aches yes no
- Muscle cramps yes no
- Muscle spasms yes no
- Back pain yes no

ENDOCRINE

- Excessive sweating yes no
- Excessive thirst yes no
- Sex drive issues yes no
- Sensitivity to hot/cold yes no
- Changes in hair yes no

NEURO-PSYCH

- Dizziness/Vertigo yes no
- Fainting yes no
- Lightheadedness yes no
- Memory loss yes no
- Speech problems yes no
- Balance problems yes no
- Sleep issues yes no
- Anxiety yes no
- Depression yes no

MISSED APPOINTMENTS

UNLESS CANCELED AT LEAST 24 HOURS IN ADVANCE, OUR POLICY IS TO CHARGE FOR MISSED APPOINTMENTS AT THE RATE OF A NORMAL OFFICE VISIT. PLEASE HELP US TO SERVE YOU BETTER BY KEEPING YOUR SCHEDULED APPOINTMENTS.

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 UNDERSTAND THAT COVID-19 IS PREVALENT IN THE COMMUNITY AND IS A RISK WITH ANY MEDICAL VISIT OR PROCEDURE. 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.

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 RESPONSIBLE PERSON
(WHERE APPLICABLE)

DATE

PRINT NAME OF PATIENT

PRINT NAME OF RESPONSIBLE PERSON

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



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