



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?** Google \_\_ Facebook \_\_ Friend \_\_ Other \_\_\_\_\_

**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):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

*I understand that my insurance is not a guarantee of payment and I am responsible for any remaining amount my insurance may not during any office visit. I am also responsible for updating my provider with my most recent insurance information.*

**Consent For Disclosure and Emergency Contact:**

*I agree that PremierMED| Family & Sport Medicine may disclose my medical information to me and the following individual(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:** \_\_\_\_/\_\_\_\_/\_\_\_\_

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



**NEW PATIENT HEALTH HISTORY INTAKE FORM**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Reason for visit:** What brings you in today? (Top 3 Medical concerns or problems to discuss today)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Medication or Food Allergies:** (What happens?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:** (Name, dose, instructions)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Preferred Pharmacy:** (Name, location, zip code)

\_\_\_\_\_

**Family History:** (Major Medical Conditions- Diabetes, Heart Disease, Cancer, etc.) (Please indicate if they are alive (A) or deceased (D))

Your Mom: \_\_\_\_\_

Grandparents: Moms Mom \_\_\_\_\_ Moms Dad: \_\_\_\_\_

Your Dad: \_\_\_\_\_

Grandparents: Dads Mom: \_\_\_\_\_ Dads Dad: \_\_\_\_\_

Siblings: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Do you see any Specialists?** (Name and Specialty, Inc. OBGYN, Dermatology, etc.)

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

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When was your last **Annual Physical Exam**? Who did you see?

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**Female:**

Last **Pap Smear**: When? \_\_\_\_\_ Doctor's Name? \_\_\_\_\_

Last **Mammogram**: When? \_\_\_\_\_ Imaging Center? \_\_\_\_\_

**Male:**

Have you had your **Prostate checked**? YES NO When was the last time? \_\_\_\_\_

**Social History:**

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

How many per day? \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_ Quit Date? \_\_\_\_\_

Do you drink any alcohol: YES NO (Never) BEER WINE LIQUOR

How drinks per week? \_\_\_\_\_

**Surgical History:** What surgeries have you had?

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PremierMED  
Family & Sports Medicine



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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\*\***