NEW PATIENT PACKET

Patient Information

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr ☐ Other ☐ Male ☐ Female

Patient's Name (Last) ____________ (First) ____________ (Middle) ____________
Also Known as Name (Last) ____________ (First) ____________

☐ Married ☐ Widowed Social Security Number ____________

☐ Single ☐ Legally Separated Date of Birth ____________

☐ Divorced ☐ Other Email Address ____________

Phone Numbers
Home: ____________ ☐ Day ☐ Evening
Cellular: ____________ ☐ Day ☐ Evening
Work: ____________ ☐ Day ☐ Evening
Pager: ____________
May we contact you at work ☐ Yes ☐ No

Address: ____________

City, State, Zip (+4) ____________

Employment Status: ☐ Employed ☐ Self Employed ☐ Unemployed
☐ Full-Time Student ☐ Part Time Student ☐ Retired

Employer: ____________ Occupation: ____________

Emergency Contact Name: ____________ Phone Number: ____________
Relationship to patient: ____________

Responsible Party Information

Resp Party Name (Last) ____________ (First) ____________ (Middle) ____________
Also Known as Name (Last) ____________ (First) ____________

Social Security Number: ____________ ☐ Male ☐ Female DOB ____________

Email Address ____________

Phone Numbers Home: ____________ Work: ____________

Address: ____________

City, State, Zip (+4) ____________

Employment Status: ☐ Employed ☐ Self Employed ☐ Unemployed
☐ Full-Time Student ☐ Part Time Student ☐ Retired

Employer: ____________ Employer Phone Number: ____________

Patient Relationship to Responsible Party ____________

Primary Insurance Information

NEW PATIENT PACKET

Please Provide your Insurance Card to the Front Desk

Name of Insured ______________________________

Patient Relationship to Insured ______________________________

Insurance Company / Phone Number ______________________________ (   ) ______________

Subscriber ID (Policy Number) ______________________________ Group ID ______________

Effective Date ______________________________

Insured Date of Birth______________________________

Insurance Company Address ______________________________

Secondary Insurance Information Please provide your insurance card to the front desk

Name of Insured ______________________________

Patient Relationship to Insured ______________________________

Insurance Company / Phone Number ______________________________ (   ) ______________

Subscriber ID (Policy Number) ______________________________ Group ID ______________

Effective Date ______________________________

Insured Date of Birth______________________________

Insurance Company Address ______________________________

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge

Patient Signature: ______________________________ Date: ______________

NEW PATIENT PACKET

Patient Consent Form

Please Read and Sign

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary and advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures / tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgement of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Capital Regional Health may include consent at satellite offices under common ownership.

I, the undersigned, authorize Capital Regional Health Care physicians to use and disclose my information for the purpose of treatment, payment and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Capital Regional Health Care.

I acknowledge that I have been given the Capital Regional Health Care Notice of Privacy Practices.
I understand that if I have questions or complaints that I should contact the Privacy Official.
Patient Initial: ______

I certify that I have read and fully understand the above statements and consent fully and

voluntarily to its contents.

____ ____________________________

Patient (or Responsible Party) Signature **Date**

NEW PATIENT PACKET

PRESCRIPTION ORDER PICK-UP

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

______ (Patient/Representative Initials) I ***wish*** to designate the following individual to pick up a prescription order on my behalf:

Name: ____ Date: ____________

Name: ____ Date: ____________

______ (Patient/Representative Initials) I ***do not want to*** designate the anyone to pick up a prescription.

______________________________________ ______________________________________
Patient/Parent/Guardian/Patient Representative Signature **Date**

Patient/Parent/Guardian/Patient Representative Name (Printed) ______________________________

Patient Name (Printed):______________________________ **Date of Birth:** ____________________

Updated: December 20, 2016 replacing April22, 2016, October 28, 2015, June 12, 2015 & November 21, 2013 version
A photocopy of this consent shall be considered as valid as the original.

NEW PATIENT PACKET

Patient Medications

Today's Date ________________ Patient Name ________________________________ DOB ______________________

Insurance ____ Email ____________________________________

ALL NEW PATIENTS MUST HAVE PRIOR MEDICAL RECORDS

CRMG PROVIDERS DO NOT PRESCRIBE LONG TERM PAIN MEDS:

Medication refill requests made through your pharmacy will be addressed as soon as possible. Please allow a processing time of 3 days for your pharmacy to receive approval of your medications. In the event your pharmacy does not have your medications refilled after this period of time, please contact our office and we will be happy to assist you.

Please list ALL MEDICATIONS you are actually taking, including over the counter drugs, such as vitamins, aspirin, etc.

Medications	Dosage/Frequency	Refills (circle)
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N
		Y N

Pharmacy Name: ______________________________________ Location: ____________________________________

Phone: ____

Lab Results

Unless otherwise directed by your physician, you will be notified within 2 weeks of your results.
Any critical or abnormal results will be communicated to you immediately by your Provider team.

NEW PATIENT PACKET

MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it.
PLEASE PRINT AND COMPLETE ALL INFORMATION.

Please answer the following questions:	Y	N
Do you frequently have severe headaches?	☐	☐
(If yes, answer the following)	☐	☐
Do they cause visual trouble?	☐	☐
Do they occur on one side of the head?	☐	☐
Do they awaken you at night from sleep?	☐	☐
Do they feel like a tight hat band?	☐	☐
Do they hurt most in the back of the head and neck?	☐	☐
Does aspirin relieve them?	☐	☐

Have you recently had pain in the stomach which:	Y	N
Occurs 1-2 hours after a meal?	☐	☐
Is brought on by eating fried foods, gassy foods?	☐	☐
Awakens you at night?	☐	☐
Is relieved by antacid medications?	☐	☐
Is relieved with milk or eating?	☐	☐
Occurs while eating or immediately after?	☐	☐
Is relieved by a bowl movement?	☐	☐
Causes loss of appetite?	☐	☐

Have you ever fainted?	Y	N
Spells of dizziness?	☐	☐
Spells of weakness of an arm of leg?	☐	☐
Ringing of ears?	☐	☐
Have you ever had a convulsion?	☐	☐
Double Vision?	☐	☐
Pain in ear(s)?	☐	☐
Nosebleeds?	☐	☐

Do you frequently have:	Y	N
Bleeding Gums?	☐	☐
Trouble Swallowing?	☐	☐
Hoarseness?	☐	☐
A sore tongue?	☐	☐
Nausea and vomiting?	☐	☐

Have you ever had shortness of breath?	Y	N
During your usual work?	☐	☐
Climbing a flight of stairs?	☐	☐
Which awakens you at night?	☐	☐
Do you have a chronic cough?	☐	☐
Which causes you to cough?	☐	☐
Accompanied by wheezing?	☐	☐
Have you ever coughed blood?	☐	☐
Do you cough up much sputum?	☐	☐

Have you had:	Y	N	When/Since When
Burning with urination?	☐	☐	____________
Loss of control of bladder?	☐	☐	____________
Blood in the urine?	☐	☐	____________
Dark colored urine?	☐	☐	____________
Trouble starting to urinate?	☐	☐	____________
Trouble holding the urine?	☐	☐	____________
To get up frequently at night?	☐	☐	____________
Passed a kidney stone?	☐	☐	____________

Have you ever had pain or tightness in the chest which begins:

	Y	N
When exerting yourself?	☐	☐
When walking against a wind?	☐	☐
When walking up a hill?	☐	☐
After having a heavy meal?	☐	☐
When upset or excited?	☐	☐
Palpations?	☐	☐
Do you sleep on more than one pillow?	☐	☐
Radiates down the arm?	☐	☐
Disappears if you rest?	☐	☐
Occurs only at rest?	☐	☐
When walking fast?	☐	☐
When walking in cold weather?	☐	☐

If you have chest pain or tightness please explain: ______________________________

____

Have you recently had:	Y	N	When/Since When
Pain in your calves when walking?	☐	☐	____________
Craps in legs at night?	☐	☐	____________
Pain in the big toe?	☐	☐	____________
Varicose veins?	☐	☐	____________
Phlebitis or inflamed leg veins?	☐	☐	____________
Swelling in the ankles?	☐	☐	____________

If you've had a change bowl habit recently answer below:

	Y	N	When/Since When
Crampy pain in the abdomen?	☐	☐	____________
Alternating diarrhea and constipation?	☐	☐	____________
Pain during or after bowl movement?	☐	☐	____________
Mucous in the stool?	☐	☐	____________
Ribbon-like stools?	☐	☐	____________
Black stools?	☐	☐	____________
Require the use of strong laxatives	☐	☐	____________
Or enemas?	☐	☐	____________

Describe briefly your present medical symptoms and anything else we should know about your health below.

____

____

____

____

CAPITAL REGIONAL
MEDICAL GROUP

Capital Medical Blvd., Suite 200
Tallahassee, FL 32308
850.878.8235

NEW PATIENT PACKET – MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it.
PLEASE PRINT AND COMPLETE ALL INFORMATION.

Last Name	First	Middle	Today's Date
Birth Date	Male ☐ Female ☐	Marital Status	Occupation
Home Phone	Daytime Phone	Preferred Number	
Last physical Examination	By Doctor	Phone	

What are your present medical symptoms?

FAMILY HISTORY	Living Age	Living HEALTH Good Fair Poor	Deceased Death Age	Deceased Death Cause	ANY BLOOD RELATIVES WHO HAVE/HAD ANY OF THE LISTED CONDITONS	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Father					Asthma				Hay Fever			
Mother					Arthritis				Insanity			
Brothers Sisters					Allergies				Kidney Disease			
1. M F					Anemia				Leukemia			
2. M F					Alcoholism				Migraine			
3. M F					Bleeding Tend.				Nervous Break 'n			
4. M F					Cancer				Obesity			
5. M F					Colitis				Rheumatism			
Sons Daughters Circle Sex					Congenital Heart				Rheumatic Fever			
1. M F					Diabetes				Stroke			
2. M F					Epilepsy				Suicide			
3. M F					Goiter				Stomach Ulcers			
4. M F					High Blood Pressure				Tuberculosis			
5. M F					Heart Disease							

HABITS

DO YOU	Y	N	DAILY CONSUMPTION
SMOKE	☐	☐	______ PKGS
DRINKI COFFEE	☐	☐	______ CUPS
DRINK ALCOHOL	☐	☐	______ OZ
DRINK BEER	☐	☐	______ OZ
FALL ASLEEP EASILY	☐	☐	
AWAKEN EARLY	☐	☐	

MEDICATIONS (✔ IF TAKEN)

Antacids ☐	Blood Thinning Pills ☐	Insulin, Diabetic Pills ☐	Thyroid Med ☐
Antibiotics ☐	Cortisone ☐	Iron/Poor Blood Med ☐	Tranquilizers ☐
Aspirin, Bufferin, Anacin ☐	Cough Medicine ☐	Laxatives ☐	Vitamins ☐
Barbiturates ☐	Digitalis ☐	Phenobarbital ☐	Water Pills ☐
Birth Control Pills ☐	Dilantin ☐	Shots ☐	Weight Reduc. Pills ☐
Blood Pressure Pills ☐	Hormones ☐	Sleeping Pills ☐	Other ______

Operations you have had: Year
______
______
______

Diseases that required hospitalization: Year
______
______
______
______

Serious Illness – no hospitalization req: Year
______
______
______
______

Drugs you are allergic to:
______
______
______

Describe any serious injuries or accidents you have had:
______
______
______

WOMEN ONLY

	Y	N	
Are you still having regular monthly periods?	☐	☐	
Have you ever had bleeding between your periods?	☐	☐	When?______
Do you have very heavy bleeding with you periods?	☐	☐	When?______
Do you feel bloated and irritable before your period?	☐	☐	
Are you now on or have you ever taken birth control pills?	☐	☐	When?______
Have you ever had a miscarriage?	☐	☐	When?______
Have you ever had discharge from the nipple of your breast?	☐	☐	When?______
Do you regularly have the cancer test of the cervix?	☐	☐	

If yes, Date of Last Test ______

How many children born alive?______
How many stillbirths?______
How many premature births?______

How many miscarriages?______
How many cesarean operations?______
Any Complication of pregnancy? (explain)______
______

MEN ONLY

HAVE YOU EVER HAD:	Y	N
	☐	☐
Loss of sexual activity?	☐	☐
If yes, for how long?______		
Treatment for genitals?	☐	☐
(private parts)	☐	☐
Discharge from penis?	☐	☐
Hernia (rupture)?	☐	☐
Prostate Trouble?	☐	☐

MEDICAL RECORDS RELEASE

Section A; This section must be completed for all Authorizations

Patient Name: | **Birth Date:** | **Social Security No. (optional):**

Provider's Name: | **Recipient's Name:**

Provider's address | **Address 1:**

FAX: **PHONE#**

City: **State:** **Zip**

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐All PHI in medical record		☐Operative Information		☐Labor/delivery sum.	
☐Admission form		☐Cath Lab		☐OB Nursing assess	
☐Dictation reports		☐Special test/therapy		☐Postpartum flow sheet	
☐Physician orders		☐Rhythm Strips		☐Itemized Bill	
☐Intake/outtake		☐Nursing Information		☐UB-92	
☐Clinical Test		☐Transfer Forms		☐Other:	
☐Medication Sheets		☐ER Information		☐Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, IIIV testing, HIV results or AIDS information. ___________________ (Initial)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy the information described on this form. for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If Yes, Describe:

Section C; Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative: | Date: