Adult and Adolescent Health History

Doctor's Inlet Internal Medicine, Spine and Pain/Avenues Internal Medicine

Name:________________________________ Date of birth:__________ Today's Date__________
Reason for today's visit:_______________________________________
Current/Last Primary Care Provider:______________________________ Phone:________________
Fax:________________
Date of Last Routine Physical (Wellness visit):____________ Date of Last Colonoscopy:_________

Allergy information

Do you have any allergies to **medications**? Yes/No If yes, please list (ex: rash, trouble breathing, constipation, nausea or vomiting, ect):
Medication:______________________ Reaction:_________________
Medication:______________________ Reaction:_________________
Medication:______________________ Reaction:_________________
Medication:______________________ Reaction:_________________
Medication:______________________ Reaction:_________________

Do you have any **food or environmental allergies**? Yes/No If yes, please list:
Allergy:_________________________ Reaction:__________________
Allergy:_________________________ Reaction:__________________
Allergy:_________________________ Reaction:__________________
Allergy:_________________________ Reaction:__________________
Allergy:_________________________ Reaction:__________________

Previous Surgeries/Hospitalizations

Have you ever been hospitalized: Yes/No If yes, please list:
Date:____________ Reason for hospitalization:____________________
Date:____________ Reason for hospitalization:____________________
Date:____________ Reason for hospitalization:____________________
Date:____________ Reason for hospitalization:____________________
Date:____________ Reason for hospitalization:____________________

Have you ever had surgery? Yes/No If yes, please list:
Date:___________Surgery:____________________________________
Date:___________Surgery:____________________________________
Date:___________Surgery:____________________________________
Date:___________Surgery:____________________________________
Date:___________Surgery:____________________________________

Social History:

Smoking history (circle one): non-smoker, former smoker, current smoker
Tobacco use: Yes/No Type:_______________ Amount:__________________________
Alcohol use: Yes/No Type:_______________Amount:__________________________
Alcohol or Drug Problems: Yes/No type:_______________________ Last use:________
History of IV drug use: Yes/No Number of sexual partners in past 5 years: ______________________
Had sex for money: Yes/No Had sex with HIV risk person: Yes/No

Currently sexually active: Yes/No Sexual orientation:___________________
Exercise (20 min, 3 x a week): Yes/No Describe:___________________
Recent Weight Change: Yes/No Describe:___________________

Immunizations (please enter date received)
MMR:_______ Tetanus:_______ Flu:_______ Pneumonia:_______ Hep B:_______

Women only:
Using birth control: Yes/No Method:___________________
Date of Last PAP:_______ History of abnormal PAP: Yes/No
Date of Last mammogram:_______
Date of Last Bone Density Scan:_______

Personal Medical history
(This section is about you only)

Stroke	Yes/No	Detail:
High Blood pressure	Yes/No	Detail:
Heart Disease	Yes/No	Detail:
Diabetes	Yes/No	Detail:
Cancer	Yes/No	Type:
Congenital/Genetic Disorder	Yes/No	Detail:
Blood disorder/sickle cell anemia	Yes/No	Detail:
Lung/COPD/Asthma	Yes/No	Detail:
Headaches	Yes/No	Detail:
Neuro/Mental/Emotional Health	Yes/No	Detail:
Breast Disease	Yes/No	Detail:
Gall Bladder	Yes/No	Detail:
Liver/Hepatitis	Yes/No	Detail:
Kidney Problems	Yes/No	Detail:
GI problems (stomach/Intestines)	Yes/No	Detail:
Skin	Yes/No	Detail:
Skeletal (joint/spine problems)	Yes/No	Detail:
Thyroid disorder	Yes/No	Detail:
Phlebitis/Blood Clot (DVT)	Yes/No	Detail:
STD/HIV infection	Yes/No	Detail:
Pelvic infection/disorder	Yes/No	Detail:
Blood transfusion before 1992	Yes/No	Detail:
Other	Yes/No	Detail:

Family medical history on last page

Current Medications

Name:	Dose:	Frequency:
Name:	Dose:	Frequency:
Name:	Dose:	Frequency:
Name:	Dose:	Frequency:
Name:	Dose:	Frequency:
Name:	Dose:	Frequency:
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Name:	Dose:	Frequency:
Name:	Dose:	Frequency:

Family Medical History
(With exception of **Cancer**, include immediate family only: mother, father, siblings)

Stroke	Yes/No	Who:
High Blood pressure	Yes/No	Who:
Heart Disease	Yes/No	Who:
Diabetes	Yes/No	Who:
Cancer (include extended family)	Yes/No	Type and Who:
Congenital/Genetic Disorder	Yes/No	Who:
Blood disorder/sickle cell anemia	Yes/No	Who:
Lung/COPD/Asthma	Yes/No	Who:
Headaches	Yes/No	Who:
Neuro/Mental/Emotional Health	Yes/No	Who:
Breast Disease	Yes/No	Who:
Gall Bladder	Yes/No	Who:
Liver/Hepatitis	Yes/No	Who:
GI problems (stomach/Intestines)	Yes/No	Who:
Skin	Yes/No	Who:
Skeletal (joint/spine problems)	Yes/No	Who
Thyroid disorder	Yes/No	Who:
Phlebitis/Blood Clot (DVT)	Yes/No	Who
STD/HIV infection	Yes/No	Who:
Other:		Who:

ADULT CONFIDENTIAL PATIENT PROFILE

PATIENT INFORMATION	LAST NAME: ______________ FIRST: ______________ MIDDLE: __________ AGE: __________ HOME MAILING ADDRESS:** ______________ **IF PO BOX, PHYSICAL ADDRESS ALSO ______________ CITY: ______________ STATE: ____ ZIP: __________ HOME PHONE: ______________ CELL PHONE: ______________ MALE: ___ FEMALE: ___ DATE OF BIRTH: __________ S/S #: ______________ MARITAL STATUS: SINGLE MARRIED OTHER: __________ EMAIL ADDRESS: ______________ OCCUPATION: ______________ EMPLOYER: ______________ WORK PHONE:
SPOUSE'S INFORMATION (IF APPLICABLE)	NAME: ______________ S/S #: __________ DOB: __________ HOME/CELL PHONE: __________ HOME MAILING ADDRESS: ______________ CITY: ______________ STATE: ____ ZIP: __________ EMPLOYER: ______________ OCCUPATION: ______________ WORK PHONE: __________
EMERGENCY INFORMATION	NAME & PHONE # OF PERSON TO CONTACT IN CASE OF EMERGENCY NAME: ______________ RELATIONSHIP: ______________ PHONE#: __________

DOCTORS INLET PEDIATRICS & PRIMARY CARE, PA
d/b/a Doctors Inlet Internal Medicine, Spine and Pain
d/b/a Avenues Internal Medicine, Spine and Pain
430 COLLEGE DRIVE SUITE 104-106
MIDDLEBURG, FL 32068
Phone: (904) 298-1994 Fax: (904) 298-1973

DOCTORS INLET PEDIATRICS & PRIMARY CARE, P.A.
d/b/a Avenues Pediatrics & Avenues Internal Medicine

430 College Drive, Suite 100-102-104
Middleburg, FL 32068-8531

10175 Fortune Parkway, Suite 401
Jacksonville, FL 32256-6746

ADULT CONSENT FOR RELEASE OF MEDICAL INFORMATION/TREATMENT AND PHARMACY INFORMATION

I, ____, hereby authorize any one of the following individuals to obtain any or all of my medical information as deemed necessary and appropriate for treatment by a physician licensed in the state of Florida. This consent includes, but is not limited to, medical information and treatment.

____________________________________ RELATIONSHIP ____________

____________________________________ RELATIONSHIP ____________

____________________________________ RELATIONSHIP ____________

I further agree to reimburse the health care provider for the cost of rendering these services. This authorization is good until it is withdrawn..

____________________________________ DATE ________________
Signature of Patient

PHARMACY INFORMATION
Pharmacy Name: ____________________________ Phone #: ________________
Address: ____
City: ________________________________ Zip: ____________________

PLEASE NOTE THIS PHARMACY WILL BE USED FOR ALL PRESCRIPTIONS.
PLEASE NOTIFY US OF ANY CHANGES IMMEDIATELY.

OFFICE STAFF:
Driver's License OR Photo Identification checked and scanned into system

____
Initials

Address on Driver's License matches information on form

____
Initials

DOCTORS INLET PEDIATRICS & PRIMARY CARE, PA
d/b/a Doctors Inl 430 COLLEGE DRIVE SUITE 104-106
d/b/a Avenues Internal Medicine, Spine and Pain
MIDDLEBURG, FL 32068
Phone: (904) 298-1994 Fax: (904) 298-1973

I. RELEASE INFORMATION - By signing below, I, the parent, legal guardian, or responsible party for the afore mentioned patient, do hereby authorize any physician examining and/or treating the patient to release to any third party (such as a hospital, other physician or other medical facility as well as an insurance company or governmental agency) any medical and psychiatric information and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a method of treatment and/or diagnosis or a claim for payment.

II. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining or treating the patient of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to Social Security Administration/Division of Family Services or its intermediates or carriers any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE

I AGREE THAT SHOULD THE AMOUNT OF THE INSURANCE BENEFITS BE INSUFFICIENT TO COVER THE EXPENSES, I WILL BE RESPONSIBLE FOR PAYMENT OF THE DIFFERENCE. I WILL BE RESPONSIBLE FOR THE ENTIRE AMOUNT DUE FOR PROFESSIONAL SERVICES RENDERED IF THE EXPENSE IS NOT COVERED BY MY POLICY. I UNDERSTAND THAT FAILURE TO PROVIDE ACCURATE INSURANCE INFORMATION TO DOCTORS INLET PEDIATRICS & PRIMARY CARE, INC ((d/b/s AVENUES INTERNAL MEDICINE) , IS FRAUD. I ALSO UNDERSTAND IF I FAIL TO DISCLOSE *ALL* INSURANCE INFORMATION I MAY BE RESPONSIBLE FOR THE COST OF ALL SERVICES RENDERED.

PATIENT, POLICYHOLDER OR RESPONSIBLE PARTY ______________________________

RELATIONSHIP TO PATIENT: ____________________

IS THE PATIENT COVERED BY MEDICARE? YES NO

IF 'YES' IS MEDICARE THE PATIENT'S ONLY INSURANCE CARRIER? YES NO

IF 'YES' DO NOT COMPLETE #'s 1-6, JUST SIGN & DATE BELOW

IF 'NO' PLEASE ANSWER #'s 1-6, THEN SIGN & DATE BELOW.

PRIMARY COMMERCIAL NSURANCE INFORMATION

1. INSURED PARTY'S NAME____________________ DOB__________ SEX_____
2. ADDRESS____________________ CITY__________ STATE___ZIP__________
3. PHONE#____________________ S/S #____________________
4. EMPLOYER'S NAME____________________ WORK PHONE #____________________
5. INSURANCE PLAN/PROGRAM NAME____________________
6. INSURANCE I.D. #____________________ POLICY OR GROUP #____________________
7. RELATIONSHIP TO PATIENT:

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

1. INSURED PARTY'S NAME____________________ DOB__________ SEX_____
2. ADDRESS____________________ CITY__________ STATE___ZIP__________
3. PHONE#____________________ S/S #____________________
4. EMPLOYER'S NAME____________________ WORK PHONE #____________________
5. INSURANCE PLAN/PROGRAM NAME____________________
6. INSURANCE I.D. #____________________ POLICY OR GROUP #____________________
7. RELATIONSHIP TO PATIENT:

Doctors Inlet Pediatrics & Primary Care, P.A.
d/b/a Doctors Inlet Internal Medicine, Spine & Pain

Privacy Notice

In accordance with the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, patients of this practice are entitled to the greatest degree of privacy possible. This office will strive to ensure that patient information is used only for authorized purposes as agreed to by the patient or parent/guardian.

Parents/guardians/patients are advised that they have a right to review the patient's medical records in accordance with Florida statute 456.057 upon reasonable notice to the practice and during normal business hours, and to make comments to the same.

The complete Notice of Privacy Practices is posted in our office waiting area. Please take a few minutes to read this document, as it contains very important information about how confidential health information is handled by our office. If you want a copy of this policy for your records please make your request to the staff and a copy will be provided to you.

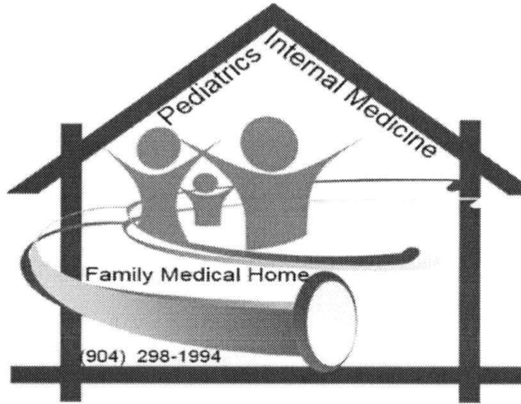
If you have any questions about our Notice of Privacy Practices please contact Robin Christopher, Practice Administrator at 904-298-1994.

Patient Name: ______________________________ Acct. #: __________

____ Date: __________

Parent/Guardian (if applicable) Relationship

Doctors Inlet Internal Medicine, Spine & Pain
430 College Drive
Suite104-106
Middleburg, FL 32068
(904) 298-1994 Phone
(904) 298-1973 Fax



Avenues Internal Medicine,
Spine & Pain
10175 Fortune Parkway
Suite 401
Jacksonville, FL 32256
(904) 298-1994 Phone
(904) 298-1973 Fax

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ____ **Date of Birth:** ______________________________
CurrentAddress: ____ **Phone#:** ______________________

I, ____, **hereby authorize:**

Doctors Inlet Internal Medicine, Spine & Pain/Avenues Internal Medicine, Spine & Pain
_________disclose/release to **___________obtain from**

Name: ____ **Phone#:** ________________ **FAX#:** ____________________
Address: ____
STREET **CITY** **STATE** **ZIP**

□ Date(s) of Service Requested ________________
□ Full Record Release which may include information relating to communicable disease(s), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

RESPONSE REQUIRED
Description of the purpose of the use and/or disclosure:

____**Change of Provider**	____**Second Opinion**	____**Emergency/Acute Care**
____**Consultation**	____**Insurance**	____**Social Security/Disability**
____**Legal Purposes**	____**Personal Use**	____**Other**__________________________ **Describe**

I have carefully read this consent, understand its contents and authorize the release of the above specified information. I understand this Authorization will remain in effect for one (1) year, but I may revoke it in any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization and that my ability to obtain treatment from Doctors Inlet Pediatrics and Primary Care, Inc., d/b/a Doctors Inlet Internal Medicine, Spine & Pain and d/b/a Avenues Internal Medicine, Spine & Pain will not depend in any way whether I sign this Authorization. I understand that I have a right to receive a copy of this Authorization.
I understand that information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and may no longer be protected by State and Federal privacy regulations. I hereby release Doctors Inlet Pediatrics and Primary Care, Inc., d/b/a Doctors Inlet Internal Medicine, Spine & Pain and d/b/a Avenues Internal Medicine, Spine & Pain from any and all liability related to their reliance upon this Authorization of the release of information pursuant to this Authorization.

______________________________________ ________________ ________________
Signature of Patient or Legal Guardian **Relationship** **Date**

______________________________________ ________________________
Printed name of Patient or Legal Guardian **Witness**