PREMIER MD CARE

NAME: ____

PERSONAL AND FAMILY HISTORY:

	SELF	MOTHER	FATHER	GRAND PARENTS	SIBLINGS	CHILDREN	
DIABETES							
HIGH BLOOD PRESSURE							
HIGH CHOLESTEROL							
HEART DISEASE							
HEART ATTACK							
HEART FAILURE							
STROKE							
ASTHMA							
COPD/EMPHYSEMA							
BOWEL POLYPS							
THYROID DISEASE							
OSTEOPOROSIS							
CANCER (SITE)							
ENLARGED PROSTATE							

LIST CURRENT MEDICATIONS:

MEDICATION	DOSE

LIST ALL OTHER ILLNESSES, PREVIOUS HOSPITALIZATIONS, SURGERIES IN CHRONOLOGICAL ORDER WITH APPROXIMATE DATE ___________________________

____

____

____

LIST ANY ALLERGIES: ___________________

____

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____

____

DO YOU HAVE ANY OF THE FOLLOWING? PLEASE CHECK YES or NO COLUMN.

	Y	N		Y	N		Y	N		Y	N
Recent weight gain/loss			Headache			Chest pain			Abdominal pain		
Fever/Chills			Seizures			Swelling of legs			Heartburn		
Night sweats			Numbness			Palpitations			Vomiting		
Insomnia			Depression			Leg pain with walking			Nausea		
Fatigue			Anxiety			Varicose veins			Constipation		
High stress			Suicidal thoughts			Cough			Diarrhea		
Joint aches			Vision problems			Wheezing			Black stool		
Muscle aches			Eye irritation			Shortness of breath			Blood in stool		
Excessive hunger			Dry mouth						Pain with urinating		
Excessive thirst			Throat pain			Rash			Urinary frequency _______/day		
Forgetfulness			Nasal drainage			Skin sore			Urinating at night_______/night		
			Hoarseness			Change in moles			Urinary incontinence		
			Earache						History of sexually transmitted disease		

MEN ONLY:			WOMEN ONLY:		
Poor erection			Heavy menstrual bleeding		
Unable to have sex			Irregular menstrual bleeding		
Decreased interest in sex			Vaginal dryness		
			Pain with Intercourse		
			PMS		

PERSONAL HISTORY OF:

	YEAR STARTED	YEAR QUIT	TOTAL YEARS USED	# PER DAY	WANT TO STOP		
ALCOHOL USE				DRINKS	Y N		
SMOKING				PACKS	Y N		

LIST DATES OF FOLLOWING PROCEDURES AND CIRCLE "A" IF THE TEST WAS EVER ABNORMAL:

	TETANUS SHOT	PNEUMONIA SHOT	SHINGLES SHOT	FLU SHOT	RECTAL EXAM	COLONOSCOPY	PSA (MEN ONLY)
DATE / ABNORMAL					A	A	A

WOMEN ONLY:

	BREAST EXAM	PELVIC EXAM	PAP SMEAR	MAMMOGRAM	BONE DENSITY TEST	LAST MENSTRUAL PERIOD	
DATE / ABNORMAL	A	A	A	A	A		

____ **Signature**

_______________________________ **Date**

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PREMIER MD CARE

PATIENT INFORMATION SHEET

Name: Last________________________________First____________________________MI__________
*If patient is a minor please fill out legal guardian's information listed below.

Sex: MALE FEMALE Do you have a living will? YES NO

DOB ______/______/________ Social Security # _____________________________

Local Address ____

City ___________________________________ State ____________________ Zip _________________

Local Phone ( ) _____________________ Out of State Phone ( ) ______________________

Email ____

Out of State Address ____

City ___________________________________ State ____________________ Zip_________________

*Employer _______________________________________ Phone ( ) _______________________

*Employer's Address ____

City ___________________________________ State ____________________ Zip _________________

Marital Status: Married Single Widowed Divorced Spouse's Name___________________

Primary Insurance Holder:

Name: Last________________________________First____________________________MI__________

Address ____

City ____________________________________State ___________________ Zip __________________

DOB ______/______/________ Social Security # _____________________________

Phone ( ) ___________________________

***Name & Phone number of nearest relative *NOT* living with you:**

Name ____ Phone ( ) _______________________

Relationship to Patient ____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Premier MD Care may use and disclose protected health information ("PHI") about me to carry out treatment, payment and healthcare operations ("TPO"). Please refer to Premier MD Care Notice of Privacy Practices for a more complete description of such uses and disclosures.
I have the right to review the Notice of Privacy Practices prior to signing this consent. Premier MD Care reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Premier MD Care Privacy Officer at 13831 Metropolis Avenue, Ft. Myers, FL 33912. With my consent, Premier MD Care may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. With my consent, Premier MD Care may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Premier MD Care restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Premier MD Care use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Premier MD Care may decline to provide treatment to me.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Premier MD Care Notice of Privacy Practices with the effective date of September 24, 2014.

X____ __________/__________/______________

Signature of Patient Date

PREMIER MD CARE

PHYSICIAN TEAM LIST

PATIENT'S NAME: ____

PREVIOUS PCP (Primary care physician)
NAME
PHONE
FAX
CITY, STATE

CARDIOLOGIST
NAME
PHONE
FAX
CITY, STATE

GASTROENTEROLOGIST
NAME
PHONE
FAX
CITY, STATE

GYNECOLOGIST
NAME
PHONE
FAX
CITY, STATE

NEUROLOGIST
NAME
PHONE
FAX
CITY, STATE

UROLOGIST
NAME
PHONE
FAX
CITY, STATE

NAME
PHONE
FAX
CITY, STATE

PLEASE BRING TO YOUR FIRST APPOINTMENT

Valid photo ID

Current insurance card

All medications
you are currently taking, including supplements, in the original containers so we can correctly document your dosages

All other records
you can bring would be helpful, especially the following:

Female patients:
Last laboratory results
Colonoscopy reports
Mammogram reports
Pap smear reports
Bone density (DEXA) reports
Immunization records, including last flu vaccine, pneumonia vaccine, Shingles vaccine, Tdap (tetanus) vaccine

Male patients:
Last laboratory results, including last PSA
Colonoscopy reports
Immunization records, including last flu vaccine, pneumonia vaccine, Shingles vaccine, Tdap (tetanus) vaccine