

**PRIMARY CARE PATIENT INFORMATION FORM**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_ Sex: M / F Marital Status: M S D W

Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR VISIT / MAIN CONCERN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Physical\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESCRIPTION MEDICATIONS** *(PLEASE INCLUDE NAME, DOSE AND NUMBER PER DAY)*

|  |  |
| --- | --- |
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

**NON PRESCRIPTION MEDICATIONS** *(LIST OVER THE COUNTER, HERBAL, AND VITAMINS)*

|  |  |  |
| --- | --- | --- |
| 1. | 3. | 5. |
| 2. | 4. | 6. |

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU HAVE ANY ALLERGIES OR REACTIONS TO ANY MEDICATIONS?**

NO\_\_\_\_\_\_\_\_\_\_\_\_\_ YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REACTION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REACTION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REACTION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**: *(PLEASE CIRCLE IF YOU HAVE /HAVE HAD IN THE PAST 12 MOS)*

|  |  |  |  |
| --- | --- | --- | --- |
| **GENERAL** | **EYES** | **EAR, NOSE,THROAT** | **SKIN** |
| Weight Loss | Double Vision | Hearing Loss | Bruise Easily |
| Fever | Dry Eyes | Ringing in Ears | Rashes |
| Night Sweats | Redness | Sore Throat | Change in Moles |
| Depression | Pain | Bloody Nose | Hair loss/thinning hair |

|  |  |  |  |
| --- | --- | --- | --- |
| **CARDIOVASCULAR** | **RESPIRATORY** | **GASTROINTESTINAL** | **URINARY** |
| Heart Palpitations | Chronic Cough | Constipation | Frequent Urination |
| Chest Pain | Bloody Sputum | Diarrhea | Blood in Urine |
| Heart Racing | Shortness of Breath | Blood in Stools | Painful Urination |
| Ankle Swelling | Wheezing | Excessive Thirst | Lack of Control |

|  |  |  |  |
| --- | --- | --- | --- |
| **NEUROLOGICAL** | **MUSCULOSKELETAL** | **HEMATOLOGIC** | **ALLERGIC** |
| Headaches | Joint Pain | Bleeding Gums | Swelling |
| Dizziness | Muscle Pain | Unexplained Bleeding | Hives |
| Numb Arms/ Legs | Weak Arms/Legs | Transfusion | Redness/ Scaling |

IF NONE OF THESE APPLY, PLEASE INITIAL HERE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE CIRCLE ALL THAT YOU HAVE EXPERIENCED IN THE PAST 12 MONTHS**

|  |  |  |  |
| --- | --- | --- | --- |
| Decreased libido | Night sweats | Hot flashes | Irritability |
| Fatigue after meals | Insomnia | Erectile problems | Exercise intolerance |
| Swelling | Cold intolerance | Brittle hair/nails | Dry/flaky skin |

**Past Medical History**: Please circle if you have or have ever been diagnosed with any of the following conditions:

Heart Disease Diabetes Asthma or Emphysema

High Blood Pressure Arthritis Hepatitis or Liver Disease

Depression/Anxiety HIV or AIDS Alcohol or Drug Dependency

Thyroid Problems Kidney Disease Tuberculosis

Sleep Apnea Osteoporosis PCOS

High Cholesterol

Cancer (Type and Treatment)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (Please Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When was your last:**

Colonoscopy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prostate Exam/PSA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PAP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menstrual Cycle \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST SURGICAL HISTORY:**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:**

Do you smoke? (YES)\_\_\_\_ (NO) \_\_\_\_

(How Much?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Quit? (When?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink Alcohol? (NO) \_\_\_\_\_\_\_\_\_\_\_ (OCCASIONALLY) \_\_\_\_\_\_\_\_\_\_ (DAILY) \_\_\_\_\_\_\_\_

What is your weight?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For you, is this Low\_\_\_\_\_\_ Normal \_\_\_\_\_\_\_High\_\_\_\_\_\_

FAMILY HISTORY: Has anyone in your immediate family had any of the following conditions?

* Heart or coronary arterial disease (congestive heart failure, angina, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Atherosclerosis (hardening of the arteries) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* High cholesterol or other form of abnormal lipids \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Heart attack or stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Diabetes or any form of metabolic disease or obesity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Cancer and list type(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Osteoporosis or any form of bone disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Thyroid disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other diseases in your family or additional information you think we should know:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I UNDERSTAND THAT THE ABOVE ANSWERS ARE IMPORTANT FOR MY MEDICAL CARE AND I, THEREFORE, CERTIFY THAT ALL OF THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**HIPAA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES**

You may be contacted by our office to remind you of appointments, healthcare treatment options or other health services that may be of interest to you. In order to maintain your privacy, please answer the following:

May we contact you at home? \_\_\_\_\_Yes \_\_\_\_\_No Ok to leave message? \_\_\_\_\_Yes \_\_\_\_\_No

May we contact you at work? \_\_\_\_\_Yes \_\_\_\_\_No Ok to leave message? \_\_\_\_\_Yes \_\_\_\_\_No

May we contact you via cell? \_\_\_\_\_Yes \_\_\_\_\_No Ok to leave message? \_\_\_\_\_Yes \_\_\_\_\_No

Is it ok to leave a message that includes:

Practice name and phone number only? \_\_\_\_\_Yes \_\_\_\_\_No

Detailed or specific message? \_\_\_\_\_Yes \_\_\_\_\_No

Would you like to authorize someone else to schedule, confirm, or change appointments? \_\_\_\_\_Yes \_\_\_\_\_No

If so, please provide:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to authorize someone else to receive medical information on your behalf?

If so, please provide: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the purpose of marketing, advertising, special events and offers, may we contact you via email and/or newsletter? \_\_\_\_\_Yes \_\_\_\_\_No

HOW DID YOU HEAR ABOUT US?

\_\_\_ Friend or Family Member (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Website: \_\_\_ *Tampahealthcenter.com* \_\_\_ BCBS Website

\_\_\_ Internet Search (Google / Yahoo / Other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Newspaper/Newsletter or Mailer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ An Article or Advertisement in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Michael P. Heim, DO has posted my rights as a patient under the HIPAA (Health Insurance Portability and Accountability Act) on his website [www.tampahealthcenter.com](http://www.tampahealthcenter.com). I have had the opportunity to read and understand my rights. I understand I can request a written copy at any time. I have been provided the opportunity to ask questions regarding my rights and received answers to my satisfaction.



**AUTHORIZATION TO PAY MEDICAL OR SURGICAL BENEFITS DIRECTLY TO PHYSICIAN:**

I hereby authorize my insurance company (*Please print name of insurance company)*, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to make payments directly to Michael P. Heim, DO, of *The Center for Health and Age Management*, for all medical expense benefits otherwise payable to me for this period of treatment. Any remaining balance due *The Center for Health and Age Management* will be charged to your credit card. If we are NOT providers for your insurance plan, the office policy remains the same: *you are required to pay in full at the time of your visit; we will file your medical claim with your insurance company as a courtesy, and, after receiving an Explanation of Benefits (EOB) from your insurance company, any credits will be refunded to you by your insurance plan or our office. It is in your best interest to understand your insurance plan.*

INSURANCE MEMBER ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY INSURED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PROVIDER SERVICES/CUSTOMER SERVICE PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*** *The Center for Health and Age Management* currently participates with BCBS PPO and TriCare Standard. This is subject to change at any time without notice. I understand that I am financially responsible for all charges not covered by my insurance benefits. I also authorize release of my records to the insurance company for the purpose of billing.

I authorize *The Center for Health and Age Management* to charge outstanding balances on my account and refills for compounded medication (if applicable) to the following credit card. If the billing address for this card differs from your home address, please advise the billing address. Thank you.

Visa \_\_\_\_\_\_\_\_\_\_\_\_\_ MC \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discover \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HSA\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date: \_\_\_\_\_\_\_\_\_\_\_ Security Code: \_\_\_\_\_\_\_\_\_\_

Name on Card (PRINT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name *(Please Print)* Patient/Parent/Guardian Signature Date