PRIMARY CARE PHYSICIANS OF FLORIDA

Welcome!

On behalf of the medical professionals and other staff members, we'd like to thank you for choosing Primary Care Physicians of Florida for your healthcare needs. Whether you're an existing patient or a new one, our goal is to provide you with the very best care in an environment focused on compassion and respect.

To make your experience with our healthcare organization even better, we offer the following convenient patient services at most office locations:

- **Free transportation**
- **Walk-ins welcome**
- **Saturday hours**
- **Late hours**
- **Valet parking (Aventura & West Pembroke Pines)**
- **Same day appointments**
- **Prescription home delivery**
- **In-house pharmacy**

For more information, or to schedule another appointment, please call: **954.983.9191** or visit us online at: **pcpfla.com**

13 CONVENIENT OFFICE LOCATIONS

Central Hollywood / Main Office
TAFT MEDICAL PLAZA
6517 Taft Street, Suite 101, Hollywood, FL 33024

Aventura 21000 NE 28th Ave, Ste 100 Aventura, FL 33180
Coral Springs 8880 Royal Palm Blvd, Ste 105 Coral Springs, FL 33065
Davie 10650 W SR. 84, Ste 104, Davie, FL 33324
East Hollywood 3700 Washington St, Ste 203 Hollywood, FL 33021
Lauderdale Lakes 3001NW 49th Ave, Ste 100 Lauderdale Lakes, FL 33313
Margate 612 S SR 7 Margate, FL 33068
Pembroke Pines 2488 N University Dr Pembroke Pines, FL 33024
Plantation 8251 W Broward Blvd, Ste 102 Plantation, FL 33324
Pompano Beach 2701 E Atlantic Blvd, 1st Floor Pompano Beach, FL 33062
Sunrise 2057 N University Dr. Sunrise, FL 33322
West Palm Beach 100 Century Blvd, Ste 200 West Palm Beach, FL 33417
West Pembroke Pines 601 N. Flamingo Rd, Ste 104 Pembroke Pines, FL 33028

PATIENT INFORMATION SHEET

FIRST NAME_____**MIDDLE** _____

LAST NAME_____**DATE OF BIRTH**_____/_____/_____

PERMANENT ADDRESS_____**CITY** _____

STATE_____**ZIP**_____**EMAIL** _____

SOCIAL SECURITY_____**CELL PHONE** _____

HOME PHONE_____**WORK PHONE** _____

HOW DO YOU WISH US TO CONTACT YOU? _____

SEX_____**ETHNICITY:**_____**RACE:** _____

PREFERRED LANGUAGE_____**MARITAL STATUS** _____

PRIMARY PHYSICIAN _____

OCCUPATION_____**EMPLOYER** _____

EMERGENCY CONTACT (2 person, you authorize us to contact regarding your health information)

Name_____ **Relationship**_____

Cell Phone _____ **Work Phone** _____

Name_____ **Relationship**_____

Cell Phone _____ **Work Phone** _____

INSURANCE INFORMATION **Please provide proof of insurance to the Receptionist**

Insurance Company_____**Insured Date of Birth** _____

Insurance/Card Holder's Name_____**Relationship** _____

ID #_____**Group #**_____**Phone** _____

Second Insurance Company_____**Insured Date of Birth** _____

Insurance/Card Holder's Name_____**Relationship** _____

ID #_____**Group #**_____**Phone** _____

CONSENT FOR TREATMENT

I,_____hereby authorize Primary Care Physicians of Florida, the attending physician, or the physician designated by him or her and other employees to examine and treat me. I also authorize such treatment and procedures as deemed necessary by the physician, including but not limited to the taking of X-Rays, medications, blood samples, urine samples and other treatments or procedures not listed.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made or implied to me as to the results that may be obtained by examination and treatment.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by Primary Care Physicians of Florida for purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of Primary Care Physicians of Florida including disclosing my protected health information with Primary Care Physicians of Florida's Business Associates. I consent to the marketing and sale of my protected health information in accordance with federal and state laws. I understand that diagnosis or treatment of me by Primary Care Physicians of Florida is conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information and for purposes of this document personal information. Protected health information includes my demographic information, collected from me and created, received or stored by my physician, another health care provider, a health plan, my employer. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have a right to review the Primary Care Physicians of Florida Notice of Privacy Practices prior to signing this document which is included in these documents. The Primary Care Physicians of Florida Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of use and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the activities of health care operations of Primary Care Physicians of Florida. The Notice of Privacy Practices can be provided at any of our locations, please ask the receptionist for a copy. This Notice of Privacy Practices also describes my rights and the duties of Primary Care Physicians of Florida with respect to my protected health information. Primary Care Physicians of Florida reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by requesting in writing from Primary Care Physicians of Florida or asking for one at the time of my next appointment.

FINANCIAL RESPONSIBILITY

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Primary Care Physicians of Florida and for any charges not covered by healthcare benefits. Payments for services are due at the time services are rendered, unless a payment arrangement has been approved.

INITIALS _____

Primary Care Physicians of Florida accepts checks, cash and credit cards. It is my responsibility to notify Primary Care Physicians of Florida of any changes in my healthcare coverage. I am responsible for the entire bill or balance of the bill as determined by Primary Care Physicians of Florida and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payments in regards to medical services.

ASSIGNMENT OF BENEFITS

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Primary Care Physicians of Florida for all covered medical services during the course of treatment and care provide by Primary Care Physicians of Florida and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with Primary Care Physicians of Florida, which will authorize and all for direct payment to Primary Care Physicians of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services and/or care provided to me by Primary Care Physicians of Florida.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Primary Care Physicians of Florida and its employees are dedicated to maintaining the privacy of your personal health information ("PHI"), as required by applicable federal and state laws. These laws require us to provide you with this Notice of Privacy Practices, and to inform you of your rights and our obligations concerning Protected Health Information, or PHI, which is information that identifies you and that relates to your physical or mental health condition. We are required to follow the privacy practices described below while this Notice is in effect.

A. Permitted Disclosures of PHI. We may disclose your PHI for the following reasons:

1. **Treatment**. We may disclose your PHI to a physician or other health care provider providing treatment to you. For example, we may disclose medical information about you to physicians, nurses, technicians or personnel who are involved with the administration of your care.

2. **Payment**. We may disclose your PHI to bill and collect payment for the services we provide to you. For example, we may send a bill to you or to a third party payor for the rendering of services by us. The bill may contain information that identifies you, your diagnosis and procedures and supplies used. We may need to disclose this information to insurance companies to establish insurance eligibility benefits for you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.

3. **Health Care Operations**. We may disclose your PHI in connection with our health care operations. Health care operations include quality assessment activities, reviewing the competence or qualifications of health care professionals, evaluating provider performance, and other business operations. For example, we may use your PHI to evaluate the performance of the health care services you received. We may also provide your PHI to accountants, attorneys, consultants and others to make sure we comply with the laws that govern us.

4. **Emergency Treatment**. We may disclose your PHI if you require emergency treatment or are unable to communicate with us.

5. **Family and Friends**. We may disclose your PHI to a family member, friend or any other person who you identify as being involved with your care or payment for care, unless you object.

6. **Required by Law**. We may disclose your PHI for law enforcement purposes and as required by state or federal law. For example, the law may require us to report instances of abuse, neglect or domestic violence; to report certain injuries such as gunshot wounds; or to disclose PHI to assist law enforcement in locating a suspect, fugitive, material witness or missing person. We will inform you or your representative if we disclose your PHI because we believe you are a victim of abuse, neglect or domestic violence, unless we determine that informing you or your representative would place you at risk. In addition, we must provide PHI to comply with an order in a legal or administrative proceeding. Finally, we may be required to provide PHI in response to a subpoena discovery request or other lawful process, but only if efforts have been made, by us or the requesting party, to contact you about the request or to obtain an order to protect the requested PHI.

7. **Serious Threat to Health or Safety**. We may disclose your PHI if we believe it is necessary to avoid a serious threat to the health and safety of you or the public.

8. **Public Health**. We may disclose your PHI to public health or other authorities charged with preventing or controlling disease, injury or disability, or charged with collecting public health data.

9. **Health Oversight Activities**. We may disclose your PHI to a health oversight agency for activities authorized by law. These activities include audits; civil, administrative or criminal investigations or proceedings; inspections; licensure or disciplinary actions; or other activities necessary for oversight of the health care system, government programs and compliance with civil rights laws.

10. **Research**. We may disclose your PHI for certain research purposes, but only if we have protections and protocols in place to ensure the privacy of your PHI.

11. **Workers' Compensation**. We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs.

12. **Specialized Government Activities**. If you are active military or a veteran, we may disclose your PHI as required by military command authorities. We may also be required to disclose PHI to authorized federal officials for the conduct of intelligence or other national security activities.

13. **Organ Donation**. If you are an organ donor, or have not indicated that you do not wish to be a donor, we may disclose your PHI to organ procurement organizations to facilitate organ, eye or tissue donation and transplantation.

14. **Coroners, Medical Examiners, Funeral Directors**. We may disclose your PHI to coroners or medical examiners for the purposes of identifying a deceased person or determining the cause of death, and to funeral directors as necessary to carry out their duties.

15. **Disaster Relief**. Unless you object, we may disclose your PHI to a governmental agency or private entity

(such as FEMA or Red Cross) assisting with disaster relief efforts.

16. **Direct Contact with You**. We may use your PHI to contact you to remind you that you have an appointment, or to inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

B. Disclosures Requiring Written Authorization.

1. **Not Otherwise Permitted**. In any other situation not described in Section A above, we may not disclose your PHI without your written authorization.

2. **Psychotherapy Notes**. We must receive your written authorization to disclose psychotherapy notes, except for certain treatment, payment or health care operations activities.

3. **Marketing and Sale of PHI**. We must receive your written authorization for any disclosure of PHI for marketing purposes or for any disclosure which is a sale of PHI.

C. Your Rights.

1. **Right to Receive a Paper Copy of This Notice**. You have the right to receive a paper copy of this Notice upon request.

2. **Right to Access PHI**. You have the right to inspect and copy your PHI for as long as we maintain your medical record. You must make a written request for access to the Privacy Coordinator at the address listed at the end of this Notice. We may charge you a reasonable fee for the processing of your request and the copying of your medical record pursuant to Fla. Stat. 381.028 (7)(c). In certain circumstances we may deny your request to access your PHI, and you may request that we reconsider our denial. Depending on the reason for the denial, another licensed health care professional chosen by us may review your request and the denial

3. **Right to Request Restrictions**. You have the right to request a restriction on the use or disclosure of your PHI for the purpose of treatment, payment or health care operations, except for in the case of an emergency. You also have the right to request a restriction on the information we disclose to a family member or friend who is involved with your care or the payment of your care. However, we are not legally required to agree to such a restriction.

4. **Right to Restrict Disclosure for Services Paid by You in Full**. You have the right to restrict the disclosure of your PHI to a health plan if the PHI pertains to health care services for which you paid in full directly to us.

5. **Right to Request Amendment**. You have the right to request that we amend your PHI if you believe it is incorrect or incomplete, for as long as we maintain your medical record. We may deny your request to amend if (a) we did not create the PHI, (b) is not information that we maintain, (c) is not information that you are permitted to inspect or copy (such as psychotherapy notes), or (d) we determine that the PHI is accurate and complete.

6. **Right to an Accounting of Disclosures**. You have the right to request an accounting of disclosures of PHI made by us (other than those made for treatment, payment or health care operations purposes) during the 6 years prior to the date of your request. You must make a written request for an accounting, specifying the time

period for the accounting, to the Privacy Coordinator at the address listed at the end of this Notice.

7. **Right to Confidential Communications**. You have the right to request that we communicate with you about your PHI by certain means or at certain locations. For example, you may specify that we call you only at your home phone number, and not at your work number. You must make a written request, specifying how and where we may contact you, to the Privacy Coordinator at the address listed at the end of this Notice.

8. **Right to Notice of Breach**. You have the right to be notified if we or one of our business associates become aware of a breach of your unsecured PHI.

D. Changes to this Notice. We reserve the right to change this Notice at any time in accordance with applicable law. Prior to a substantial change to this Notice related to the uses or disclosures of your PHI, your rights or our duties, we will revise and distribute this Notice.

E. Acknowledgment of Receipt of Notice. We will ask you to sign an acknowledgment that you received this Notice.

F. Questions and Complaints. If you would like more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made regarding the use, disclosure, or access to you PHI, you may complain to us by contacting the Privacy Coordinator at the address and phone number at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

Privacy Officer: Audra Harding, 6517 Taft Street, #101, Hollywood FL 33024, 1-866-935-5186.

Continued on next page.

ACKNOWLEDGMENT OF RECEIPT
CONSENT OF TREATMENT, FINANCIAL POLICY, ASSIGNMENT OF BENEFIT AND NOTICE OF PRIVACY PRACTICE

I acknowledge that I have received a copy of Primary Care Physicians of Florida's Notice of Privacy Practices, which describes how Primary Care Physicians of Florida will use and protect my health information. This Notice describes my rights under the Health Insurance Portability and Accountability Act (HIPAA) and Primary Care Physicians of Florida's policies on use and disclosure of my protected health information.

I acknowledge that this form explains the consent I give Primary Care Physicians of Florida to render me treatment and healthcare services, Primary Care Physicians of Florida's financial policies, Primary Care Physicians of Florida's assignment of benefits and Primary Care Physicians of Florida's Notice of Privacy Practice. This acknowledgment shall be considered as effective and valid as the original on the date signed below.

_____ _____

Patient Name (Print) **Signature of Patient or Healthcare Surrogate (if applicable)**

_____ _____

Name of Healthcare Surrogate (if applicable) **Today's Date**

INITIALS _____

FINANCIAL INTEREST DISCLOSURE NOTICE TO PATIENTS

Please carefully review the information contained in this notice:

1. **Primary Care Physicians of Florida has an investment interest in, and is part owner of, Wound Care Management Specialists.**

2. **Wound Care Management Specialists is a medical facility for treating wounds that do not heal, located at 6495 Taft Street, Hollywood, FL 33024.**

3. **Among the alternative wound care centers you may consider for any wound care treatment, that Primary Care Physicians of Florida may order, recommend, request or establish in a plan of care are:**
   a. **Wound Technology Network in Hollywood, 3440 Hollywood Blvd., Hollywood, FL 33021.**
   b. **Wound Care at Memorial Hospital Pembroke, 7800 Sheridan Street, Pembroke Pines, FL 33024.**

4. **Primary Care Physicians of Florida has an investment interest in, and is part owner of, IFB Pharmacy.**

5. **IFB Pharmacy is a pharmacy located at 2488 North University Drive, Pembroke Pines, FL 33024.**

6. **Among the alternative pharmacy's you may consider for the dispensing of your medications, that Primary Care Physicians of Florida may order, recommend, request or establish in a plan of care are:**
   a. **CVS Pharmacy, 6665 Taft St., Hollywood, FL 33024.**
   b. **Walgreens Pharmacy, 6817 Taft St., Hollywood, FL 33024.**

7. **You, as the patient, have the right to obtain treatment or other medical services and items or services for which you may be referred to by any physician or practitioner of Primary Care Physicians of Florida at the location or from the provider, or supplier of your own choice, including Wound Care Management Specialists or IFB Pharmacy.**

8. **You will not be treated differently by any physician or practitioner of Primary Care Physicians of Florida if you choose to obtain treatment or other medical services and items of services at any other provider or supplier recommended by Primary Care Physicians of Florida.**

9. **By signing this Financial Interest Disclosure, you acknowledge that you have read and understand the foregoing notice and understand that Primary Care Physicians of Florida has an investment and ownership interest in the above-mentioned; and understand that you have a choice in location and provider, supplier or center where any medical services and items of services you may need will be performed; and you acknowledge that you have been aware of this right prior to making any choice of location or provider, supplier or center and prior to any referral by Primary Care Physicians of Florida to Wound Care Management Specialists and IFB Pharmacy.**

_____ _____

Patient Name or Healthcare Surrogate (Print) **Signature of Patient or Healthcare Surrogate**

INITIALS _____

Authorization (Permission) to Use or Disclose (Release) Protected Health Information (PHI) for Research by Primary Care Physicians of Florida

1. What is the purpose of this form?

This form is required by the Health Insurance Portability and Accountability Act of 1996. Specifically the privacy regulation (HIPAA) permits the research investigators listed above to use and disclose health information about you for the research study identified above which has been approved by the Solutions Institutional Review Board.

Primary Care Physicians of Florida in conjunction with Pines Clinical Research and Clinical Research of Hollywood would like to use your protected health information for research. The elements of protected health information as defined by HIPAA are:

Data Elements for Protected Health Information (PHI)

- Names
- All geographic subdivisions smaller than a state (except for the first 3 digits of the zip code in some cases)
- All elements of dates (except year) for dates directly related to an individual (e.g., birth date, admission date, discharge date, date of death) and all ages over age 89 and dates indicative of that age
- Telephone numbers
- Fax numbers
- E-mail addresses
- Social security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web Universal Resource Locators (URL)
- Internet Protocol (IP) addresses
- Biometric identifiers, including finger and voice prints
- Full face photos and any comparable images
- Any other unique identifying number, characteristic, or code

2. What protected health information do the researchers want to use?

The researchers want to copy and use the portions of your medical record that they will need for their research. If you enter a research study, medical information that will be used and/or released may include the following:

- the history and diagnosis of your disease;
- specific information about the treatments you received, including previous treatment(s) you may have had;

- information about other medical conditions that may affect your treatment;
- medical data, including laboratory test results, tumor measurements, CT scans, MRIs, x-rays, and pathology results;
- long-term information about your general health status and the status of your disease;
- data that may be related to tissue and/or blood samples that may be collected from you; and

You may request a blank copy of the data forms from the study doctor or his/her research staff to learn what information will be shared.

3. Why do the researchers want my protected health information?

The researchers will collect your protected health information and use it if you enter a research study.

4. Who will be able to use my protected health information?

The researchers will use your health information for research. As part of this research, they may give your information to the following groups taking part in the research. The researchers may also permit these groups to come in to review your original records that are kept so that they can monitor their research study.

5. How will information about me be kept private??

The researchers will keep all patient information private to the extent possible, even though the researchers are not required to follow the federal privacy laws. Only researchers working with the study will have access to your information. The researcher will not release personal health information about you to others except as authorized or required by law. However, once your information is given to other organizations that are not required to follow federal privacy laws, we cannot assure that the information will remain protected.

6. What happens if I do not sign this permission form?

If you do not sign this permission form, you will not be able to take part in the research study for which you are being considered.

7. If I sign this form, will I automatically be entered into the research study?

No, you cannot be entered into any research study without further discussion and separate consent. After discussion, you may decide to take part in the research study. At that time, you will be asked to sign a specific research consent form.

Treatment by your physician will not be affected by whether you provide authorization for the requested use or disclosure except if your treatment is related to research.

8. What happens if I want to withdraw my permission?

You can change your mind at any time and withdraw your permission to allow your protected health information to be used in the research. If this happens, you must withdraw your permission in writing. Beginning on the date you withdraw your permission, no new protected health information will be used for research. However, researchers may continue to use the protected health information that was provided before you withdrew your permission. If you sign this form and enter the research study, but later change your mind and withdraw your permission, you will be removed from the research study at that time.

To withdraw your permission, please contact the person below. She will make sure your written request to withdraw your permission is processed correctly.

Contact Name:	Rebecca Suarez, Compliance Officer
Contact Address:	6517 Taft Street Suite #101 Hollywood,FL 33024
Contact Phone and FAX:	Tel: 954-983-9191 & 1-866-935-5186 / Fax: 954-983-1152

9. How long will this permission last?

If you agree by signing this form that researchers can use your protected health information, this permission has no expiration date. However, as stated above, you can change your mind and withdraw your permission at any time.

10. What are my rights regarding access to my personal health information?

You have the right to refuse to sign this permission form. You have the right to review and/or copy records of your protected health information kept by the researcher. You do not have the right to review and/or copy records kept by the researchers associated with the research study.

****

Signatures

I agree that my protected health information may be used for the research purposes described in this form.

Patient Signature: _____ Date:_____

or Legal Representative:_____ Date: _____

Printed Name of Legal Representative (if any): _____

PRIMARY CARE PHYSICIANS OF FLORIDA

PATIENT HISTORY FORM

NAME_____**DATE OF SERVICE** _____

AGE_____**DATE OF BIRTH**_____**DATE OF LAST EXAM** _____

REASON FOR TODAYS VISIT _____

PREVIOUS OR REFERRING DOCTOR_____**MARITAL STATUS** _____

HOW DID YOU HEAR ABOUT OUR OFFICE_____**?**

Immunizations and dates: ☐ Tetanus: _____ ☐ TDAP:_____ ☐ Pneumonia: _____ ☐ Prevnar: _____
☐ Hepatitis A:_____ ☐ Hepatitis B:_____ ☐ Chickenpox:_____ ☐ Influenza:_____
☐ MMR:_____

Medical History:		
☐ Allergies	☐ Elevated Cholesterol	☐ Mumps
☐ Anemia	☐ Frequent infections	☐ Osteoporosis
☐ Arthritis	☐ Gallbladder disease	☐ Peripheral Vascular Disease
☐ Asplenia	☐ GERD	☐ Pneumonia
☐ Asthma	☐ GI disorders	☐ Polio
☐ Bowel irregularity	☐ Gout	☐ Pregnancy currently
☐ Bronchitis	☐ Headache	☐ Prostate Disease
☐ Cancer	☐ Heart Disease	☐ Renal dysfunction
☐ Chronic liver disease	☐ Heart murmur	☐ Rheumatic Fever
☐ Chronic rashes	☐ Heart palpitations	☐ Scarlett Fever
☐ Clotting disorder	☐ Hepatitis	☐ Sexually Transmitted Disease
☐ COPD	☐ HIV Infections	☐ Sickle Cell Disease
☐ Coronary Artery Disease	☐ Hypertension	☐ Stroke/TIA
☐ Depression	☐ Illicit drug use	☐ Tetanus
☐ Developmental Disability	☐ Immediately postpartum	☐ Thyroid Disorder
☐ Diabetes Mellitus	☐ Iron deficiency	☐ Ulcer
☐ Diet related illness (obesity)	☐ Lactose intolerance	☐ Other
☐ Diphtheria	☐ Measles	
☐ Dizziness/Fainting	☐ Menopausal or postmenopausal	

Surgeries:		
Year	*Reason*	*Hospital*
Other Hospitalizations:		
Year	*Reason*	*Hospital*

INITIALS _____

List your prescribed drugs and over-the-counter drugs, such as vitamins:		
Name of drug	*Strength*	*Frequency Taken*
Allergies:		
Name of drug	*Reaction you had*	

Family Health History:		☐ **Adopted/Unknown**
Relative	*Age*	*Significant Health Problems/Cause of death (if applicable)*
Father ☐Living ☐Deceased		
Mother ☐Living ☐Deceased		
Siblings	M ☐ F ☐	
	M ☐ F ☐	
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

Screening for Men & Women:		
Test	*Date*	*Result*
Colonoscopy		
Bone Density		
Rectal Exam		
Mammography		
Complete blood tests		
Test for blood in stool		
Pelvic and pap test (women only)		
Chest x-ray		
PSA		

Social History:		
Exercise	☐No Exercise ☐Mild exercise (i.e. climb stairs, walk 3 blocks) ☐Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 min) ☐Regular vigorous exercise (i.e. work or recreation 4x/week for 30 min)	
Caffeine	☐None ☐Coffee ☐Tea ☐Cola	
	# of cups/cans per day?	
Alcohol	Do you drink alcohol?	☐Yes ☐No
	If yes, what kind?	
	How many drinks per day?	
Tobacco	Do you use tobacco?	☐Yes ☐No

INITIALS _____

Tobacco cont.	☐ Cigarettes – _____ Pks./day	☐ Chew-#/day	☐ Pipe-#/day	☐ Cigars-#/day	
	☐ # of years _____		☐ Or year quit _____		
Drugs	Do you want to discuss any drug use with your provider?				☐ Yes ☐ No
Sexual History/ Misc.	Are you sexually active?				☐ Yes ☐ No
	Do you live alone?				☐ Yes ☐ No
	Do you have a glasses?				☐ Yes ☐ No
Personal	Do you have hearing aids?				☐ Yes ☐ No
	Do you have an advance directive and/or living will?				☐ Yes ☐ No
	If No, would you like to complete one at this time?				☐ Yes ☐ No
Safety	Would you like information on the preparation of these?				☐ Yes ☐ No
Misc cont.	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes ☐ No
	Highest Level of Education _____				
	Do you have any special religious or ethnic customs to disclose?_____				☐ Yes ☐ No
	Do you or have you needed help reading Health Ins. or Hospital Information?				☐ Yes ☐ No

Women Only:		
Age at onset of menstruation: Period every days		
Date of last menstruation:		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies: Number of live births:		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

Men Only:		
Do you often get up to urinate during the night?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No

HAVE YOU EVER HAD A BLOOD TRANSFUSION? _____

If yes, please state when _____

OCCUPATIONAL INJURIES (circle): STRESS / HAZARDOUS SUBSTANCES / HEAVY LIFTING
If other _____

INITIALS _____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

PATIENT NAME_____**DATE OF BIRTH** _____

I authorize Primary Care Physicians of Florida to share my protected health information with the following person:

_____ **Date of Birth** _____
Name of Person

_____ **Relationship** _____
Phone Number

_____ **Date of Birth** _____
Name of Person

_____ **Relationship** _____
Phone Number

_____ **Date of Birth** _____
Name of Person

_____ **Relationship** _____
Phone Number

The information allowed to be disclosed to these person includes (please check all areas that apply)

- ☐ All Medical Information
- ☐ Lab Results
- ☐ X-ray Results
- ☐ Medication (RX Renewal and Pickup)
- ☐ Telephone Consults
- ☐ Hospital Information
- ☐ Insurance Information
- ☐ Dialysis Clinic Information
- ☐ Appointment Information
- ☐ Other (please specify)

This authorization will be in effect until the authorization for any of these selections or persons is revoked.

Patient Signature_____**Date** _____

Witness _____

INITIALS _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME_____**DATE OF BIRTH** _____

ADDRESS _____

SOCIAL SECURITY # _____

I HEREBY AUTHORIZE AND REQUEST THAT _____
RELEASE COPIES OF MY MEDICAL RECORDS TO:

PRIMARY CARE PHYSICIANS OF FLORIDA
2488 N. UNIVERSITY DRIVE, PEMBROKE PINES, FL 33024
Phone: 954-983-9191 Fax: 954-983-1152

For the purposes of medical treatment, which shall include: entire record (including and excluding sensitive PHI), medication list, problem list, list of allergies, immunization records, most recent history & physical, laboratory results, x-ray and imaging reports, consultation reports, visits/encounters, other.

The facility named above is released from all legal liability that may arise from the release of the information requested, and is in compliance with HIPAA Privacy and Security Rules. This authorization is subject to revocation at any time, by written request, except to the extent that action has been taken into reliance thereon, and in any event this authorization expires without express revocation 90 days form the date that appears below.

Signature_____ **Date** _____

Witness
FLORIDA LAW REQUIRES A SPECIFIC AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION PERTAINING TO ALCOHOL, DRUG ABUSE, PSYCHIATRIC, HIV TESTING, SEXUALLY TRASMITTED DISEASES AND GENETIC DISEASES. IF ANY OF THESE STATEMENTS APPLY TO YOUR MEDICAL RECORDS PLEASE SIGN AND WITNESS. IF UNDER 18 YEARS OF AGE, PARENT OR GUARDIAN MUST SIGN.

I authorize the release of information concerning drug and alcohol abuse.

_____ _____
Signature **Date**

I authorize the release of information concerning Psychiatric/Psychological treatment.

_____ _____
Signature **Date**

I authorize the release of information concerning the diagnosis and treatment of HIV test results, AIDS diagnosis and treatment and/or other sexually transmitted diseases.

_____ _____
Signature **Date**

INITIALS _____

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I_____authorize Primary Care Physicians of Florida to view my external prescription history via electronic means including, but not limited to, our electronic medical records system, eClincialworks and RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ _____

Patient Name **Date of Birth**

_____ _____

Signature **Today's Date**

_____

Print Health Surrogate Name (if applicable)

INITIALS _____