



**PATIENT
INFORMATION PACKET**

Patient Name: (last, first, Int) _____

D.O.B.: _____ Male Female Marital Status: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____

Place of Employment: _____ Occupation: _____

Insurance Information

Insurance Name: _____

ID #: _____ Group #: _____

Insurance Address: _____

Insurance Phone: _____

If this is not your policy, please provide policy holders information below.

Name: _____ D.O.B. _____

Employer: _____

Address: _____

Emergency Contact Information

Name: _____

Name: _____

Relationship: _____

Relationship: _____

Home Phone: _____

Home Phone: _____

Work Phone: _____

Work Phone: _____

Cell: _____

Cell: _____

Do you have a living will, advanced directive or durable power of attorney for health care? Yes No

Patient Signature

Date

What is your present medical complaint?

Social History

Tobacco Use: No Yes
Number of cigarettes a day _____

Drug Use: No Yes
Please explain: _____

Alcohol Use: No Yes
Number of drinks a day _____

Family History

Children (List Age, Gender, State of Health) _____

Age and Health (If deceased, age and cause of death)

Mother _____

Father _____

Sister _____

Brother _____

Allergies

Food (Shell Fish): _____

History of Asthma (Hay Fever): _____

Medicine (Aspirin): _____

No Known Allergies: _____

Medications and Supplements

Please list name, dosage, brand and directions:

Past History - Operations/Hospitalizations

Year	Hospital	Type of Surgery	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



**Consent for Purposes
of Treatment, Payment and
Healthcare Operations**

Name of Patient/Representative

Signature of Patient/Representative

Date



**Communication
with Friends, Family, or Others
Involved in Your Care**

I acknowledge and agree that the Practice [] may disclose my protected information and medical record information to the following individuals who are my family members, legal representative, guardians, healthcare surrogate, or power of attorney on my behalf.

Name	Relationship	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I agree and consent to the practice releasing information to me in the following alternative manner. (Initial the appropriate spaces below)

_____ Via regular mail with any envelopes being marked personal and confidential and addressed to me.

_____ Via telephone, if I contact the practice [] and provide the appropriate information (including my name, social security number and unique personal identifier).

_____ Via fax to my designated fax number, which is: _____

At all times you retain the right to revoke this consent. Such revocation must be submitted to the practice [] in writing. The revocation shall be effective except to the extent that the practice [] has already taken action based on the prior consent.

Name of Patient/Representative

Signature of Patient/Representative

Date

Please list all the PREVIOUS Physicians below.

Make sure to include the Physician name, address, and telephone and fax number:

Name	Address	Telephone	Fax Number

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer’s disease), they are considered incapacitated. To make sure that an incapacitated person’s decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death.

An Advanced Directive is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Patient Name

Date of Birth

In order to care for you, it is important that we know if you have addressed any medical concerns with an advanced medical directive. Do you have any of the following:

1. A Living Will Yes No
2. A Health Care Surrogate Yes No
3. Do not Resuscitate Yes No
4. Power of Attorney Yes No

Would you be interested in information in regard to addressing an Advance Directive?

Information given: _____

Date: _____

Please obtain copies of Advance Directives for patient’s chart.

If patient does not wish to discuss or obtain information on Advance Directives at this time, please have him/her sign and date here:

Patient Signature

Date



**Authorization for Review/
Release of Protected Health
Information (Medical Records)**

I, _____ hereby authorize
PATIENT/LEGAL REPRESENTATIVE

- Allow Review (open and closed records)
- Release Copies of the medical record of _____
PATIENT

To/From _____
Name of Individual, Health Facility, Or Agency

Address / City / State _____ Phone / Fax Number _____

For the Purpose of: Continued Treatment Personal Records Other

Date of Service From: _____ To: _____

This authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration event or condition, the authorization will expire in one (1) year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization, Mental health, alcohol, drug, HIV and / or AIDS information is confidentiality protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/ testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information from the list to be released by placing my initials in the space provided. Furthermore, I understand that the disclosure of information from my records carries with the potential for an unauthorized re disclosure of my health information. I further that Metro Health of Orlando may not condition the provision of treatment, payment, and enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Place a Check by Each Item to be Released or Reviewed

- Complete Records All Diagnostic test results Pathology reports
- Therapy Records Consultation / Progress Note(s) Other (specify): _____
- Abstract Records Labs Only _____

In Addition, Place a Check by Each Specific Item: (if applicable)

- Mental Drug and/or Alcohol Genetic counseling HIV / AIDS Information

Patient/ Legal Representative or Legal Guardian _____

Date of Authorization _____ Date of Birth _____

Last four of Social Security number _____ Identification Shown _____

Please do not send me more than 20 pages. If over 20 please mail. Thank you!