Name: _____ DOB: _____

Please Print

Patient Information

You must fill out every line on this sheet

Name: _____ Social Security #: _____
Last Name *First Name* *M.I.*

Mother's Name If minor patient: _____ Father's Name If minor patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Home #: _____ Cell #: _____

Email: _____ Work #: _____ Circle your preferred contact number

PLEASE CIRCLE

Gender: Male / Female Marital Status: Single / Married / Widowed / Separated / Divorced

Race: African American / Asian / Caucasian / Hispanic / Other: _____

Ethnicity: Latino/Hispanic or Other Do you require assistance for a hearing impairment? (Circle One) Yes / No

Preferred Language: _____ If not English, will you require an interpreter? (Circle One) Yes / No

Do you have a Living Will or Medical Advance Directive: Yes / No Will you provide FMOM a copy? Yes / No

Emergency Contact

Name: _____ Home #: _____

Address: _____ Cell #: _____

City/State/Zip: _____ Work #: _____

Relationship: _____

Do you have a request as to which provider you would like to see:

Have you ever been a patient at ELITE MEDICAL GROUP?

Please list any family members who are currently patients at ELITE MEDICAL GROUP and their relationship to you:

Who was your primary care provider and what is the reason(s) you are leaving that provider?

Are you under the care of any other health care provider for any medical problems? Yes / No
If yes, list whom and for what medical condition.

_____

_____

_____

Name: _____ DOB: _____

PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD – FRONT AND BACK

Primary Insurance Information

Policy Holder Information

Name: _____
Last *First* *Middle*

Date of Birth: _____ Relationship to Patient: _____

Insurance Carrier: _____
Name *Address* *Phone Number*

Member ID._____ Group No. _____ Copay: _____ Deductible: _____ Co-Ins:. _____

Policy Holder Employment Information

Policy Holder Employer: _____ Occupation: _____

Business Address_____ City: _____ State: _____ Zip: _____

Business Phone Number: _____

Secondary Insurance Information

Policy Holder Information

Name: _____
Last *First* *Middle*

Date of Birth: _____ Relationship to Patient: _____

Insurance Carrier: _____
Name *Address* *Phone Number*

Member ID._____ Group No. _____ Copay: _____ Deductible: _____ Co-Ins:. _____

Policy Holder Employment Information

Policy Holder Employer: _____ Occupation: _____

Business Address_____ City: _____ State: _____ Zip: _____

Business Phone Number: _____

Release

Primary Policy Holder Signature _____ Relationship _____ Date _____

Secondary Policy Holder Signature _____ Relationship _____ Date _____

Pharmacy Name _____ # _____

Name: _____ DOB: _____

Current Medical History

Please indicate each of your chronic medical problems by marking the appropriate box below: ☐ None

- ☐ High Blood Pressure
- ☐ Heart Disease (Describe Type Below)
- ☐ Diabetes
- ☐ Stroke
- ☐ Cancer Type: _____
- ☐ Thyroid
- ☐ Asthma
- ☐ Emphysema
- ☐ Kidney Problems
- ☐ Anemia
- ☐ High Cholesterol
- ☐ Depression/Anxiety

List any other medical conditions / problems:

List all medications that you are now taking, strength and how often. Indicate in left column with an "X" if you wish to have our providers manage the medication. No Medication ☐

X	Medication	Strength (mg.)	Directions (ex. Once per day)

Are you allergic to any medications? If so, please list medication and reaction:

Please list any other allergies and their reaction:

Name: _____ DOB: _____

Please list any childhood diseases (ex: chicken pox): ☐ None

Social History

Tobacco _____ a day

# of years _____ Year Quit _____

Exercise _____

Times per week (min/session) _____

Street Drugs _____

Alcohol _____ drinks per week

Caffeine _____ cups per day

Water _____ cups per day

Low fat diet (circle one) Yes / No

Women Only

Age at first menstrual cycle: _____

Date of first day of last menstrual period: _____

Number of pregnancies: _____

Number of live births: _____

Date of last PAP? _____

Date of last Mammogram: _____

Men Only

Date of last Prostate Exam: _____

Date of last PSA: _____

Procedures

Indicate years and results if known

☐ None

Procedure	Year(s)	Results
DEXA		
Stress Test (Heart)		
Doppler		
Ultrasounds		
Angiography		
EKGs (ECGs)		
MRI		
MRA		
CT Scan		
Colonoscopy		
Sigmoidoscopy		
Mammogram		
PAP		

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____