QUALITY PRIMARY CARE

PATIENT INFORMATION

Patient's Name: *First:* *MI:* *Last:*			***Date of Birth:*** _____ / _____ / _____
Social Security #:	***Cell Phone #:***	***Home Phone #:***	
Gender: ❑ Male ❑ Female ❑Other _____	***Marital status (circle one):*** Single / Married / Divorced / Separated / Widow		
Demographics: ❑ Caucasian ❑ African American ❑ Asian ❑ Hispanic/Latino ❑ Other _____			
Email Address:	***Preferred Method of Contact:*** ❑ Home # ❑ Cell # ❑ Text ❑ Email		
Home Address:	***City:***	***State:***	***ZIP:***
Previous Primary Care Provider:	***Would you like to register for our patient portal?*** ❑ Yes ❑ No	***Do you consent to receive HIPAA compliant text messages from QPC at the Cell# listed above?*** ❑ Yes ❑ No	
Preferred Pharmacy:	***Pharmacy Location:***		
Emergency Contact: Name:	Phone #:	Relation:	

INSURANCE INFORMATION

PRIMARY

Primary Insurance:	***Policy #/ Member ID/ Subscriber ID:***	
Subscriber's Name:	***SSN :***	***DOB:***
Patient's relationship to subscriber: ❑ *Self* ❑ *Spouse* ❑ *Child* ❑ *Other*		

SECONDARY *(if applicable)*

Secondary Insurance:	***Policy #/ Member ID/ Subscriber ID:***	
Subscriber's Name:	***SSN :***	***DOB:***
Patient's relationship to subscriber: ❑ *Self* ❑ *Spouse* ❑ *Child* ❑ *Other*		

By signing below, I confirm the information above is true and correct to the best of my knowledge.

_____ _____

Patient Signature Date

PLEASE REVIEW THE INFORMATION BELOW AND INITIAL NEXT TO EACH SECTION AS ACKNOWLEDGMENT.

_____ ***Appointments, Cancellations, and No Shows***
Initial

- To help us better serve you**, please arrive 15 minutes prior to your appointment.**
- If you are running late for you scheduled appointment, please contact the office immediately to them.

If you are unable to make your scheduled appointments a 24-hour cancellation notice is required. If you do not cancel within 24-hours of your scheduled appointment or fail to cancel an appointment you are unable to make, you will be responsible for a $25.00 Late Cancellation/No Show Fee. Three (3) no call, no show, or late cancellations may result in dismissal from QPC.

_____ ***Urgent Care***
Initial

- If an appointment with Primary Care is unavailable, and you need to be seen for an urgent issue you may been seen at **Quality Urgent Care and Wellness** without an appointment.
  - Quality Urgent Care and Wellness is open extended hours, **7 days a week**.
  - **25% discount** off your Urgent Care out of pocket expenses as an established patient of Quality Primary Care.

_____ ***Fee Responsibility***
Initial

- It is your responsibility to pay any deductible, coinsurance, and co-payment as assigned by your insurance company.
- Co-pay's must be paid at the time-of-service.
- If you have a secondary insurance, we will file it as a courtesy to you, but we are not guaranteed to be in network with your secondary insurance company.
- Our verification of these benefits is based on information that is provided to us by a third-party. If these benefits do not reflect your current member responsibility, please inform office staff.
- It is the patient's responsibility to update insurance information should there by any changes.

_____ ***Assignment of Benefits and Coordination of Care***
Initial

- I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other agency reimbursements to Quality Primary Care (QPC) for services rendered by the clinic and provider of QPC.
- This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.
- I hereby authorize said assignee to release all information necessary to secure payment.

_____ ***Consent for Treatment***
Initial

- **By signing below on the signature line, you are consenting to the following policies:**
  - Medical treatment at Quality Primary Care.
  - Prescription history monitoring via any pharmacy or drug-monitoring agency.
  - By signing this agreement, you agree to the Notice of Privacy Practices, which can be provided per your request.

***** CONFIDENTIALITY NOTICE *****
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my provider and/or clinical and administrative staff of Quality Primary Care to disclose my medical information and other protected health information to the following person(s) and/or other entities listed below. **If no one is listed below, protected health information will not be disclosed except in those situations described in the HIPAA Notice of Privacy Practices.**

Name of Person or Entity	**Relationship to Patient**	**Personal Identifier (i.e. DOB, last 4 of SSN)**
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____

If applicable, the information authorized for disclosure may relate to ***(check all that apply):***

_____ Complete copy of medical records
_____ Psychotherapy Notes Only
_____ Mental Illness (excludes psychotherapy notes)
_____ HIV/AIDS related illnesses
_____ Drug or alcohol treatment
_____ Other/Restriction Request:_____

By signing below, I understand and agree this authorization to use and disclose my protected health information is being submitted by my request and shall be in effect until revoked by me in writing. I understand that information used or disclosed pursuant to this authorization may be disclosed by Quality Primary Care & Quality Urgent Care & Wellness and may no longer be protected by federal or state law.
I understand that the revocation is not effective to the extent that my provider has relied on the use or disclosure of the protected health information to obtain payment from my health insurance company.

_____ _____
Patient Signature Date

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____ DOB _____ Last 4 of SS# _____

Maiden/Previous Name *(if applicable)* _____

REQUESTING INFORMATION FROM:

Name/Entity ____Quality Urgent Care & Wellness_____ Fax ___850-226-6712_____

Name/Entity _____ Fax _____

Name/Entity _____ Fax _____

Name/Entity _____ Fax _____

TO BE RELEASED TO:

_____ **Quality Primary Care – Ft Walton Beach**
514 Mary Esther Cutoff NW
Ft Walton Beach, FL 32548
Ph: 850-226-8550 | Fax: 850-807-5278

_____ **Quality Primary Care- Pensacola**
5115 N Palafox St
Pensacola, FL 32505
Ph: 850-378-8773 | Fax: 850-807-5362

This authorization permits the above listed entity to disclose the following individually identifiable health information (PHI) about me.

_____ All Records

_____ Visit notes, lab results, and reports | _____ Most Recent and/or Specific Date(s) _____

_____ Specific Items Only *(please list)*: _____

_____ Yes _____No I authorize the release of my **STI** (Sexually Transmitted Infection) results, **HIV/AIDS** testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

_____ Yes _____ No I authorize the release of any records regarding **drug**, **alcohol**, or **mental health** treatment to the person(s) listed above.

I understand that I have the right to revoke this request at any time; I understand that I may request a copy of this authorization; I understand that signing this authorization is voluntary, my care and treatment will not be a conditioned upon my authorization of this disclosure.

_____ _____
Signature of Patient Date

HOSPITALIZATION AND POST OPERATIVE FOLLOW-UP ❑ Decline this section

In the event I *(the above-named patient),* undergo any type of operation, procedure, or am hospitalized, I authorize Quality Primary Care to request my medical records from the facilities indicated below.

By signing below, I give Quality Primary Care permission to notate which facility to request records from in the event I undergo any type of operation, procedure, or am hospitalized, based on the information I give them about the event.

_____ _____
Signature of Patient Date

For Office Use Only:
❑ White Wilson ❑ Sacred Heart ❑ FWBMC ❑ Twin Cities ❑Baptist ❑ West FL Hospital
❑Other_____ Fax # _____

THIS ENTIRE RELEASE OF INFORMATION IS VALID FOR 1 YEAR FROM DATE OF THE PATIENT'S SIGNATURE.

Allergies

❑ No Known Drug Allergies

Allergy	Reaction	Severity *(mild, moderate, sever)*
1.		
2.		
3.		

Female Patients Only

Date of Last Menstrual Period:	**Method of Birth Control:**
Number of Pregnancies:	**Number of Child Births:**

Past Medical History (Diagnosed by a Healthcare Provider)

❑ *None*

- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding tendency
- ☐ Blood clots
- ☐ Cancer (past or present) Type:_____
- ☐ Chronic Back Pain
- ☐ Colon Polyps
- ☐ Congestive Heart failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Eczema
- ☐ Fibromyalgia
- ☐ GERD (Heartburn)
- ☐ Gout
- ☐ Heart disease
- ☐ Hernia Type: _____
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ High blood pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Lupus
- ☐ Migraines
- ☐ Pacemaker
- ☐ Pancreatitis
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Prostate Disorder
- ☐ Psoriasis
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcerative Colitis

Please list any other diagnosed medical conditions below:

_____

Medication List

❑ None

(please bring all medications with you to your appointment.)

Medication	Strength	When/How is it taken

Past Surgical History ❑ None

Please list the <u>date</u> next to the surgical procedure performed.

☐ Appendectomy:	☐ Colon Surgery:	☐ Neck Surgery:
☐ Back Surgery:	☐ Gall Bladder:	☐ Orthopedic Surgery:
☐ Breast Cancer:	☐ Hernia Repair:	☐ Ovaries Removed:
☐ Cardiac Bypass:	☐ Hysterectomy:	☐ Weight Loss Surgery:
Please list any other surgeries:		

Family History

Indicate who had:	Mother	Father	Grandparents	Siblings
Heart Disease			Maternal / Paternal	
Blood clots			Maternal / Paternal	
Bleeding disorders			Maternal / Paternal	
Cancer *(list type)*			Maternal / Paternal	
Sudden Death before 40			Maternal / Paternal	

Preventative Care

Cancer Screenings

Cancer Type	Test Performed	Test Date	Where was the Test Performed	Unsure
Prostate				
Colon				
Lung				
Breast				
Cervical				

Vaccinations

Vaccine Type	Yes	No	Vaccination Date	Unsure
Influenza (Flu)				
Tetanus				
Pneumonia				
Hepatitis B				
Gardasil (HPV)				
Zoster (Shingles)				

Social History

Tobacco Use: ☐ Non-smoker ☐ Former Smoker ☐ Current Smoker Packs per day _____ For how long _____

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No **If <u>yes</u>**: How much?_____ How often?_____

Drug Use: Do you use illicit drugs? ☐ Yes ☐ No

Exercise: Do you exercise? ☐ Yes ☐ No **If <u>yes</u>:** How many days per week? _____ For how long? _____ minutes/hours

Diet/Nutrition: Do you feel that you have a mixed/balanced diet? ☐ Yes ☐No

Do you drink caffeine? ☐ Yes ☐No **If <u>yes</u>**: How much?_____ How often?_____

Hobbies: List any hobbies you may have: _____

Sexual Orientation: Do you consider yourself: ☐Heterosexual, straight ☐ Homosexual, gay or lesbian ☐ Bisexual

Education: Highest level completed: ☐ High School ☐ Some College ☐ AA ☐ Bachelors ☐ Masters ☐ Other _____

Employment: Current Employment Status**:** ☐ Full-Time ☐ Part-Time **Employer**: _____ ☐ Retired