



## PATIENT'S PERSONAL INFORMATION

### General

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt.: \_\_\_\_\_ City: \_\_\_\_\_

Number Street State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Telephone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Sex: \_\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_\_

Driver's License Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Marital Status (Circle): Single Married Domestic Partner Divorced/Widowed

### Primary Insurance Company

Name: \_\_\_\_\_ Group Number: \_\_\_\_\_ Policy Number \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Name: \_\_\_\_\_

Insured's Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

### Secondary Insurance

Name: \_\_\_\_\_ Group Number: \_\_\_\_\_ Policy Number \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Name: \_\_\_\_\_

Insured's Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

### Authorization

I understand that this office will submit claims to the listed insurance company, but that I am ultimately responsible for this account. I also authorize the release of any medical information necessary to process my claim.

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





**PAST MEDICAL HISTORY**

Do you now or have you ever had:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart murmur        | <input type="checkbox"/> Crohn's disease         |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Colitis                 |
| <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Pulmonary embolism  | <input type="checkbox"/> Anemia                  |
| <input type="checkbox"/> Hypothyroidism      | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Jaundice                |
| <input type="checkbox"/> Goiter              | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Hepatitis               |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia            | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever         |
| <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Angina              | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Kidney stones       |  |

Other medical conditions (please list):

---



---

**PERSONAL HISTORY**

Marital status:

- Never married    Married  
 Divorced    Separated  
 Widowed  
 Partnered/significant other

Highest level of education:       High school    Some college    College graduate    Advanced degree

What is your current or past occupation?

Are you currently working? :    Yes    No

**FAMILY HISTORY**

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:



## SYSTEMS REVIEW

In the past month, have you had any of the following problems?

### GENERAL

- Recent weight gain; how much \_\_\_\_\_
- Recent weight loss: how much \_\_\_\_\_
- Fatigue
- Weakness
- Fever
- Night sweats

### MUSCLE/JOINTS/BONES

- Numbness
  - Joint pain
  - Muscle weakness
  - Joint swelling
- Where?

### EARS

- Ringing in ears
- Loss of hearing

### EYES

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

### THROAT

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Pain in jaw

### HEART AND LUNGS

- Chest pain
- Palpitations
- Shortness of breath
- Fainting
- Swollen legs or feet
- Cough

### NERVOUS SYSTEM

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss

### STOMACH AND INTESTINES

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

### SKIN

- Redness
- Rash
- Nodules/bumps
- Hair loss
- Color changes of hands or feet

### BLOOD

- Anemia
- Clots

### KIDNEY/URINE/BLADDER

- Frequent or painful urination
- Blood in urine

### Women Only:

- Abnormal Pap smear
- Irregular periods
- Bleeding between periods
- PMS

### PSYCHIATRIC

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep
- Difficulties with sexual arousal
- Poor appetite
- Food cravings
- Frequent crying
- Sensitivity
- Thoughts of suicide / attempts
- Stress
- Irritability
- Poor concentration
- Racing thoughts
- Hallucinations
- Rapid speech
- Guilty thoughts
- Paranoia
- Mood swings
- Anxiety
- Risky behavior

### OTHER PROBLEMS:

### WOMENS REPRODUCTIVE HISTORY:

Age of first period:

# Pregnancies:

# Miscarriages:

# Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N



**Informed Patient Consent**  
**HIPAA Compliance Patient Consent Form**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

I am initiating contact with the understanding that the medical encounter will be conducted through the use of:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

This consent was signed by (Print): \_\_\_\_\_ Date of  
Birth: \_\_\_\_\_

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

Power of Attorney: \_\_\_\_\_

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



# HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

## I. My Authorization

I authorize the following using or disclosing party:

**\_\_\_\_\_**  
to use or disclose the following health information.

- All of my health information

- My health information relating to the following treatment or condition:

\_\_\_\_\_

- My health information covering the period from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)

- Other: \_\_\_\_\_

**The above party may disclose this health information to the following recipient:**

Name (or title) and organization CLOUD CARE MEDICINE

Address 1222 10<sup>TH</sup> St

City St Cloud State Florida Zip 34769

Phone 407-593-0323 Fax 407-593-0324

**The purpose of this authorization is (check all that apply):**

- At my request

- Other: \_\_\_\_\_

- To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.



- To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

## **II. My Rights**

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

**Signature of Patient:** \_\_\_\_\_

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

**Please fax records to: 407-593-0324**