New Patient Intake Form

PATIENT INFORMATION

Name:_____Date of Birth:_____Social: _____

Address: _____

(Street) (City) (Postal Code)

Home Ph. #:_____Cell:_____Email: _____

Gender:_____Marital status:_____# of Children: _ Occupation: _____

Race: ☐ Asian ☐ African American ☐ Caucasian ☐ Other Ethnicity: ☐ Hispanic ☐ Not Hispanic

Language spoken: ☐ English ☐ Spanish ☐ Hebrew ☐ Other_____

How did you hear about us:

Friend ☐ Website ☐ Letter ☐ Postcard ☐ Flyer ☐ Facebook ☐ Google ☐ Instagram ☐ Newspaper ☐

Referral:_____ ☐ Event:_____ ☐ Other:_____ ☐

Emergency Contact:

Name:_____

Phone Number: _____ Relationship:_____

*Please give us at least two different phone numbers by which we can reach you in case of emergency

Preferred Pharmacy:_____**Phone:** _____

INSURANCE INFORMATION

Name of Insured (if Different) _____

Primary_____ID_____Group _____

Secondary_____ID_____Group _____

Employer:_____

Employer's Address: _____

My usual health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

MAIN HEALTH CONCERNS

Please list, in order of importance, your chief concerns:

1. _____ 3. _____

2. _____ 4. _____

New Patient Intake Form

PERSONAL HISTORY

Please tell us if you have the following conditions:

Cancer:	Kidney disease:
Neurological:	Arthritis:
Diabetes:	Allergies:
Heart disease:	Asthma/COPD:
High blood pressure:	Addictions:
Stroke:	Liver disease:
Thyroid disease:	Mental illness:
Other:	

PMH:

Surgical History: _____

Family History:_____

Allergies:_____

Tobacco? □ Yes □ No #cigarettes per day _____ Former Smoker? ____ Quit Date _____

Alcohol? □ never □ occasional □ often amount per day _____

Substance Abuse? □ Yes □No Substances used _____

GYNECOLOGICAL HISTORY:

□ Not applicable

pregnancies _____ #live births_____Date of Last Period _____

Menopause? □ Yes □ No

Immunizations: Have you had any of the following shots?

	Date of Last Shot
Pneumonia	
Influenza	
Hepatitis B	
Shingles	
Tetanus	
Others:	

New Patient Intake Form

Preventive Screenings: When was your last . . .

Type of labs	Date	Where
Pap Smear		
Mammogram		
Bone Density		
Colonoscopy		
Others:		

MEDICATION LIST

(Please print out clearly in capital letters)

Date	Medication	Dose	Qty	Frequency

New Patient Intake Form

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name (Print): _____

Date of Birth: _____

I authorize the following facility/ doctor

Facility Name: _____

Address: _____

_____

Phone (Must have): _____

Fax (Must have): _____

To release any and all information acquired in the course of my examination and/or treatment to Personal Physician Care, PA for the purpose of my future examinations and/or treatment. Please mail or fax to address below:

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

Personal Physician Care, PA 4800
Linton Blvd, Suite F-107 & F-101
Delray Beach, Fl 33445
Phone (561)498-5660 Fax (561)498-0753

Patient Signature:_____Date: _____

New Patient Intake Form

Consent For Treatment/ Authorization to Release Information

I (print your name), _____
voluntarily consent to the rendering of medical care. I understand that I am under the care and supervision of my attending physician and it is the responsibility of the staff to carry his/her instructions.

__ I authorize Personal Physician Care, PA to release any and all information acquired in the course of my examination and/or treatment for the purpose of insurance, ACO, worker's compensation, or Medicare benefit payment.

__I agree to comply with the 24 hour notice to cancel an appointment with the physician(s). If I do not notify the office of my cancellation before 24 hours period I will be charged $25.

__ I Guarantee payment of any and all bills rendered for said patient who are not covered or allowable by insurance. This office will file the bill to your insurance company provided you supply and proper and current information.

__ I am aware that it is my responsibility to notify the receptionist of any changes to my insurance coverage, before being seen by doctor or having blood work done. If I fail to notify the office prior to being seen or having blood work done, I will be responsible for all charges incurred.

Acknowledgement of Receipt of Notice of Privacy Practice

Personal Physician Care, PA reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of a Notice of Privacy Practices for Personal Physician Care, PA.

Patient Name: Date: _____

Patient signature: _____

Patient Representative: _____

Signature: _____

(Required if patient is minor or adult who is unable to sign this form)

New Patient Intake Form 2019

PREFERRED DISCLOSURE

To our patients,

In general, the HIPAA privacy gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to an address other than your home address.

The physician and staff of Personal Physician Care, PA, respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind, please indicate your preferences for the areas noted below:

I wish to be contacted in the following manner (check all that apply)

☐	Home telephone:		
	☐ Ok to leave message with detailed information		
	☐ Leave message with call-back number only		
☐	Work telephone:		
	☐ Ok to leave message with detailed information		
	☐ Leave message with call-back number only		
	I consent to receiving email and or text message communications regarding educational information related to my health condition(s) at the following locations: Email:_____ Mobile:_____		
	I consent to all photographs, videotapes, digital or other images that may be recorded for my documentation of care and/or educational and social events that I may attend.		
☐	Written communication		
	☐ Ok to mail to my home address		
	☐ Ok to mail to my work/office address		
	☐ Ok to fax to this number:		
☐	☐ Other individuals (family, friends, etc.) you may speak with about my care/treatment:		
	Name:	Relation:	Phone:

_____ _____

Patient Signature Date