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?

_____

_____

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****NO CD MEDICAL RECORDS****

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **DOB**: _____/_____/_____

Phone: _____ **Email:** _____

I authorize PremierMED Family & Sports Medicine to obtain from the following:

☐ **Progress Notes** ☐ **Radiology Reports** ☐ **Pathology Reports**

Dates: _____**to**_____ ☐ **All Diagnostic Results** ☐ **All Medical Records**

Please release my health information from the following providers/facilities:

Name: _____ **Name:** _____

Address: _____ **Address:** _____

_____ _____

Phone: _____ **Phone:** _____

Fax: _____ **Fax:** _____

The information may be used for the following purposes:

☐ **Continued Treatment** ☐ **Insurance** ☐ **Personal use**

☐ **Disability** ☐ **Legal** ☐ **Other:** _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by Federal Privacy Laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. This consent form maybe revoked in writing and otherwise expires five years from the date listed below.

Patient Signature: _____ **Date:** _____/_____/_____

**Note: If these records contain any information from previous providers, or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted diseases, you are hereby authorizing disclosure of this information.*

*****This form expires one year from the signed date*****