Adam Langley, M.D. Gary Visser, M.D. Ferdinand Brits, M.D. Carolyn Knopfle, ARNP Heather Sheldon, ARNP

PremierMED
Family & Sports Medicine

2940 Maguire Road STE 200
Ocoee, FL 34761-4752
Ph. 407-581-9065
Fax. 321-348-5827

NEW PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** _____/_____/_____

Home Phone#: _____ **Cell Phone#:** _____

Please circle one: **Leave a detailed message** **OR** **Leave a call back number**

How did you hear about us? _____

Street Address: _____

City: _____ **State:**_____ **Zip Code:**_____

E-Mail Address: _____

This will only be used for correspondence regarding your health records, insurance, and general office information.

I hereby acknowledge that I have read or received a copy of the patient Notice of Privacy Practices.
Patient Signature: _____
(Parent or Guardian if the patient is under age 18)

Insurance Information:

***Primary Insurance*:** _____ **Circle One - HMO or PPO**

Policy/Member ID #: _____ **Group #:**_____

Policy Holder (Subscriber's Name): _____

Policy Holder DOB: _____/_____/_____ **Relation:** _____

Secondary Insurance: _____ **Circle One - HMO or PPO**

Policy/Member ID #: _____ **Group #:**_____

Policy Holder (Subscriber's Name): _____

Consent For Disclosure To Family Member And/ OR Personal Representative (emergency contact):

I agree that PremierMED| Family & Sport Medicine may disclose my medical information to me and the following individuals(s) in the event I am not physically present, including disclosures by telephone, voice mail, facsimile, e- mail or regular mail. I agree to let certain individual(s) participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for PremierMED| Family & Sport Medicine and or staff to disclose my personal medical information to the following individual(s):

Name: _____ **Relationship:** _____ **Phone #:** _____

Name: _____ **Relationship:** _____ **Phone #:** _____
(Parent or Guardian list yourself or other adults authorized

Patient Signature: _____ **Date:** _____/_____/_____
(Parent or Guardian if the patient is under 18 years old)

I understand that this consent may be revoked by me at any time by written notice to PremierMED| Family & Sports Medicine.

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NEW PATIENT HEALTH HISTORY INTAKE FORM

Name: _____ **Date of Birth:** _____

Allergies: (What happens?)

_____

_____

Medications: (Name, dose, instructions)

_____

_____

_____

_____

Preferred Pharmacy: (Name, location, zip code)

_____

_____

Family History: (Major Medical Conditions)

Your Mom:_____

Grandparents: Moms Mom_____ Moms Dad: _____

Your Dad:_____

Grandparents: Dads Mom: _____ Dads Dad: _____

Personal Medical History: What medical conditions have you been diagnosed with?

_____

_____

_____

Social History:

Do you smoke? YES NO Ever been a smoker? YES NO

How many per day? _____ For how many years did you smoke? _____

Do you drink any alcohol: YES NO (Never) BEER, WINE, or LIQUOR (Circle all that apply)

How drinks per week? _____

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Surgical History: What major surgeries have you had?

_____

_____

_____

Do you see any Specialists? (Name and Specialty)

_____

_____

_____

Have you had a **Colonoscopy**? YES NO What year? Where? Name of doctor?

_____

_____

When was your last **Annual Physical Exam** performed by a Primary Care Physician? Who?

_____

_____