Chris R. Gelvin, MD., P.A.
1217 S. East Ave. Suite #301
Sarasota, FL 34239
Phone: (941) 366-4440 | Fax: (941) 366-2049

PLEASE COMPLETE IN FULL

Date: ____/_____/_____
Account # _____

Name: _____
(Last name) (First name) (Middle name)

SSN: _____-_____-_____ Date of birth: ___/____/____
Sex: _____ Age: _____ Marital Status: _____

Local Address: _____ Phone: _____
City: _____ State: _____ Zip code: _____

Out of town address: _____ Phone: _____
City: _____ State: _____ Phone: _____

Employer: _____ Occupation: _____
Business Address: _____ Business phone: _____

Whom may we thank for referring you? _____

Emergency contact: _____
Relationship: _____ Phone: _____

Insurance Information

Is the subscriber to the primary insurance someone other than you? ( ) Yes ( ) No
Insurance: _____
Policy holders name: _____ Date of birth: ___/____/____
SSN: _____-_____-_____ Relationship: ( ) Self ( ) Spouse ( ) Child ( ) Other
Insurance ID #: _____ Group #: _____
Insurance address: _____
Phone number: _____ Effective date: _____

Is the subscriber to the primary insurance someone other than you? ( ) Yes ( ) No
Insurance: _____
Policy holders name: _____ Date of birth: ___/____/____
SSN: _____-_____-_____ Relationship: ( ) Self ( ) Spouse ( ) Child ( ) Other
Insurance ID #: _____ Group #: _____
Insurance address: _____
Phone number: _____ Effective date: _____

Health History
(Confidential)

Name: _____ Date: _____

Date of birth: _____/ _____/ _____ SSN: _____-_____-_____

Previous Primary care Physician name and location: _____

Allergies: _____

Current Chronic Medical Problems (check all that apply):

___ Angina
___ Migraines
___ Stroke
___ Heart Failure
___ Heart valve problems
___ Ulcers
___ Liver Disease
___ Chronic skin ulcers
___ Anxiety
___ Memory loss
___ Enlarged Prostate
___ Asthma
___ High cholesterol
___ Emphysema
___ High blood pressure
___ Mitral Valve Prolapse
___ Kidney disease
___ Gallstones
___ Seizures
___ Skin Cancers
___ Osteoporosis
___ Depression
___ Arthritis _____
___ Diabetes _____
___ Cancer _____
___ History of Heart attack
___ Atrial Fibrillation
___ Eye disease _____
___ Abdominal Aneurism
___ Reflux/ Hiatal Hernia
___ Arterial Insufficiency
___ Leg swelling
___ Low/high thyroid _____
___ Others not listed: _____

Systems Review (check all symptoms that you have noticed in the past year):

___ Weight loss
___ Weight gain
___ Difficulty sleeping
___ Chronic sinus congestion
___ Night sweats
___ Fevers
___ Chest pain
___ Dizziness/fainting
___ Frequent urination at night
___ Short of breath
___ Leg swelling
___ Excessive feeling of sadness
___ Excessive urination
___ Poor appetite
___ Stomach ache
___ Memory loss
___ Chronic diarrhea
___ Constipation
___ Hemorrhoids
___ Breast lump
___ Indigestion
___ Difficulty swallowing
___ Leg pain with walking
___ Excessive thirst
___ Fatigue
___ Chronic cough
___ Cold feet
___ Always cold
___ Hearing loss
___ Frequent headaches
___ Changes in vision
___ Palpitations
___ Skin rash
___ Irregular menses
___ Burning urination
___ Hot flashes

Accidents/Injuries: _____

Date of last complete Physical Exam: _____/_____/_____
Date of last pelvic/rectal exam: _____/_____/_____
Date and description of last routine blood test: ____/____/____ _____
Date and description of other testing: _____/_____/_____ _____
_____/_____/_____ _____

Immunization status: _____ Up to date ___ Will need: _____

Social History: **Yes** **No**

Do you smoke? ____ ____ If yes, how much/how long? _____
Have you ever smoked? ____ ____ If yes, when did you quit? _____
Do you drink alcohol? ____ ____ If yes, how much/how often? _____

Family History: **Age** **Health Problems**

Mother: _____ _____
Father: _____ _____
Siblings: _____ _____
_____ _____
_____ _____
Maternal Grandmother: _____ _____
Maternal Grandfather: _____ _____
Paternal Grandmother: _____ _____
Paternal Grandfather: _____ _____

Current Medications:	**Dosage**	**Frequency**

Surgeries: **Date** **Type/Location**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Physicians:

Cardiologist: _____ Pulmonologist: _____
Endocrinologist: _____ Gastroenterologist: _____
Gynecologist: _____ Infectious disease: _____
Urologist: _____ Dermatologist: _____
Neurologist: _____ Ophthalmologist: _____
Orthopedic: _____ Podiatrist: _____
Psychologist: _____ Other: _____

Patient Consent to Receive Mail and/or Telephone Messages

Name: _____
(Last name) (First name) (Middle name)

Do we have permission to:	Yes	No
Send a yearly appointment card to your home?	_____	_____
Send test results to your home?	_____	_____

Leave the following information on your home answering machine/voice mail:

	Yes	No
Appointment information:	_____	_____
Billing information:	_____	_____
Medical information:	_____	_____

I give permission to share appointment information with the person listed below:
Name(s): _____
_____

I give permission to share medical information including biopsy and lab results with the person listed below:
Name(s): _____
_____

I give permission to share billing information with the person listed below:
Name(s): _____
_____

_____ _____
Signature of Patient or Authorized Representative **Date**

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Patient Consent for Uses and Disclosures of Protected Health Information (PHI)

I do hereby authorize Chris R. Gelvin, MD., P.A. to release to any subsequent treating physician and/or any third party payor (i.e. insurance company, etc.) and to any State or Federal governmental agencies which regulate or oversee the healthcare industry, all or any part of my medical record related to my treatment.

I understand I may request restrictions regarding how my protected health information is used or disclosed in order to carry out treatment or payment regarding services provided. However, I understand Chris R. Gelvin, MD., P.A. personnel cannot abide by a restriction that would prohibit the office from complying with State and Federal regulatory agencies. If, after appropriate discussions and explanations, Chris R. Gelvin, MD., P.A. personnel agrees to my restrictions, I understand the restriction is binding.

I understand that I may revoke this consent in writing.

_____ (Initial) The staff at Chris R. Gelvin, MD., P.A. may leave discrete telephone messages on my personal answering machine or other number that I may provide.

I hereby request restriction of the following information:

_____

_____

_____ _____

Signature of Patient or Authorized Representative **Date**

☐ Accepted ☐ Denied

For Office Use Only

_____

Date

_____ _____

Signature of staff member Title

Patient Acknowledgment of Receipt of Privacy Practice Notice

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human services.

Signature: _____ Date: ____/_____/_____
Patient or Authorized Representative

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

- ○ Patient refused to sign (date of refusal): _____/_____/_____.
- ○ Communications barriers prohibited obtaining an acknowledgment.
- ○ An emergency situation prevented us from obtaining an acknowledgment.
- ○ Other: _____

Attempt was made by: _____ Date: _____/_____/_____

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Authorization to Release Medical Information

(If under 18 years of age, parent or guardian must sign)

Name: _____ Date of birth: ___/___/___
(Last name) (First name) (Middle name)

Local Address: _____ Phone: _____
City: _____ State: _____ Zip code: _____

I hereby authorize Chris R. Gelvin, MD., P.A. to receive or send the following information from the health records, for the purpose of continuation of medical care.

Name of Physician: _____ Address: _____

City/State: _____ Zip: _____

The information to be disclosed is:

____ All Records _____ Other: _____

_____ (initial) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or Hepatitis. It may also include information about behavior or mental health services, and treatment for alcohol and drug use.

_____ (initial) I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclose of the above information about, or medical records of my medical condition to those persons or agencies named above. Disclosure by the recipient will no longer be protected by the federal regulations governing the Privacy of Individually Identifiable Health Information (45 C.F.R. Part 164). A photocopy of this authorization shall have the same effect as the original.

If the patient is a minor, this authorization must be signed by a parent or legal guardian. If the patient is physically unable to sign this authorization, he/she should put an "X" on the signature line and have his/her assent witnessed. If the patient has been declared mentally incompetent, this authorization may be signed by a legally appointed guardian. If the patient is deceased, this authorization may only be signed by the next-of-kin or personal representative of the estate.

Unless revoked in writing, this authorization will NOT expire.

I understand that this consent is revocable by me, in writing, at any time except to the extent this action has been taken in reliance to it.

_____ _____ _____
Signature of Patient or Authorized Representative Relationship Date

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Prescription Refill Policy

All medication refill requests need at least 72 business hours to be addressed.

The request may not be granted if the MD requires a follow up visit.

It is your responsibility to keep track of how much medication you have left and give us a week to address your needs.

Please make an attempt to ask for any needed refills at the time of your visit.

Chris R. Gelvin will not call in last minute refill requests.

When the office is closed, the on call MD **WILL NOT** call in refills.

I have read and understand this policy:

Signature: _____
Patient or Authorized Representative

Date: _____/_____/_____