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					**Currently Pregnant/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**

Patient Insurance Information

Patient's Name_____ **Today's Date**_____

Patient's Social Security #_____ **Patient's DOB** _____

1) **Primary Insurance**

Name of Insurance Company_____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's Social Security #_____

Is the subscriber's address the same as yours? _____ Yes _____ No

If not, please print subscriber's address:

_____

2) **Secondary Insurance**

Name of Insurance Company_____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's Social Security #_____

Is the subscriber's address the same as yours? _____ Yes _____ No

If not, please print subscriber's address:

_____

3) **Tertiary (third) Insurance**

Name of Insurance Company_____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's Social Security #_____

Is the subscriber's address the same as yours? _____ Yes _____ No

If not, please print subscriber's address:

_____

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: _____