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? 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 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:** ____/____/____

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:** ____________________

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?

____

____

____

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

____

____

____

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

____

____

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

____

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/Vape? YES NO Ever been a Smoker/Vaper? YES NO

How many per day? ________ How many years did you Smoke/Vape? ________ 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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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*****