ACCIDENT PATIENT'S MEDICAL HISTORY

Date: ________ Name ____ Male ____Female ____DOB ____/____/_____

Marital Status ______ Race________ Weight ________ Height ______

Ethnicity (circle one): White-Caucasian African-American Asian Korean Hispanic Other_________

Primary Language Spoken_________________ Patient's Social Security # _________________________

Address____ City__________________________ ST_______

ZIP__________ Home # __________________ Cell # ________________Emergency Contact #_______________________

Email Address____

Preferred Pharmacy ______________________________Pharmacy Location ______________________

Medical History: Please check if you have / had any of the following. Give date of ailment. Advise any ailments afflicting biological parents.

	Self	Mom / Dad				Self	Mom / Dad	
Heart Attack					Migraine			
Heart Disease					Diabetes (Type 1 or Type 2)			
Atrial fibrillation					Asthma			
COPD					Arthritis			
High Blood Pressure					Cancer - What kind ?			
Gastroesophageal Reflux Disease					Other ____________________			
Splenectomy					Other ____________________			

List **ALL MEDICATIONS** you are currently taking, including prescription & over the counter. INCLUDE ASPIRIN, MOTRIN, IBUPROFEN & VITAMINS.

Drug	Dosage (if known)		Drug	Dosage (if known)

List **ALLERGIES TO MEDICATIONS** ____ **REACTIONS TO MEDICATIONS** ________________

List **ALLERGIES TO ENVIRONMENTAL FACTOR** ________________________________ **REACTIONS** ________________________

ALLERGIC TO LATEX _______ **ALLERGIC TO TAPE** _________ **ALLERGIC TO IODINE**_________ **DO YOU SMOKE?** _____ **DRINK ALCOHOL?** _____

List **ALL SURGERIES**____

Type of Accident: Work injury ____ Auto accident while working ____

Date of Accident: __________________ Time of Accident ______ A.M./P.M.

Describe accident in detail: ____

____

Location of Injury/Pain: ____

Did you lose consciousness? _____Yes _____No Were you treated at a hospital? ______ Yes _____ No

If you were treated at a hospital, which one? ____

Who is your employer?____

What are your normal job duties?____

If you were in an auto accident, in which state did it occur? _____Florida _____ Other State ___________________

Were you the: _____ Driver ______Front passenger______ Rear passenger

Wearing a seat belt? Yes / No Airbag deployed? Yes / No

I, the undersigned, certify that I have answered the above questions truthfully to the best of my abilities.

____

Patient's Signature **Date**

North Florida Medical Group

AUTHORIZATIONS AND ASSIGNMENT OF BENEFITS

I authorize my insurance company, attorney or any third party payor to pay directly to North Florida Medical Group and its subsidiaries, Coastal Urgent Care, Plastic Surgery Institute and Spa, and Coastal Surgical Associates all charges submitted for services rendered to me by staff members of the above listed clinics. I understand that I will be responsible for any and all charges not paid by my insurance company. Should my account become delinquent, I understand that it may be turned over to a collection agency, and additional fees and interest may be added. I authorize North Florida Medical Group to release all information necessary concerning my medical condition to my insurance carrier or attorney for the purpose of processing a claim. I further authorize the use of this signature on all insurance submissions. This authorization and assignment of benefits will remain valid until I notify North Florida Medical Group in writing of its cancellation. A photocopy of this authorization shall be as valid as the original.

I authorize electronic prescription history to be downloaded from other sources, as available.

I understand that there may be times that NFMG may need to refer me to another physician/provider for further medical care. I authorize NFMG to release the medical records and/or information needed in order to facilitate any referrals.

I give my permission for NFMG to leave a message for me on my phone:	YES	NO
I give my permission for NFMG to contact me by e-mail:	YES	NO

If yes, what is your e-mail address? ______________________________

I give my permission for NFMG to discuss my medical care, appointments, financial information regarding my account, and any other issues related to my care with the following person(s):

NAME:______________________________ Relationship to me______________

NAME: ______________________________ Relationship to me______________

I also acknowledge that I was given the HIPAA Notice Of Privacy Policy to read and I understand that if I want a copy, one will be provided to me. I also understand that this authorization will remain in effect unless terminated in writing by me.

Patient's Printed Name______________________________

______________________________ ______________________________

Signature Date

Relationship if signer is not the patient: ______________________________