



**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?**

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**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 \_\_\_\_\_

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**Family History**

**Children** (List Age, Gender, State of Health) \_\_\_\_\_

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**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:

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**Past History - Operations/Hospitalizations**

Year	Hospital	Type of Surgery	Physician
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**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!*