HARBOUR MEDICAL CENTERS

1411 SE Ocean Blvd, Stuart, FL, 34994

Patient Name_____ Date: _____

Patient's Address _____City _____

State_____ Zip_____

Home phone_____Cell Phone_____

Email: _____

SS #/SIN_____ DOB_____ □ Male □Female

Check appropriate Box: □Minor □Single □Married □Divorced □Widowed □Separated

Employer Name:

_____

Spouse's name_____ Spouse's D.O.B:_____

Whom may we thank for referring you?

_____

Person to contact in case of an

emergency_____Phone_____

Relationship to patient:_____

Responsible Party

Name of The Person responsible for this account

_____

Relationship to Patient

_____

Address

_____

Home Phone _____ Cell Phone _____

E-Mail _____

Driver's License # _____ Date of Birth:_____

Do you have any Medical insurance? □ Yes □ No if yes, complete the following:

Name of the

insured_____

Relationship to

patient_____

If the subscriber is NOT the patient, please provide the following information for the policy holder:

Birthdate_____ SS#/SIN_____

Name of Employer_____ Work Phone _____

Address of Employer_____

City_____State _____

Zip_____

Insurance Company_____ Group #_____

Ins. Co. Address _____ City _____

State _____ Zip_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **HARBOUR MEDICAL CENTERS** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

X_____
(patient signature)

X_____(SEAL)
(Signature of Guardian if applicable)

X_____
(Please print patient name)

Health History

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint: _____

History of Present illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(Example: normal vs abnormal color, activity, etc..)

Severity: _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____
(How long have you had this pain/ problem? When did it start?)

Timing: _____
(Does the pain/problem occur at a specific time?)

Context: _____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____
(What other associated problems have you been having?)

Modifying Factors _____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "Y" or "N"/ leave blank if you are uncertain.)

Measles..... Y/N	Anemia.....Y/N	Back Trouble..... Y/N	Hepatitis..... Y/N
Mumps..... Y/N	Bladder Infection..... Y/N	High Blood Pressure..... Y/N	Ulcer..... Y/N
Chicken Pox..... Y/N	Epilepsy..... Y/N	Low Blood Pressure..... Y/N	Kidney Disease..... Y/N
Whooping Cough... Y/N	Migraine Headaches. .Y/N	Hemorrhoids..... Y/N	Thyroid Disease..... Y/N
Scarlet Fever..... Y/N	Tuberculosis..... Y/N	Bleeding Tendency..... Y/N	
Diphtheria..... Y/N	Diabetes..... Y/N	Asthma..... Y/N	Any Other Disease..... Y/N
Small pox..... Y/N	Cancer..... Y/N	Hives of Eczema .....Y/N	
Pneumonia..... Y/N	Polio.....Y/N	AIDS & HIV..... Y/N	
Rheumatic Fever.... Y/N	Glaucoma..... Y/N	Infectious Mono..... Y/N	
Arthritis..... Y/N	Hernia..... Y/N	Bronchitis..... Y/N	
Venereal Disease.... Y/N	Blood or Plasma	Mitral Valve Prolepses.... Y/N	
Transfusion..... Y/N	Stroke..... Y/N		

Date of Last Chest X-Ray_____

Please explain any **YES** answers: _____

_____

_____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication: (include nonprescription)

_____

_____

Have you ever taken Fen-Phen/Redux? **Y/N**

Are you taking any medications (prescription or over the counter) for acid indigestion? **Y/N**

Patient Social History:

Marital Status	Single: _____	Married: _____	Separated: _____	Divorced: _____	Widowed: _____
Use of Alcohol	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Tobacco	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Drugs	Never: _____	Type/Frequency: _____			

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:** _____

PATIENT NAME: _____ **DATE:** _____

Name:_____ DOB_____ Date:_____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Diarrhea	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

_____ _____

Signature of Doctor Date

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES
FOR
HARBOUR MEDICAL CENTERS

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for appointment reminders, follow up calls, birthday greetings, etc.:

_____Mail: Address:_____
_____Email: Email address:_____@_____
_____Cell Phone: (_____)_____ _____Ok to leave detailed message
_____**I agree to receive text messages on this number**
_____Home Phone: (_____)_____ _____Ok to leave detailed message

By initialing the line below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____
Patient Name (please print) Date

_____
Signature of Patient, Parent, Guardian or Patient's legal representative

_____
Print name (if other than patient)