PATIENT INTAKE FORM

Name**:**		
Street Address**:**		
City:	Postal Code**:**	
Phone**:** (home)	(Cell)	(Work)
Email Address:	Occupation:	
Social Security Number:		
Would you like to receive South Florida Injury and convenient Care emails regarding appointment Information? Yes ☐ No ☐		
Would you like to receive South Florida Injury and convenient Care texts regarding appointment Information? Yes ☐ No ☐		
Gender*(circle)*: M F	Date of Birth**:**	
Family Doctor**:**		
Preferred Pharmacy**:**	Phone Number**:**	

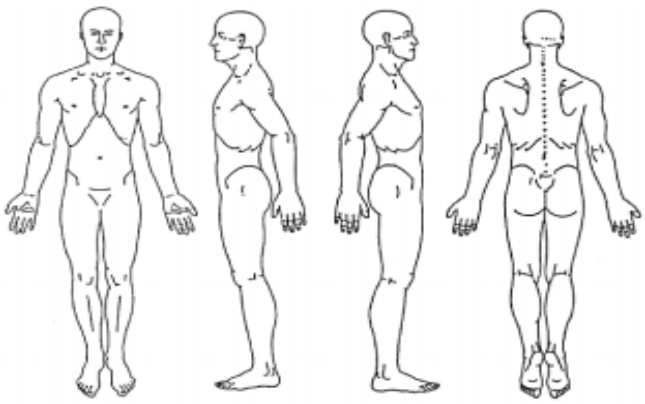
REASON FOR VISIT/ INJURIES:

PAIN RATING:

On a Scale of 0-10, rate your pain: (Please circle the number that best describes your pain)

No Pain Severe Pain

0 1 2 3 4 5 6 7 8 9 10



MEDICAL HISTORY

Height: _____ Weight: _____

Do you have any of the following?

Diabetes?	Yes	No
Heart Trouble?	Yes	No
Epilepsy?	Yes	No
High Blood pressure?	Yes	No
Circulation problems?	Yes	No
Osteoporosis?	Yes	No
Bowel/Bladder Problems?	Yes	No
AIDS/HIV positive?	Yes	No
Have you ever had cancer?	Yes	No
Have you ever experienced dizziness or blackouts?	Yes	No
Sudden weight loss?	Yes	No
Breathing problems?	Yes	No
Are you pregnant?	Yes	No
Recent surgery?	Yes	No
Arthritis?	Yes	No

Describe any other health problems:

_____

_____

List of Past Surgeries:

_____

List any allergies:

_____

List all medications you are taking:

_____

Have you had any X-RAYS/MRI taken related to this Injury? YES NO

If so, Where? _____

Right or Left Handed? R L

SOCIAL HISTORY:

___Smoker ___Non-Smoker
___Drink Alcohol How much? _____
___Does not Drink Alcohol

Is this injury related to a motor vehicle accident/Slip and Fall: Yes No

Motor Vehicle Accident Patients

(*Please fill out this section*)

Insurance Company *(Branch Office if applicable)*	
Address	
Telephone Number	
Fax Number	
Adjuster's Name	
Date of Accident	
Policy Number	
Claim Number	
Name of Policy Holder *(If different from claimant)*	

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS
If you want 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 about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed 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 your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

_____

Print Patient's Name Date

I,_____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

Have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I,_____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

My personal health information by your office for Treatment, Billing / Payment and Health care Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

Cancellation / Now Show Policy – South Florida Injury and Convenient Care understands that there are times when you must miss an appointment. Please understand that we (South Florida Injury and Convenient Care) reserve the right to charge a $50 dollar cancellation fee if an appointment is not cancelled at least 24-hours in advance or there is a no show.