

NEW PATIENT'S MEDICAL HISTORY

Date: _____ Name: _____ Male _____ Female _____ DOB: _____

Marital Status: _____ Race: _____ Ethnicity(circle one): Caucasian African-American Asian Korean Hispanic Other _____

Primary Language Spoken: _____ Patient's Social Security Number: _____

Address: _____ City: _____ ST: _____ Zip: _____

Cell #: _____ Home #: _____ Work #: _____

Emergency Contact: _____ Phone #: _____

Parent/Guardian (if minor) _____ Phone #: _____

E-mail: _____ Primary MD: _____

Preferred Pharmacy: _____ Pharmacy Location: _____

Detailed Reason for Visit Today: _____ Weight: _____ Height: _____

Medical History:

	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				Pregnancy/Breast Feeding			
Anxiety/Depression				Other _____			

Medications: List all medications you are currently taking, including prescription and over the counter, and the dosage. Include Aspirin, Motrin, Tylenol, & Vitamins.

Drug	Dosage		Drug	Dosage

Allergies to Medications: _____ Reactions to Medications: _____

Do you currently take(circle one): **COUMADIN / PLAVIX / ASPIRIN** If so, MD that is monitoring: _____

ALLERGIC TO LATEX: Yes/No ALLERGIC TO TAPE: Yes/No ALLERGIC TO IODINE: Yes/No

Surgical History:

Surgery	Date		Surgery	Date

Social History:

Do you smoke?		Do you drink alcohol?	
How often?		How often?	

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

Responsible Party Signature

Date

Coastal Urgent Care

Insurance Information Sheet for Tricare Prime Patients

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

TRICARE INFORMATION

Sponsor's Name: _____ Sponsor's DOB: _____

Sponsor's SSN: _____ Relationship to Sponsor: _____

Sponsor's Address (*if different*): _____

City, State & Zip: _____ Sponsor's Phone Number: _____

Tricare Authorization Number (*if active duty sponsor*): _____

SECONDARY INSURANCE INFORMATION (*IF APPLICABLE*)

Name of Insurance Company: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's SSN: _____ Relationship to Subscriber: _____

Subscriber's Address (*if different*): _____

City, State & Zip: _____ Subscriber's Phone Number: _____

Thank you for allowing the Providers and staff of Coastal Urgent Care to attend to your medical needs.
We will send copies of the notes from today's visit to your Primary Care Manager.

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 and Plastic Surgery Institute and Spa 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 for the purpose of processing a claim. I further authorize the use of this signature on all insurance submissions. I authorize NFMG to release the medical records and/or information needed in order to facilitate any referrals and/or further medical care. 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 prescription history to be downloaded from other sources. YES NO
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 request a patient portal web account to be created and a welcome email to be generated to the email provided above. YES NO

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 Name: _____ Patient's Date of Birth: ____/____/____

Signature: _____ Date: ____/____/____

Relationship to patient: _____