New Patient Intake Form

Name_____ Date of Birth_____

Address_____
(Street/apt) (City) (State) (Zip code)

Cell Phone: _____ I consent to be reminded of my appointments via text message: Yes / No

Email: _____
I consent to the email address being used for appointment reminders as well as added to the Priority You MD email newsletter, where I will get information on specials and promotions.
Driver License or Social Security Number: _____

Single/Married/Widowed/Divorced Advanced Directive Y/N Living Will: Y/N Power of Attorney: Y/N

How did you hear about us? _____

Employer _____ Occupation _____

Person to contact in case of an emergency _____Phone _____

Pharmacy Preference _____ Phone ( ) _____

I request that medical information, test results, or messages:

(INITIAL below all that apply)
_____ be given only to me directly in person or over the phone
_____ be left on my home/cell answering machine/voice mail
_____ be left with a member of my household. Name_____
_____ be mailed to my mailing address listed above
_____* be emailed to me at _____
* I understand that email is not secure and may be intercepted by unauthorized people and possibly made available on the internet. Understanding this possibility and that you have advised me that you would prefer to send my confidential information by mail, I still request that you email me the confidential information to the above email address.

I consent to medical treatment. I agree to pay all charges for myself, and for members of my family, as applicable, promptly upon presentation thereof. Charges as shown by statements are agreed to be correct unless protested in writing within thirty days. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney fees or other such costs as the Court determines proper.

_____ _____
Patient/ Parent/Guardian Signature Date

Continued on Back

PAST MEDICAL HISTORY

Previous or current primary care physician (PCP): _____

Date of last physical examination or visit to PCP: _____

Past/ Current Medical Conditions:

_____

_____

_____

Medication **ALLERGIES**: _____

Medications (please include dosages):

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

Over-the-counter medications taken at least once weekly: _____

Herbal products, supplements, vitamins or minerals: _____

_____

PREVENTATIVE CARE

Last colonoscopy: _____ Last chest x-ray: _____ __ Last testicular exam: _____

Last EKG: _____ Last mammogram: _____ Last pap smear: _____

Last breast exam: _____ Last bone scan: _____Last prostate exam and PSA: _____

SOCIAL HISTORY:

Do you smoke? Y/N How much? _____ packs/day How many years have you smoked? _____

High, medium, or low nicotine content? _____ If you quit, what year(s)? _____

Do you drink alcohol? Y/N How much and how often? beer_____ wine _____ liquor_____

Subjective Symptom Assessment

Physical Symptoms	Score	Mental Health Symptoms	Score
How satisfied with you with your **body**?		How would you rate your overall **mood**?	
How satisfied are you with your **weight**?		How would you rate your response to **stress?**	
How satisfied are you with your **sleep quality**?		How would you rate your ability to **manage stress?**	
How satisfied are you with your overall **strength**?		Rate your level of **Anxiety**	
How satisfied are you with your overall **health**?		Rate your level of feeling **depressed**	
How satisfied are you with your **exercise regimen**?		How would you rate your **job satisfaction?**	
How satisfied are you with your **energy level**?		Are you satisfied with **OTHERS perception** of you?	
How satisfied are you with your **libido**?		How satisfied are you with completing **tasks**?	
How satisfied are you with your **sexual performance**?		How satisfied are you with your **memory**?	
		How satisfied are you with your **self-confidence**?	
		How satisfied are you with your current **life**? (current day to day activities)	
		How satisfied are you with your **future plan**?	
Total Physical Score:		**Total Mental Health Score:**	
Total Wellness Score:			

Severity	Score
Poor/ None	1
Could be better	2
Average	3
Content	4
Excellent/Very Happy	5

Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can gain access to this information. Please review this notice carefully.

Allowed Uses and Disclosures of Your Medical Information:

- Treatment – ie: ordering diagnostic tests or consultations
- Payment – ie: submitting bills to your insurance company
- Health Care Operations – ie: quality assurance and eligibility verification

We may also use your medical information for emergency treatment when we attempt to obtain consent and are unable to do so, and consent for treatment is implied under the circumstances.

You Have a Right to:

- Request restriction on certain uses and disclosures, however, we are not required to agree to any requested restriction
- Receive confidential communications from us, upon written request
- Inspect and request copies of your medical information, upon written request
- Request to amend incorrect or incomplete medical information, upon written request
- Receive an accounting of any disclosures made, upon written request

We are Responsible for:

- Maintaining the privacy of your medical information
- Abiding by the terms of this notice
- Providing written notice of any change to this notice

Authorizations: Upon your written authorization (verbal or implied in the event of an emergency), we may disclose your medical information to a requesting entity, such as another provider, relative, or an attorney. You may revoke any authorization you make at any time, except to the extent that it was already relied on.

Patient Contact: We may contact you by telephone, SMS text, mail, or e-mail to provide such information as appointment reminders, treatment information or any other necessary communications.

Complaints: You may complain to us or to the Department of Health and Human Services if you believe that your privacy has been violated. If you wish to complain to us, please provide the Office Manager with written notice if you believe your privacy has been violated. All notices received will be investigated and reviewed by a Compliance Officer. You will receive a response to any notice within two weeks. To Obtain Information: Contact our Office Manager at 727-230-1438

I have received and reviewed a copy of the "Notice of Privacy Practices" Statement from Priority You MD.

_____ _____

Signature Date

Medical Records Release Authorization Form

Release Records From:

Physician/Facility: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Authorization Expires: _____

Information to be Disclosed:
___ All Records ___Imaging ___Labs ___EKG ___Other: _____

Purpose for Disclosure: _____

Release Records to:

Priority You
2744 Summerdale Drive
Clearwater, FL 33761
Fax to: (727) 230-1437

Authorization: I certify that this request has been made freely and voluntarily and that the information given above is accurate and complete to the best of my knowledge. I understand that I have the right to receive a copy of this form after I sign it. I may revoke this authorization in writing at any time except to the extent that action has already been taken comply with it. Written revocation is effective upon receipt at our facility.

Patient Signature: _____ Date: _____