

# How did you hear about FPG?

PLEASE COMPLETE THIS FORM IN FULL. PRINT CLEARLY AND CAREFULLY.



Family Physicians Group

OFFICE LOCATION

DATE

## MEDIA (CHECK ALL THAT APPLY)

Newspaper

Which?

Radio Commercial

Which?

Television Commercial

Which?

Mail/Postcard

Flyers

Public Sign/Display

Health Fair Seminar

Marketing Representative

Insurance Representative

Which?

Family and Friends

Others

Explain:



# Pharmacy Enrollment Form

6404 Old Winter Garden Rd.  
Orlando, FL 32835  
Phone: 1-877-490-8987 Toll Free  
Fax: 1-877-490-1060  
www.1sourcepharmacy.com

PLEASE PRINT OR TYPE - BE SURE FORM IS COMPLETED  
IN FULL AND SIGNED TO ENSURE ENROLLMENT.

## PERSONAL INFORMATION

1. Preferred Language/Lenguaje Preferido:  English  Spanish

2. First Name/Primer Nombre:		3. Last Name/Apellido:		4. Date of Birth/Fecha de Nacimiento:		5. SEX/Sexo: <input type="checkbox"/> M <input type="checkbox"/> F	
6. Social Security #/Seguro Social:			7. Home Phone #/Telefono Casa:		8. Cell Phone #/Celular:		
9. Address/Dirección:				10. Address 2/Dirección 2 (Apt. #, etc.)			
11. City/Ciudad:		12. State/Estado:	13. ZIP Code/Codigo Postal:		14. PCP (Primary Doctor) / Doctor Primario		
15. Health Plan/Plan de Salud:		16. Plan ID #/Numero Identificador:	17. RX GROUP #:(See Prescription Card)		18. BIN #:(See Prescription Card)		
19. Allergies/Alergias: <input type="checkbox"/> None <input type="checkbox"/> Aspirin <input type="checkbox"/> Sulfa <input type="checkbox"/> Penicillin <input type="checkbox"/> Other:(please define)							
20. Preferred Method of Delivery: <input type="checkbox"/> Mail <input type="checkbox"/> Hand Delivery <input type="checkbox"/> Pick-Up at Pharmacy				21. Method of Payment: <input type="checkbox"/> Credit Card (Please call Pharmacy) <input type="checkbox"/> Invoice Me (30 Days)			
22. <input type="checkbox"/> YES <input type="checkbox"/> NO		I would like to sign for my prescription package "Hand Delivery Only" if I choose NO I assume responsibility for lost/stolen packages.					
23. <input type="checkbox"/> YES <input type="checkbox"/> NO		Enroll me in Automatic Refills.					

**24. Free OTC Products with Enrollment**

**PICK 2 ITEMS (90 Day Supply)**  
Items will ship on first order

- Advil® Generic 200mg
- Alcohol Swabs
- Aspirin 81mg
- Calcium 500mg + Vitamin D
- Claritin® Generic 10mg
- Dulcolax® Generic 100mg
- Ferrous Sulfate (Iron) 325mg
- Folic Acid 400mcg
- Mucinex® IR DM Generic 400mg
- Mucinex® IR Generic 400mg
- Bengay® Generic Muscle Cream
- Omega Fish Oil 1000mg
- Senior Vitamins
- Tylenol® Generic 325mg
- Vitamin B12 100mcg
- Vitamin C 500mg
- Vitamin E 400iu

**25. Free Items (with first order only)**

- Large Pill Box
- Pill Key Chain
- First Aid Kit



**Ways to enroll:**

- 1) \*Take enrollment form to your Primary Care Physician office to send an electronic fax or e-script to: **(877) 490-1060.**
- 2) Bring Prescription into One Source Pharmacy.
- 3) Mail original RX with completed enrollment form to:  
**One Source Pharmacy**  
**6404 Old Winter Garden Rd.**  
**Orlando, FL 32835**

**\*Preferred Method**

26. I certify that all my information is true and correct to the best of my knowledge and I elect to use One Source Pharmacy as my preferred pharmacy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Office Use Only:** Verified Address & Phone#  
Initials / Position →

- STAT Next Day** (prescriptions must arrive to pharmacy by 12pm not available on Friday)
- 1-2 Business day**
- 3-5 Business day**
- Prescription sent
- No Prescription sent (reason why):

# Patient Information Sheet - Adults

PLEASE COMPLETE THIS FORM IN FULL. PRINT CLEARLY AND CAREFULLY.



## PERSONAL INFORMATION

PATIENT'S LAST NAME		PATIENT'S FIRST NAME		PATIENT'S M.I.	
ADDRESS		CITY		STATE	ZIP CODE
HOME PHONE	CELL PHONE	SOCIAL SECURITY NUMBER		DATE OF BIRTH	AGE
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
ARE YOU EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No		PLACE OF EMPLOYMENT			
WORK PHONE	EMAIL ADDRESS		DRIVER'S LICENSE NUMBER		

## PHARMACY INFORMATION

PHARMACY NAME		PHARMACY PHONE NUMBER			
PHARMACY ADDRESS		CITY		STATE	ZIP CODE

## EMERGENCY CONTACT

EMERGENCY CONTACT'S NAME		RELATIONSHIP TO PATIENT			
HOME PHONE	CELL PHONE	WORK PHONE			

## HEALTH INSURANCE INFORMATION

DO YOU HAVE MEDICAL INSURANCE?  YES  NO (IF NO, YOU MAY STOP HERE)

INSURED'S NAME		RELATIONSHIP TO PATIENT			
INSURED'S ADDRESS		CITY		STATE	ZIP CODE
INSURED'S SOCIAL SECURITY NUMBER		DATE OF BIRTH			AGE
INSURED'S PLACE OF EMPLOYMENT		INSURED'S WORK PHONE			
NAME OF INSURANCE		POLICY ID NUMBER			
GROUP NAME		GROUP NUMBER			
CLAIMS ADDRESS		CITY		STATE	ZIP CODE

## IF MEDICARE IS YOUR PRIMARY

MEDICARE NUMBER (INCLUDING LETTERS)	NAME OF PRIMARY INSURANCE	NAME OF SECONDARY INSURANCE
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# Health Care Services Agreement

PLEASE COMPLETE THIS FORM IN FULL. PRINT CLEARLY AND CAREFULLY.



The undersigned hereby request and consent to the services of Family Physicians Group (FPG), Including examination, treatment and other procedures deemed appropriate from dates onwards.

I agree to be responsible for all fees and costs related to these services, either directly or through my health care insurance provider. In this regard, I authorize their lease of any information required by such provider for the processing of claims for payment. I further authorize payment of benefits directly to FPG.

It will be my responsibility to notify FPG of any insurance that I have and any changes I make with my insurance plans, plus, to submit to them my insurance cards for copying.

I understand that I will be individually responsible for fees incurrent, like co-pays and deductibles, regardless of insurance. I further understand that FPG will make every attempt to collect from the insurance that I have and will bill me for any balance due after insurance has made their determination of payment, this balance will be paid by me within 30 days of receiving my statement.

I understand that I will be responsible for any additional costs to collect my past dated account, but also any additional costs that may incur for the collection of my account, such as (interest, litigation cost and attorney's fees) if so necessary.

## PERSON(S) RESPONSIBLE FOR BILL (OTHER THAN MEDICAL INSURANCE)

PATIENT'S LAST NAME

PATIENT'S FIRST NAME

ADDRESS

CITY

STATE

ZIP CODE

HOME PHONE

CELL PHONE

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

DATE OF AUTHORIZATION

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

### ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

**NOTE:** If Medicare doesn't pay for (D) \_\_\_\_\_ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) \_\_\_\_\_ below.

(D)	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

#### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) \_\_\_\_\_ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

#### (G) OPTIONS: Check only one box. We cannot choose a box for you.

**OPTION 1.** I want the (D) \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the (D) \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

**OPTION 3.** I don't want the (D) \_\_\_\_\_ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

#### (H) Additional Information:

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:

(J) Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

# Acknowledgement for Advanced Directives

PLEASE COMPLETE THIS FORM IN FULL. PRINT CLEARLY AND CAREFULLY.



## ACKNOWLEDGEMENT FOR ADVANCED DIRECTIVES

AS YOUR MEDICAL DOCTOR, WE NEED TO KNOW IF YOU HAVE EXECUTED AN ADVANCED MEDICAL DIRECTIVE:

Yes  No

IF YES, THIS DIRECTIVE IS IN THE FORM OF:

A Living Will  A Do Not Resuscitate Order  A Health Care Surrogate  An Anatomical Donor Form

If you answered **YES**, could you please provide us with a copy of the forms at your earliest convenience, sign below, and proceed to the next page.

If you answered **NO**, please read the following statement and sign below.

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment. When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about their health care will still be respected, Advance Directives were created. These directives outline in writing your wishes regarding future medical treatment. Without any written instructions from you, your family and physicians would have to guess what treatment you would want. In some cases, they may be forced to proceed with treatments they know you would not desire simply because your preference was not expressed in writing. There are several types of advance directives:

**Living Will:** It is a written statement of the kind of medical care you want or do not want if you become unable to make your own decisions.

**Health Care Surrogate:** This document names another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will.

**Anatomical donor form:** It is a document that indicates your wish to donate, at death, all or part of your body. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card, signing a uniform donor form, or expressing your wish in a living will.

**DNR form:** This is a yellow form that identifies people who do not wish to be resuscitated in the event that they stop breathing of their heart stops beating.

The Advance Directives come into effect only if you become incapacitated and you can change it at any time. As long as you are capable, you should discuss your expectations for future medical care with your physician. However, before you fill out the Advance Directives you may also want to talk to your family, friends, lawyer, or spiritual advisor.

Check here if you would like to receive advanced directive forms from our office

PATIENT'S LAST NAME	PATIENT'S FIRST NAME
SOCIAL SECURITY NUMBER	DATE OF BIRTH

PRINT PATIENT/LEGAL REPRESENTATIVE NAME

DATE OF AUTHORIZATION

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

# Authorization to Obtain or Release Protected Health Information



PLEASE COMPLETE THIS FORM IN FULL. PRINT CLEARLY AND CAREFULLY.

I, \_\_\_\_\_ hereby authorize Family Physicians Group to:

<input type="checkbox"/> Release Copies <input type="checkbox"/> Obtain Records		PATIENT'S NAME	
RELEASE TO (NAME OF INDIVIDUAL, HEALTHCARE FACILITY OR AGENCY)		OBTAIN FROM (NAME OF INDIVIDUAL, HEALTHCARE FACILITY OR AGENCY)	
ADDRESS		CITY	STATE     ZIP CODE
PHONE		FAX	
PURPOSE			
<input type="checkbox"/> Continued Treatment <input type="checkbox"/> Personal Records <input type="checkbox"/> Transfer In/Out <input type="checkbox"/> Other:			
DATES OF SERVICE: FROM:		TO:	

This authorization will expire on the following date, event or condition: \_\_\_\_\_

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my records be released without my written authorization, except as otherwise required by law. I understand that any disclosure of information Family Physicians Group may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

ITEMS TO BE RELEASED OR OBTAINED (PLEASE INITIAL NEXT TO ALL WHICH APPLY)

Complete Record      Abstract Records      Medication History      All Diagnostic Test Results      Labs  
 Therapy Records      Consultation/Progress Notes      Radiology Only      Pathology/Operative Reports  
 Other (Specify): \_\_\_\_\_

SPECIFIC ITEMS (IF APPLICABLE)

Mental Health      HIV Testing      Drugs and/or Alcohol      AIDS Information      Genetic Counseling/Testing Information

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE		DATE OF AUTHORIZATION	
DATE OF BIRTH	SOCIAL SECURITY NUMBER	TYPE OF ID SHOWN	
ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	TRANSLATOR OR INTERPRETER'S NAME		

## OFFICIAL USE ONLY

NAME OF PERSON RELEASING INFORMATION:	DATE:
NAME OF PERSON ASSISTING WITH REVIEW :	NUMBER OF PAGES COPIED:

# Authorization to Obtain Medication History

PLEASE COMPLETE THIS FORM IN FULL. PRINT CLEARLY AND CAREFULLY.



## PERSONAL INFORMATION

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	PATIENT'S M.I.
SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE

By signing this below, I hereby authorize Family Physicians Group to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

PRINT PATIENT/LEGAL REPRESENTATIVE NAME

DATE OF AUTHORIZATION

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

# Annual History and Physical (1 of 2)

PLEASE COMPLETE THIS FORM IN FULL. PRINT CLEARLY AND CAREFULLY.

## PERSONAL INFORMATION

PATIENT'S LAST NAME		PATIENT'S FIRST NAME		PATIENT'S M.I.
INSURANCE	OCCUPATION	DATE OF BIRTH	AGE	
GENDER	<input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	

## MEDICAL INFORMATION

ALLERGIES

CURRENT MEDICATIONS

PLEASE DATE AND LIST YOUR THREE MOST RECENT HOSPITAL ADMISSIONS AND SURGERIES.

DATE #1	DATE #2	DATE #3
SURGERY #1	SURGERY #2	SURGERY #3

IF APPLICABLE, PLEASE INDICATE WHICH BLOOD-RELATIVE HAS SUFFERED ANY OF THE FOLLOWING CONDITIONS.

TUBERCULOSIS	EPILEPSY	ARTHRITIS
STROKE	DIABETES	GOUT
MIGRAINE	CANCER	KIDNEY DISEASE
MENTAL ILLNESS	ALLERGY	GLAUCOMA

IF APPLICABLE, PLEASE PROVIDE THE DATES ON WHICH YOU RECEIVED THESE IMMUNIZATIONS.

HEPATITIS B	MEASLES	FLU
DIPHTHERIA	SMALL POX	MUMPS
PERTUSSIS (WHOOPING COUGH)	PNEUMOVAX	TYPHOID
RUBELLA	TETANUS	

IF APPLICABLE, PLEASE INDICATE THE DATES ON WHICH YOU LAST RECEIVED THESE PROCEDURES.

COMPLETE PHYSICAL	PROSTATE EXAM	MAMMOGRAM
PAP SMEAR	CHOLESTEROL CHECK	STOOL CHECK FOR BLOOD
BREAST EXAM	EYE EXAM	TB TEST

HEARING TEST

TRANSFUSIONS?  Y  N PLEASE LIST:

## GYNECOLOGICAL AND OBSTETRIC INFORMATION (WOMEN ONLY)

AGE AT ONSET OF MENSTRUAL PERIODS	FREQUENCY OF PERIODS	LENGTH OF PERIOD
NUMBER OF PREGNANCIES	NUMBER OF LIVE BIRTHS	NUMBER OF MISCARRIAGES

NUMBER OF ABORTIONS

PROLONGED OR ABNORMAL BLEEDING	<input type="checkbox"/> Y <input type="checkbox"/> N	IF YES, PLEASE LIST:
LEAKAGE OF URINE	<input type="checkbox"/> Y <input type="checkbox"/> N	IF YES, PLEASE LIST:
PELVIC PAIN	<input type="checkbox"/> Y <input type="checkbox"/> N	IF YES, PLEASE LIST:
ABNORMAL DISCHARGE	<input type="checkbox"/> Y <input type="checkbox"/> N	IF YES, PLEASE LIST:
HISTORY OF ABNORMAL PAP SMEAR	<input type="checkbox"/> Y <input type="checkbox"/> N	IF YES, PLEASE LIST:

# Annual History and Physical (2 of 2)

PLEASE COMPLETE THIS FORM IN FULL. PRINT CLEARLY AND CAREFULLY.



Family Physicians Group

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	DATE OF BIRTH
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## PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

<input type="checkbox"/> 1. Glaucoma or Cataracts	<input type="checkbox"/> 14. Acid Reflux	<input type="checkbox"/> 27. Diabetes/ Pre-Diabetes	<input type="checkbox"/> 40. Anxiety/Depression
<input type="checkbox"/> 2. Macular Degeneration	<input type="checkbox"/> 15. Hepatitis	<input type="checkbox"/> 28. Thyroid Disease	<input type="checkbox"/> 41. Schizophrenia
<input type="checkbox"/> 3. Frequent Ear Infections	<input type="checkbox"/> 16. Peptic or Stomach Ulcer	<input type="checkbox"/> 29. Varicose Veins/Phlebitis	<input type="checkbox"/> 42. Bipolar Disorder
<input type="checkbox"/> 4. Hay Fever/Sinus Allergies	<input type="checkbox"/> 17. Irritable Bowel Syndrome (IBS)	<input type="checkbox"/> 30. Tuberculosis	<input type="checkbox"/> 43. German Measles/Rubella
<input type="checkbox"/> 5. Chronic Sinusitis	<input type="checkbox"/> 18. Diverticulosis/Diverticulitis	<input type="checkbox"/> 31. Stroke	<input type="checkbox"/> 44. Chicken Pox
<input type="checkbox"/> 6. Asthma or Emphysema (COPD)	<input type="checkbox"/> 19. Hemorrhoids	<input type="checkbox"/> 32. Epilepsy/Seizures	<input type="checkbox"/> 45. Measles
<input type="checkbox"/> 7. Chronic Bronchitis	<input type="checkbox"/> 20. Gall Bladder Disease	<input type="checkbox"/> 33. Migraine Headaches	<input type="checkbox"/> 46. Scarlet Fever
<input type="checkbox"/> 8. Pneumonia	<input type="checkbox"/> 21. Colitis	<input type="checkbox"/> 34. Anemia	<input type="checkbox"/> 47. Mumps
<input type="checkbox"/> 9. Heart Murmur	<input type="checkbox"/> 22. Frequent Urine Infections	<input type="checkbox"/> 35. Gout	<input type="checkbox"/> 48. Polio
<input type="checkbox"/> 10. High Blood Pressure	<input type="checkbox"/> 23. Kidney Stones	<input type="checkbox"/> 36. Rheumatoid Arthritis	<input type="checkbox"/> 49. Rheumatic Fever
<input type="checkbox"/> 11. Heart Attack/Heart Disease	<input type="checkbox"/> 24. Enlarged Prostate	<input type="checkbox"/> 37. Osteoarthritis	<input type="checkbox"/> 50. Cancer Which? _____
<input type="checkbox"/> 12. Irregular Heartbeat/Pacemaker	<input type="checkbox"/> 25. Chronic Kidney Disease	<input type="checkbox"/> 38. Lupus	<input type="checkbox"/> 51. Other Which? _____
<input type="checkbox"/> 13. High Cholesterol	<input type="checkbox"/> 26. Sexually Transmitted Disease	<input type="checkbox"/> 39. Psoriasis/Eczema	_____

## REVIEW OF SYMPTOMS (CHECK ALL THAT APPLY)

<input type="checkbox"/> 1. Unusual Fatigue or Weakness	<input type="checkbox"/> 15. Hoarseness	<input type="checkbox"/> 29. Change in Bowel Habits	<input type="checkbox"/> 43. Numbness/Tingling Sensation
<input type="checkbox"/> 2. Fever or Chills	<input type="checkbox"/> 16. Wheezing	<input type="checkbox"/> 30. Diarrhea or Constipation	<input type="checkbox"/> 44. Frequent Headaches
<input type="checkbox"/> 3. Recent Weight Loss or Gain	<input type="checkbox"/> 17. Shortness of Breath	<input type="checkbox"/> 31. Bloody or Tarry Stools	<input type="checkbox"/> 45. Memory Loss
<input type="checkbox"/> 4. Decreased Hearing	<input type="checkbox"/> 18. Chronic Cough	<input type="checkbox"/> 32. Jaundice (Yellowing of Skin)	<input type="checkbox"/> 46. Muscle Weakness
<input type="checkbox"/> 5. Ringing in Ear	<input type="checkbox"/> 19. Chest Pain or Tightness	<input type="checkbox"/> 33. Hernia	<input type="checkbox"/> 47. Back Pain (Recurrent)
<input type="checkbox"/> 6. Dizzy Spells	<input type="checkbox"/> 20. Palpitations or Tachycardia	<input type="checkbox"/> 34. Painful Urination	<input type="checkbox"/> 48. Bone Fracture/Joint Injury
<input type="checkbox"/> 7. Earache	<input type="checkbox"/> 21. Swelling of Feet or Legs	<input type="checkbox"/> 35. Blood in Urine	<input type="checkbox"/> 49. Joint Pain Which? _____
<input type="checkbox"/> 8. Failing Vision	<input type="checkbox"/> 22. Fainting Spells	<input type="checkbox"/> 36. Overnight Urination	<input type="checkbox"/> 50. Cold Hands or Feet
<input type="checkbox"/> 9. Double or Blurred Vision	<input type="checkbox"/> 23. Leg Pain when Walking	<input type="checkbox"/> 37. Incontinence	<input type="checkbox"/> 51. Rashes or Itching
<input type="checkbox"/> 10. Eye Pain	<input type="checkbox"/> 24. Loss of Appetite	<input type="checkbox"/> 38. Decrease in Force of Urination	<input type="checkbox"/> 52. Hives
<input type="checkbox"/> 11. Eye Infection	<input type="checkbox"/> 25. Difficulty Swallowing	<input type="checkbox"/> 39. Urethral Discharge	<input type="checkbox"/> 53. Moodiness (Excessive)
<input type="checkbox"/> 12. Nose Bleeds	<input type="checkbox"/> 26. Indigestion/Heartburn	<input type="checkbox"/> 40. Bruise or Bleed Easily	<input type="checkbox"/> 54. Nervousness
<input type="checkbox"/> 13. Sinus Congestion or Pain	<input type="checkbox"/> 27. Persistent Nausea/Vomiting	<input type="checkbox"/> 41. Convulsions/Seizures	<input type="checkbox"/> 55. Depression
<input type="checkbox"/> 14. Sore Throat	<input type="checkbox"/> 28. Abdominal Pain	<input type="checkbox"/> 42. Tremor/Hands Shaking	<input type="checkbox"/> 56. Phobias

## ACTIVITIES, HABITS, LIFESTYLE

DO YOU WEAR SEATBELTS? <input type="checkbox"/> Y <input type="checkbox"/> N	DO YOU USE ILLEGAL DRUGS? <input type="checkbox"/> Y <input type="checkbox"/> N	DRINK CAFFEINATED BEVERAGES? <input type="checkbox"/> Y <input type="checkbox"/> N
DO YOU SMOKE TOBACCO? <input type="checkbox"/> Y <input type="checkbox"/> N	DO YOU DRINK ALCOHOL? <input type="checkbox"/> Y <input type="checkbox"/> N	DO YOU USE EYEGLASSES? <input type="checkbox"/> Y <input type="checkbox"/> N
DO YOU USE CONTACTS? <input type="checkbox"/> Y <input type="checkbox"/> N	DO YOU USE DENTURES? <input type="checkbox"/> Y <input type="checkbox"/> N	DO YOU USE HEARING AIDES? <input type="checkbox"/> Y <input type="checkbox"/> N

# Consent to Use Info for Treatment, Payment or Health Care Operations (1 of 2)



PLEASE COMPLETE THIS FORM IN FULL. PRINT CLEARLY AND CAREFULLY.

The patient hereby consents the use or disclose of his/her individually identifiable health information (“protected health information”) and patient medical record information by the “practice” in order to carry out treatment, payment or health care operations. The patient should review the practice’s Notice of Privacy Practice for a more complete description of the potential uses and disclosures of such information, and the patient has the right to review such notice prior to signing this consent form.

The practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the practice does change the terms of its Notice of Privacy Practice, patient may obtain a copy of the revised notice from our Office Manager.

Patient retains the right to request that the practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The practice is not required to agree to such requested restrictions; however, if the practice does agree to patient’s requested restriction(s); such restrictions are then binding on the practice.

Patient acknowledges and agrees that the practice may disclose patient’s protected health information and patient medical record information to the following individuals who are either the patient’s family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the patient:

PATIENT’S LAST NAME		PATIENT’S FIRST NAME		PATIENT’S M.I.
NAME OF INDIVIDUAL #1	NAME OF INDIVIDUAL #2		NAME OF INDIVIDUAL #3	
NAME OF INDIVIDUAL #4	NAME OF INDIVIDUAL #5		NAME OF INDIVIDUAL #6	

**PROTECTED HEALTH INFORMATION TO BE RESTRICTED OR LIMITED (PLEASE INITIAL NEXT TO ALL WHICH APPLY)**

<input type="checkbox"/> Home Phone Number	<input type="checkbox"/> Home Address	<input type="checkbox"/> Occupation	<input type="checkbox"/> Name of Employer
<input type="checkbox"/> Visit Notes	<input type="checkbox"/> Hospital Notes	<input type="checkbox"/> Prescription Information	<input type="checkbox"/> Patient History
<input type="checkbox"/> Office Address	<input type="checkbox"/> Office Phone Number	<input type="checkbox"/> Spouse’s Name	<input type="checkbox"/> Spouse’s Office Phone Number
<input type="checkbox"/> Test Results	<input type="checkbox"/> Other If other, please specify:		

THE PATIENT AGREES AND CONSENTS TO THE PRACTICE RELEASING INFORMATION TO PATIENT IN THE FOLLOWING ALTERNATIVE MANNERS (PLEASE INITIAL).

- Via fax, if patient contacts the practice and requests information to be sent via fax keeping in mind that the fax number provided by the patient is located in a secured area and information sent via fax will be kept confidential. Fax #: \_\_\_\_\_
- Via regular mail at home address or any other address requested by patient in writing with any envelopes being marked personal and confidential and addressed to patient.
- Via telephone, if patient contacts the practice and provides the appropriate information (including the patient’s name, social security number and date of birth).

PRINT PATIENT/LEGAL REPRESENTATIVE NAME

DATE AND TIME OF AUTHORIZATION

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

# Consent to Use Info for Treatment, Payment or Health Care Operations (2 of 2)

PLEASE COMPLETE THIS FORM IN FULL. PRINT CLEARLY AND CAREFULLY.



The practice may refuse to treat patient if he/she (or an authorized representative) does not sign this consent form. If patient (or an authorized representative) signs this consent and then revokes it, the practice has the right to refuse to provide further treatment to patient as of the time of revocation (except to the extent that the practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AN AUTHORIZED REPRESENTATIVE TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	DATE OF BIRTH
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EXPLAIN THE REPRESENTATIVE'S RELATIONSHIP TO THE PATIENT AND INCLUDE A DESCRIPTION OF THE REPRESENTATIVE'S AUTHORITY TO ACT ON THE PATIENT'S BEHALF.

PRINT PATIENT/LEGAL REPRESENTATIVE NAME	DATE AND TIME OF AUTHORIZATION
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SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE