PATIENT INFOMATION FORM

Patient Last Name: _____ First Name_____

Date of Birth: _____/_____/_____ SSN _____

Home Phone #: _____ Cell Phone #: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Gender: Male / Female

Alternate Address: _____

City: _____ State _____ Zip Code: _____

E-mail: _____ Do you want web portal access? Yes No

Marital Status: Single/ Married/ Divorced/ Widow

Spouse Name: _____ Date of Birth: _____

In case of Emergency, contact: _____Phone #: _____

Relationship to patient: _____

How did you hear about us? (Please circle)

Yellow Book / Google / Google Maps / Friend / Family Member / Co-worker/ Drive-by /

Facebook / Post card / Referral from _____

What pharmacy do you use? : _____

Phone #: _____ Fax #: _____

REDI-MED 4550 Executive Dr. # 104 Naples, FL 34119

Tel: 239-566-1226 Fax: 239-566-2519

Patient's Name: _____ **DOB**: **_____** **Date**: _____

Describe what Problem Brings you To the Doctor: _____

_____

List All Your Medications (Including; Dosage, Frequency, and Non-Prescription medications you take.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medication Allergies:

_____ _____

_____ _____

Past Medical History: Please place a x make if you and or family have ever had any of the following:

Diabetes: self/family
Thyroid: self/family
Seizures: self/family
T/B: self/family
Cancer: self/family
Type of Cancer
_____
Other_____

Infertility: self/family
Anesthesia Problem: self/family
Heart Disease: self/family
Liver Function: self/family
Psychiatric Problem: self/family
High Blood Pressure: self/family
Lung Disease: self/family

Kidney Stones: self/family
Bleeding Problems: self/family
Bleeding Problems: self/family
Kidney Disease: self/family
Urine Infections: self/family

Past Surgical History:

1._____ Date: _____

2._____ Date: _____

3._____ Date: _____

Immunizations:

1. Last Tetanus: _____
2. Pneumonia Vaccine: _____
3. Flu shot: _____

Social History:

Single___ Married____ Divorced___ Widow___

Do you or have you ever:

Use tobacco_____ If yes, how much _____ If quit when _____

Notice of Privacy Practices

Your Rights
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however you may not inspect or copy the following records: psychotherapy notes, information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction to your protected health information. This means you may ask us not to use or disclose any part of your protected information for the purposes of treatment, payment or healthcare operations. You may also request that any of your protected health information not be disclosed to family members or friend who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction request and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request your physician to emend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the secretary of health and human services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint; **We will not retaliate against you for filing a complaint.**
This notice was published and becomes effective on/or before Dec 1st, 2013.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this notice of our privacy practices.

Print Name: _____ Signature: _____
Date: _____

ASSIGMENT AND RELEASE

I, the undersigned, certify that I or my dependent **have insurance coverage or I am a self –pay patient** and assign directly to Redi-Med Family Walk-In Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission

Responsible Party Signature: _____

Relationship: _____ Date: _____

Authorization of Information

I hereby authorize employees or other agents of Redi-Med Family Walk in Clinic to use or disclose my health information about me to the following persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ **Date**: _____

Consent for Treatment

The undersigned is presenting him/herself for medical services to Redi-Med Family Walk in Clinic and voluntarily consents to the rendering of such care, including diagnostic procedures, minor surgeries, and medical treatment.

Authorized Signature: _____ **Date:** _____