ORLANDO OFFICE
716 S. Goldenrod Road
Orlando, FL. 32822
(407) 658-1719
Fax (407) 658-2536

KISSIMMEE OFFICE
3315 Orange Blossom Trail
Kissimmee, FL. 34746
(407) 343-1919
Fax (407) 343-1907

ADULT PATIENT INFORMATION

Patient Name: _____ _____ _____
First Name **MI** **Last Name**

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Cell Phone #:** _____ **Social Security:** _____

Date of Birth:_____ **Age:**_____ **Male** ☐ **Female** ☐ **Marital Status:** _____

Name of Employer: _____

Employer Phone #: _____ **Occupation:** _____

Employer Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

Person Responsible for Bill: _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **Phone #:** _____ **Social Security:** _____

Emergency Contact: _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Relationship:** _____

Please Mark all that Applies for you: ☐ **Insurance** ☐ **W/C** ☐ **Medicaid** ☐ **Self-pay**

Primary Insurance: _____ **Phone #:** _____

Claim Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Method of Payment: ☐ **Cash** ☐ **Check** ☐ **Credit/ Debit Card**

PAYMENT IS REQUIRED AT TIME OF SERVICE

I authorize Urgentmed to release information regarding my examination or treatment for the purpose of obtaining insurance compensation, precertification, or medical records. I authorize payment of medical benefits to Urgentmed when claim forms are filed upon my behalf for treatment. Also, I give authorization for medical treatment. All invoices must be paid within terms quoted. I understand that I am responsible for the bill if my insurance does not pay within 30 days.

Signature: _____ **Date:** _____

ORLANDO OFFICE
716 S. Goldenrod Road
Orlando, FL. 32822
(407) 658-1719
Fax: (407) 658-2536

KISSIMMEE OFFICE
3315 S. Young Parkway (OBT)
Kissimmee, FL. 34746
(407) 343-1919
Fax: (407) 343-1907

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do as documented below:

Date	Initial	Reason:

ORLANDO OFFICE
716 S. Goldenrod Road
Orlando, FL. 32822
(407) 658-1719
Fax: (407) 658-2536

URGENTMED CARE

KISSIMMEE OFFICE
3315 S. Young Parkway (OBT)
Kissimmee, FL. 34746
(407) 343-1919
Fax: (407) 343-1907

ADULT HEALTH HISTORY FORM

Patient Name: _____ Date: _____
Purpose of Initial Visit: _____

ALLERGIES

Drugs: _____

Food: _____

Other: _____

CURRENT MEDS:

Prescription: ☐ No ☐ Yes Please List:
_____
_____
_____

Over the Counter: ☐ No ☐ Yes Please List:
_____

FAMILY HISTORY

Use √ Marks for Yes Answers:	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Cancer						
Diabetes						
Epilepsy/Convulsions						
Glaucoma						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Mental Illness						
Stroke						
Thyroid Disease						
Drug Addiction						
Alcohol Addiction						
Other:						

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

Please check if you have had problems with or are presently complaining of any of the following:

- ○ High Blood Pressure
- ○ Diabetes
- ○ Cancer
- ○ Heart Disease
- ○ Chest Pain/ Chest Tightness
- ○ Short of Breath
- ○ Swollen Ankles
- ○ Palpitations
- ○ Lightheadedness
- ○ Frequent Urination
- ○ Rheumatic Fever
- ○ Asthma
- ○ Bronchitis
- ○ Pneumonia
- ○ Persistent
- ○ Tuberculosis
- ○ Abdominal Discomfort
- ○ Hay Fever
- ○ Indigestion
- ○ Nauseous
- ○ Vomiting
- ○ Constipation
- ○ Diarrhea
- ○ Blood in Stool
- ○ Ulcers
- ○ Gout
- ○ Hemorrhoid
- ○ Gall Bladder Disease
- ○ Unexplained Weight Gain/Loss
- ○ Colitis
- ○ Hepatitis or Jaundice
- ○ Thyroid Disease
- ○ Head or Neck Radiation
- ○ Headache
- ○ Kidney Disease
- ○ Kidney Stones
- ○ Difficulty urinating
- ○ Arthritis
- ○ Low Back Problems
- ○ Skin Diseases
- ○ Blood Disorders
- ○ Venereal Diseases
- ○ Anxiety
- ○ Depression
- ○ Anemia
- ○ Alcohol Abuse
- ○ Drug Abuse
- ○ Change in Bowel Habits
- ○ _____
- ○ _____
- _____

PLEAST LIST AND SUPPLY THE DATES OF:
Operations ☐ No ☐ Yes Please List: _____
_____
_____

Hospitalizations Other than for Surgery: ☐ No ☐ Yes Please List: _____
_____

Transfusions: No ☐ Yes ☐ Please List: _____
_____

IMMUNIZATION HISTORY- HAVE YOU HAD:

Pneumovax Immunization? ☐ No ☐ Yes When? _____
Hepatitis B? ☐ No ☐ Yes When? _____
Flu Immunization? ☐ No ☐ Yes When? _____

Tetanus? No ☐ Yes ☐ When? _____
Other? No ☐ Yes ☐ When? _____

WHEN WAS YOUR LAST:

Complete Physical	Date: _____	Results: _____	TB Test	Date: _____	Results: _____
Cholesterol Check	Date: _____	Results: _____	PAP Test	Date: _____	Results: _____
Eye Exam	Date: _____	Results: _____	Mammogram	Date: _____	Results: _____
Hearing Test	Date: _____	Results: _____	Breast Exam	Date: _____	Results: _____
Stool Check for Blood	Date: _____	Results: _____	Prostate Exam	Date: _____	Results: _____

FOR WOMEN ONLY GYNECOLOGICAL AND OBS HISTORY

Age at onset of Periods: _____ Frequency: _____ Length of Period: _____

Pregnancies: ☐ Births: ☐ Miscarriages: ☐ Abortions: ☐

Prolonged or Abnormal Bleeding: ☐ No ☐ Yes Please Describe: _____

Leakage of Urine: ☐ No ☐ Yes Please Describe: _____

History of Abnormal PAP Smear: ☐ No ☐ Yes Type of Treatment: _____

PREVENTION

Do you wear seat belts? ☐ No ☐ Yes If no, why not? _____

Do you wear a bike helmet? ☐ No ☐ Yes If no, why not? _____

Do you drink beverages with caffeine? ☐ No ☐ Yes If yes, how many per day? _____

Do you smoke? ☐ No ☐ Yes If yes, how many packs per day? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, how much per week? _____

Do you use drugs? (Marijuana, cocaine, crack, etc.) ☐ No ☐ Yes If yes, explain: _____

_____

Is there a gun in your home? ☐ No ☐ Yes

Is it unloaded and out of children's reach? ☐ No ☐ Yes ☐ N/A

RISK HISTORY

Currently sexually active? ☐ No ☐ Yes]How many partners in the past 5 years? ☐

HAVE YOU EVER EXPERIENCED:

Sex with injecting drug user? ☐ No ☐ Yes Sex with person with HIV/AIDS Risk? ☐ No ☐ Yes

Sex with same-sex partner(s)? ☐ No ☐ Yes Sex for drugs/money? ☐ No ☐ Yes

Sex while using drugs? ☐ No ☐ Yes Ever been a victim of sexual assault? ☐ No ☐ Yes

CONTRACEPTIVE METHOD LAST USED/NOW USING:

History-Other methods used: _____

Problem(s) with methods: _____

Have you been in contact with person with confirmed TB? ☐ No ☐ Yes If yes, explain: _____

_____

Are you from or have you recently traveled to regions of the world with high TB prevalence? ☐ No ☐ Yes If yes, explain: _____

_____

Are you in contact with the following: HIV + person, Migrant farm workers, Residents of nursing homes, Institutionalized/ Incarcerated person, Homeless persons, IV/street drug users, etc. ☐ No ☐ Yes If yes, explain: _____

_____

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ☐ No ☐ Yes If yes, explain: _____

_____

Are you in a relationship in which you have been physically hurt (e.g. slapped, kicked, etc.) by your partner? ☐ No ☐ Yes ☐ N/A

Do you feel afraid of your partner? ☐ No ☐ Yes

Do you have a "living will"? ☐ NO ☐ Yes (if yes, please provide a copy)

Do you have a donor card? ☐ No ☐ Yes

SIGNATURE: _____ PRIMARY LANGUAGE: _____

ORLANDO OFFICE
716 S. Goldenrod Road
Orlando, FL. 32822
(407) 658-1719
Fax (407) 658-2536

KISSIMMEE OFFICE
3315 Orange Blossom Trail (OBT)
Kissimmee, FL. 34746
(407) 343-1919
Fax (407) 343-1907

MEDICAL PROBLEMS SUMMARY SHEET

Patient's Name: _____ Date of Birth: _____

Medical Problems	Medications Maintenance
Surgeries/Injuries	

Annual Screening	Dates	Dates	Dates	Dates	Dates
Pap Smear					
Bone Density					
Cholesterol LDL Screening					
Colorectal Screening (Gualac)					
HbA1c (Diabetic Screening)					
Mammogram					
Optometry DM Screening					
PSA Screening					