METRO HEALTH, INC.
Dedicated Primary Care for Seniors

PATIENT INFORMATION PACKET

MetroHealth of Conway
4711 Curry Ford Road
Suite C
Orlando, FL 32812
Phone: 407-259-4646
Fax: 407-259-4828

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 _____

Alcohol Use: ☐ No ☐ Yes
Number of drinks a day _____

Drug Use: ☐ No ☐ Yes
Please explain: _____

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

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Consent for Purposes of Treatment, Payment and Healthcare Operations

MetroHealth of Conway
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Phone: 407-259-4646
Fax: 407-259-4828

_____ I consent to the use or disclosure of my protected health information by **MetroHealth of Conway** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **MetroHealth of Conway.** I understand that diagnosis or treatment may be conditional upon my consent as evidenced by my signature on this document.

_____ I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out my treatment or health care operations of the practice. **MetroHealth of Conway** is not required to agree to the restrictions that I may request. However, if the physicians agree to a restriction that I request, the restriction is binding by **MetroHealth of Conway** and the physicians.

_____ I have the right to revoke this consent in writing at any time, except to the extent that by **MetroHealth of Conway** and the physicians have taken action in reliance on this consent. My protected health information means health information including my demographic information, collected from me and created or received by physician, another health care provider, a health plan, my employer, or a health care clearing house. This protected health information related to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

_____ I understand I have the right to review **MetroHealth of Conway** notice of privacy practices prior to signing this document. The notice of privacy practices has been provided to me. The notice of privacy practices described the type(s) of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or the performances of health care operations of **MetroHealth of Conway** . A copy of the privacy practice is in a binder in the waiting area. **MetroHealth of Conway** reserves the right to change the privacy practices that are described in the notice of privacy practices. I may obtain a copy of the privacy practices by calling the office and requesting a revised copy be sent in the mail or requesting for a copy at the time of my appointment.

_____ _____

Name of Patient/Representative Signature of Patient/Representative

_____

Date

METRO HEALTH, INC.
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Communication with Friends, Family, or Others Involved in Your Care

I acknowledge and agree that the Practice [**MetroHealth of Conway**] 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 [**MetroHealth of Conway**] 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 [**MetroHealth of Conway**] in writing. The revocation shall be effective except to the extent that the practice [**MetroHealth of Conway**] 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

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ADVANCE DIRECTIVE

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 _____

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

I, _____ hereby authorize **MetroHealth of Conway**
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 then 20 pages. If over 20 please mail. Thank you!