1150 Anderson Street
Clermont FL, 34711
(352-227-3000

PATIENT INFORMATION

TODAY DATE: ______________________

LAST NAME: ________________________ FIRST NAME: __________________________ M.I.: ______

DATE OF BIRTH: ________________ SSN: ________________ MARITAL STATUS: ______________ SEX: _______

HOME PHONE: _________________ CELL PHONE: __________________ EMAIL: _____________________________

ADDRESS: __________________________________ _________________________ __________ ________________

STREET ADDRESS CITY STATE ZIP CODE

OCCUPATION: _____________________ EMPLOYER: ________________ PHONE NUMBER: ____________________

EMERGENCY CONTACT

NAME: ______________________________ RELATIONSHIP: ___________________ PHONE: ___________________

NAME: ______________________________ RELATIONSHIP: ___________________ PHONE: ___________________

CONSENT TO TREAT

I hereby give consent to Mini Health Clinic to provide treatment deemed necessary at office, home, or telehealth visit.

____ ___________________

PATIENT SIGNATURE/RESPONSIBLE PARTY DATE

PAYMENT AGREEMENT

I understand that I am responsible for charges incurred for service. No insurance, medicare, or medicaid accepted. All payment is due at time of service via Cash, debit, credit card, or care credit payments only.

____ ___________________

PATIENT SIGNATURE/RESPONSIBLE PARTY DATE

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DISCLOSURE OF HEALTH INFORMATION

Pursuant to requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we request consent to the following possible scenarios. It is our office policy to require your reading and signing this consent form prior to treatment or medical services in our office. If you have any questions, please ask a staff member for clarification.

EVENT OF DISCLOSURE:
Please initial and date your consent to authorize us to relay any information about you to receive benefits, payment or other information to benefit you, your healthcare/medical services or account with our office.

_________ In the event my insurance company request a copy of my medical records for clarification to receive payment on my account, I authorize Mini Health Clinic to relay such information as deemed necessary.

_________ In the event your provider needs to refer me to another physician for further treatment or consultation, I authorize either one of them to relay information as deemed necessary.

_________ In the event a hospital needs any part of my records faxed to their facility for clarification or history of treatment, I authorize the relaying of any such information as deemed necessary.

_________ In the even my pharmacy calls or faxes a request for information to fill a prescription for me, I authorize this office to relay any such information as deemed necessary.

_________ In the event another provider request copies of my medical records for the purpose of treatment, I authorize to relay any such information as deemed necessary.

_________ In the event that your provider needs to discuss my medical status/treatment and or history with a physician involved in my care, I authorize either of them to relay any such information via telephone, fax or mail as deemed necessary.

_________ In the event that a family member needs to be involved in my care or treatment, I authorize the communication of any information as needed necessary (to the following family member only: ____)

I understand that I have the right to revoke this consent in writing, at any time, and that any revocation will become effective on the date it has been received by this office and will apply to the specific uses and disclosures as addressed above.

Patient Signature (or guardian) ___________________ Printed Name:_____________________ Date: ____________

ACKNOWLEDGEMENT OF PRIVACY NOTICE

I, _________________________________, hereby acknowledge that a copy of the Notice of Privacy Practices is available upon request to me by Mini Health Clinic.

Patient/Guardian Signature: ____________________________________ Date: __________________

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MEDICAL HISTORY INTAKE FORM: PLEASE FILL IN FORM BELOW: THANK YOU.

LAST NAME: _________________ FIRST NAME_________________ DOB: ________ AGE: ______ SEX: ______

Height:_________ Weight:________

ALLERGIES:

____

____

____

PRESENTING PROBLEM:

____

____

____

____

MEDICATIONS/SUPPLEMENTS/OTC:

MEDICATION	DOSE	MEDICATION	DOSE

ILLNESS/INJURY: PLEASE CHECK/CIRCLE ALL THAT APPLIES.

YES	NO		YES	NO	
		High blood pressure			Heart Attack
		Diabetes: Type 1 or Type 2			Depression
		High cholesterol			Arthritis: Osteo. or Rheum.
		Kidney disease			Chronic Pain
		Asthma			Heart Murmur
		COPD			Thyroid problems
		Stroke			Kidney Stones
		Osteoporosis			Diverticulitis
		Anemia			Liver problems
		Reflux			Heart Failure
		Vision problems			Hearing problems
		HIV/hep C or other STD:			Heart murmur
		Erectile dysfunction			Menstrual cycle issues
		Autoimmune disease			Congenital disease

		Blood Transfusion			
		Other Illness not mentioned above:			Are you experiencing any of the following symptoms: Cough, shortness of breath, chest pain, leg swelling, fatigue, nausea, vomiting, headache, fall, numbness, and tingling?

SURGERIES/PROCEDURES: **DATES:**

FAMILY HISTORY:

____

____

SOCIAL HISTORY

Living situation: ______________________________ Occupation: ____________________________________

Substance Use: Alcohol: _____________________ Tobacco: _____________________ Drugs: ____________________

RECENT HOSPITALIZAITON:

____

____

____

GYN:

Last Menstrual Cycle:_______________ Pregnant: _________________ Children/Ages:___________________

Marital Status: _____________________ Sexually Active:__________________Birth Control:_____________________

Lifestyle Overview

Goals: ____

Biggest Obstacles: ____

How motivated are you, on a scale of 1-10? ____

What methods of weight loss have you used previously? Have you had any previous success?

____

____

24hr Food Recall: ____

How many times have you exercise in the past month? ____

How are your sleeping habits?____

Notes: ____

Patient/Guardian Signature: ______________________________________ Date: ___________________