PATIENT INFORMATION SHEET

Please print clearly

TODAY'S DATE_______________

PATIENT NAME:_______________________________

ADDRESS _______________________________

CITY_______________________STATE_____ZIP__________

HOME #:__________________ CELL #:__________________

WORK #:__________________OTHER#:__________________

SEX: M F SINGLE___ MARRIED___ DIVORCED___ WIDOWED___

DATE OF BIRTH: ________________ SS# ________________

DRIVERS LICENSE#_______________________________

STUDENT: Full-time___ Part-time___ ; EMPLOYED: Full-time___ Part-time___

RACE: White__ African-American__ Hispanic__ Other ________Language:________

*Email for Patient Portal access:_______________________________

EMPLOYER:_______________________________

WORK ADDRESS_______________________________

CITY _______________________STATE______ ZIP__________

EMERGENCY CONTACT_______________________________

PHONE #__________________ **RELATIONSHIP**__________________

Local Pharmacy __________________ Phone __________________

Address _______________________________

Mail Order Pharmacy _______________________________

PRIMARY INSURANCE NAME: _______________________________

POLICY #____________________GROUP#__________________

CLAIMS ADDRESS_______________________________

CITY_______________________ STATE_____ZIP__________

PHONE#:____________________

NAME OF INSURED____________________ **SEX: M F**

INSURED'S SS#: ________________ INSURED'S DOB:__________

INSURED'S EMPLOYER:_______________________________

RELATIONSHIP TO PATIENT:_______________________________

HOW DID YOU HEAR ABOUT US? _______________________________

PREFERRED FORM OF CONTACT: _______________________________

IS THIS AN INJURY THAT OCCURRED ON YOUR JOB OR AT YOUR WORKPLACE:

YES______NO______ DATE OF INJURY:__________________

COMPANY NAME __________________ PHONE # __________________

WHO AUTHORIZED YOUR VISIT TODAY:_______________________________

PLEASE LET RECEPTIONIST KNOW THAT THIS VISIT IS DUE TO A WORK RELATED INJURY

My signature below will serve as a legal and binding authorization for the release of any/all of my current and/or past medical records, including psychiatric, HIV and STD records, to Hunt Club Medical Care (HCMC) upon their request.

I also grant permission for HCMC and its associates to render care that may deem appropriate in my treatment and diagnosis. I understand that to receive care I must sign this authorized consent for treatment, failure to do so may result in our right to refuse treatment.

I have read the notice of privacy practices. I understand that by my acknowledgement of the terms indicated I am consenting to the sharing of my PHI (Personal Health Information) for the purpose of treatment, payment and operation. I understand that HCMC may release my PHI via mail, telephone, email, electronic medical records and/or facsimile.

I hereby assign my health plan or other applicable insurance benefits for medical treatment for myself to HCMC.

I understand that I am responsible for compliance with the standards and regulations set forth by my insurance carrier. I understand that I am ultimately responsible for any/all cost associated with any services provided to me by HCMC.

I understand that I retain the right to revoke these consents with written notice at any time. If this or any of these consent(s) are revoked at will by the patient, HCMC reserves the right to refuse further treatment to the said patient, effective immediately upon receipt of revocation.

I understand and consent to hospitalists for inpatient care and external prescription verification.

X_______________________________
PATIENT/GUARDIAN SIGNATURE

____
WITNESS SIGNATURE DATE

OTHERS WHO CAN ACCESS YOUR RECORDS

I authorize that my medical records and any information contained within may be shared with the following individual(s):

____
Person allowed to receive information Relationship

____
Person allowed to receive information Relationship

Advanced directive: All adults in a health care setting in the state of Florida have the right to an "advanced directive". This is a written or oral statement made and witnessed in advance of a serious illness or injury, stating how medical decisions will be made. It enables you to state your choice or name someone to make your choices for you, should you become unable to do so.

Do you have an advanced directive/living will?

Yes______ No_____

Please bring a copy of your Living Will for your chart.

*****PLEASE PROVIDE THE RECEPTIONIST YOUR MOST CURRENT INSURANCE AND DRIVERS LICENSE CARDS FOR THE PURPOSE OF COPYING*****

THANK YOU!