Jupiter Internal Medicine Associates, P.A.

MEDICAL HISTORY

Name: _____ Date: _____

Referred By: _____

Reason for visit: _____

Allergies including reactions: _____

_____

PAST MEDICAL ILLNESSES:

YES	NO	YES	NO	
☐	☐	HYPERTENSION	☐	☐ DIABETES MELLITUS
☐	☐	HEART DISEASE	☐	☐ HEPATITIS
☐	☐	RESPIRATORY DISEASE	☐	☐ ATRIAL FIBRILLATION
☐	☐	THYROID DISEASE	☐	☐ EMPHYSEMA (COPD)
☐	☐	STROKE (CVA)	☐	☐ PEPTIC ULCER DISEASE
☐	☐	ANXIETY	☐	☐ TUBERCULOSIS
☐	☐	KIDNEY DISEASE	☐	☐ LIVER DISEASE
☐	☐	PHLEBITIS	☐	☐ HEART MURMUR
☐	☐	AIDS/HIV+		
☐	☐	CANCER, if yes, TYPE & when diagnosed: _____		

_____

☐ ☐ Other, please specify: _____

_____

Medications and milligrams: _____

_____

_____

_____

Surgical History: _____

_____

Name: _____ Date: _____

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SOCIAL HISTORY

Do you have regular exercise habits? ☐ Yes ☐ No

Do you sleep regularly? ☐ Yes ☐ No

Do you eat well balanced meals? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How long? _____ How much? _____

Have you ever smoked? ☐ Yes ☐ No When did you quit? _____

Do you drink? ☐ Yes ☐ No How much per week? _____

FAMILY HISTORY:

Mother living? ☐ Yes ☐ No Died at age _____ Cause _____

Father living? ☐ Yes ☐ No Died at age _____ Cause _____

Brothers living? ☐ Yes ☐ No Died at age _____ Cause _____

Sisters living? ☐ Yes ☐ No Died at age _____ Cause _____

Does anyone in your immediate family have heart disease, diabetes, cancer or other chronic illness? _____

_____

_____

HEALTH MAINTENANCE:

Do you take Aspirin? ☐ Yes ☐ No

Have you had a colonoscopy? ☐ Yes ☐ No When? _____

Have you had a Pneumonia vaccine? ☐ Yes ☐ No When? _____

Have you had a mammogram? ☐ Yes ☐ No When? _____

Have you had a breast exam: ☐ Yes ☐ No When? _____

Date of last gynecological exam? _____

Date of last digital rectal exam? _____

Have you had a PSA (if male)? ☐ Yes ☐ No When? _____

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INSURANCE AUTHORIZATIONS

AUTHORIZATIONS:

I hereby authorize my doctor to release any information acquired in the course of my treatment to my insurance company. I request that payment of authorized benefits be made either to me or on my behalf for any services furnished to me by my doctor. (MEDICARE PATIENTS) I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Date: _____ Signature _____

I authorize Jupiter Internal Medicine Associates, P.A. to use and disclose a copy of health and medical information if I am unable to communicate to the following:

Name of Recipient: _____ Phone: _____

[ ] No Expiration Date

If we may leave messages on your voicemail such as test results and/or messages that may contain personal information, please check box below:

[ ] Answering Machine

Jupiter Internal Medicine Associates, P.A.

NEW PATIENT INFORMATION

(PLEASE PRINT)

Date: _____

Patient's Name: _____

SS# _____ Sex _____ Age _____ Date of Birth _____

Marital Status: S M W D

Local Address:

_____

_____

(City) *(State)* *(Zip)*

Phone: _____ Cell Phone: _____

E-Mail Address: _____

**(by giving us your email address, you are signing up for our patient portal, a website that is used to view lab results, request appointments and prescription refills and communicate with the doctor.)

Preference of contact: Home Mobile Text Email

Out of state address:

_____

_____

(City) *(State)* *(Zip)*

Phone: _____ Cell Phone: _____

Patient's Employer: _____

Occupation: _____ Phone: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____ Cell Phone: _____

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NEW OFFICE POLICY

Due to new Medicare and insurance company policies, our providers at Jupiter Internal Medicine MUST see any patient on controlled medication(s) every 90 days for refills. If you are unsure if you are taking a controlled substance, please do not hesitate to ask a team member. We apologize for any inconvenience this may cause.

If you have any questions or concerns, please discuss your concerns with your provider so that we may address your needs to your satisfaction.

Thank you,

Jupiter Internal Medicine

Patient Signature: _____

Date: _____

Jupiter Internal Medicine Associates, P.A.

PATIENT PRIVACY SIGNATURE FORM

I understand that, under the Health Insurance Portability and Accountability Act (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 that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 their address to obtain a current copy.

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 my such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. I have reviewed and understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Patient Name:

(Print) _____ Date: _____

Signature: _____

Submit