PATIENT INFORMATION

Please provide the following information. Thank you.

NAME:_____ BIRTHDAY:_____ SEX: M □ F□

ADDRESS:_____ City:_____ State:_____ Zip: _____

TELEPHONE: Home_____ Cell:_____ Work: _____

EMAIL ADDRESS: _____

RACE: Please Check One
□ American Indian □ Alaskan Native □ Black or African American □ Hispanic or Latino
□ Native Hawaiian □ Pacific Islander □ Asian □ White/ Caucasian □ Other □ Patient Declined

ETHNICITY: Please Check One
□ Hispanic or Latino □ Not Hispanic or Latino □ Patient Declined

MARITAL STATUS: □ Never Married □ Married □ Annulled □ Widowed □ Separated □ Divorced □ Domestic Partners

EMPLOYMENT STATUS: Employed Unemployed Full-Time Student Part-Time Student Other Retired Child

Occupation: _____ Last Grade Completed: _____

SOCIAL SECURITY: _____/_____/ _____

PRIMARY INSURANCE COMPANY: _____

SECONDARY/TERTIARY INSURANCE COMPANY:_____/ _____

PRIMARY CARE PHYSICIAN: _____

PREFERRED LABORATORY: Please Check One
□ QUEST □ LABCORP □ OTHER: _____

PREFERRED PHARMACY: □ CVS □ PUBLIX □ RITEAID □ WALGREENS □ WALMART □ OTHER: _____

Please list any other provider you are currently seeing:_____

Who referred you to us? _____

Do you have any of the following?
□ Living Will □ Healthcare Power of Attorney □ Other Advanced Directive □ None

Do you have any religious practices or customs which are important to you? _____

CHIEF COMPLAINT

PLEASE RESPOND TO THE FOLLOWING QUESTIONS, FILLING IN THIS SECTION COMPLETELY.

1. Briefly describe your chief complaints: _____

_____

2. Cause of Pain: Traumatic □ Gradual □ Onset □ Repetitive □ Post-Surgical □ Work-Related □ Motor Vehicle □

3. Average Pain Intensity: Last 24 Hours: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Past Week: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

4. Quality of symptoms (What does it feel like?)

Numbness Dullness Stiffness Tingling Aching Throbbing

Nagging Sharp Burning Shooting Cramping Stabbing

5. When is it aggravated?

Cough/Sneeze Neck Movement Reaching Lifting Bending Twisting

Turning Sitting/Standing Walking Work Duties Sports Activities

6. How often do you experience your symptoms?

Constantly (76% - 100% of the time) Frequently (51% - 75% of the time)

Occasionally (26% - 50% of the time) Intermittently (0% - 25% of the time)

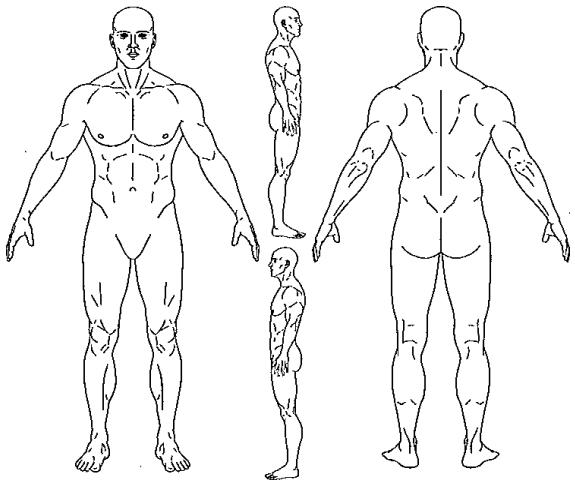
7. How much have your symptoms interfered with your usual daily activities?

Not at all A little bit Moderately Quite a bit Extremely

8. What has proven successful in relieving your pain?

Ice Heat Resting Stretching Exercising Medication

A = Dull Ache B = Burning N = Numbness P = Pins & Needles/ Tingling S = Sharp/Stabbing T = Throbbing O = Other



Name_____ **Date**_____

3800 Colonial Blvd. STE 200 Fort Myers, FL 33966
Phone 239-936-1233 | Fax 239-936-8576

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT & AUTHORIZATION

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires us to provide you with our Notice of Privacy Practices which explains our privacy practices and how we may legally use and disclose your Protected Health Information (PHI). In order to protect your privacy and confidentiality, we ask that you authorize when, and to whom, protected health information can be released.

May we leave a detailed message on your home or cell phone answering machine? □ Yes □ No

May we phone you at work and leave a message to call our office back? □ Yes □ No

May we use SMS (text messages), and/or email to inform you of upcoming appointments? □ Yes □ No

If yes, please provide the most recent cell number and email. (_____)_____-_____

Email:_____

Do we have your permission to talk to family members or other individuals? □ Yes □ No

If yes, please provide the names, phone numbers, and relation to you:

Name_____Phone_____Relationship _____

Name_____Phone_____Relationship _____

Name_____Phone_____Relationship _____

By signing this form, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them. I have been given the opportunity to ask question, and I understand the Notice of Privacy Practices, I understand that this form will be placed in my patient chart and maintained for six years.

Print Patient Name _____

Patient Signature _____Date _____

Physicians Medical Group of Southwest Florida, L.L.C.
3800 Colonial Blvd. STE 200 Fort Myers, FL 33966
Phone 239-936-1233 | Fax 239-936-8576

RECORD RELEASE AUTHORIZATION

Doctor/Hospital:_____

Phone Number:_____ Fax Number:_____

Patient Name:_____ DOB: _____

Patient Signature:_____ Date: _____

Relationship/Authority if not signed by patient: _____

Witness Signature:_____ Date: _____

Please send: Last Office Note, Medication List, recent Lab Work, and Recent Diagnostic Imaging.

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INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures, I understand that I am under the care and supervision of the attending physician(s) and it is the responsibility of the staff to carry out the instructions of such physician(s).

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different medical procedures, physical therapy procedures, and osteopathic treatment. I understand that medical treatment is not an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate of explain risks and complication and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend the best course of treatment based upon facts known that are in my best interests.

I further understand that there are certain degrees of risk associated with medical and osteopathic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strains/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future condition for which I seek treatment.

Female Patients: By my signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected of confirmed at this time. If you are pregnant or think that you may be, please notify the front desk.
Date of last menstrual period (if applicable):_____.

Print Patient Name _____

Patient Signature _____ Date _____

Relationship/Authority if not signed by patient. _____

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Power of Attorney and Medical Release

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDIATE PAYMENT TO PROVIDER FOR SERVICE RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint Physicians Medical Group of Southwest Florida, LLC (PMG) and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said PMG, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows PMG or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

THE UNDERSIGNED BY THESE PRESENTS DOES GIVE AND GRANT THE SAID *PHYSICIANS MEDICAL GROUP OF SOUTHWEST FLORIDA, LLC* AS ATTORNEY THE LIMITED POWER AND AUTHORITY TO DO AND PERFORM ALL AND EVERY ACT WHATSOEVER REQUISITE AND NECESSARY TO BE DONE IN AND ABOUT THE PREMISES AS FULLY TO ALL INTENTS AND PURPOSED AS THE UNDERSIGNED MIGHT OR COULD DO TO PERSONALLY PRESENT INSOFAR AS THE ENDORSING AND CASHING OF SAID CHECKS ARE CONCERNED AS WELL AS ANY OTHER DOCUMENT.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Physicians Medical Group of Southwest Florida, LLC or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be a binding as an original signature page.
The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I,_____, hereby authorize. _____
(Name of Insured/Patient) **(Name of Insurance Carrier)**
to make medical benefits payments otherwise payable to me for services rendered by Physicians Medical Group of Southwest Florida, LLC, but not to exceed the charges of those services, payable to and mailed directly to:

Physicians Medical Group of Southwest Florida, LLC 3800 Colonial Blvd. STE 200 Fort Myers, FL 33966

Furthermore, I hereby IRREVOCABLY ASSIGN to Physicians Medical Group of Southwest Florida, LLC the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by PMG.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this_____ of _____ _____
Day Month Year

Patient Signature_____ Print Name _____

ADULT HEALTH HISTORY

Need assistance to complete? □ Yes □ No

ALLERGIES

List any allergies and reactions to medications, food, latex, dye, etc	Allergy	Reaction
	1	
	2	
	3	
	4	

MEDICATIONS

List all current medications, including Non-prescription drugs, herbs, and Supplements	NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN
	1			5		
	2			6		
	3			7		
	4			8		

PATIENT PAST MEDICAL HISTORY

AFIB……..□ Yes □ No Depression…..□ Yes □ No High Blood Pressure....…. □ Yes □ No Osteoporosis……□ Yes □ No

Anemia .....□ Yes □ No Diabetes... ..... .□ Yes □ No High Cholesterol…… □ Yes □ No Seizures ..... □ Yes □ No

Arthritis…..... □ Yes □ No GERD. .....□ Yes □ No HIV/AIDS ……. □ Yes □ No STD..... □ Yes □ No

Anxiety .....□ Yes □ No Glaucoma…… □ Yes □ No Insomnia……..… □ Yes □ No Stroke/TIA..... □ Yes □ No

Asthma/Emphysema/COPD□ Yes □ No Gout……..……..…□ Yes □ No Kidney Disease……. □ Yes □ No Thyroid Disease…. .....□ Yes □ No

Cancer….....□ Yes □ No Heart Attack……...□ Yes □ No Migraine……...□ Yes □ No Tuberculosis ……□ Yes □ No

Dementia/Alzheimer's…□ Yes □ No

ADDITONAL MEDICAL PROBLEMS/PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS INJURIES

1_____Date: _____

2_____Date: _____

3_____Date:_____

Have you ever had any Auto Accidents or Personal Injuries? □ Yes □ No

1 _____Date: _____

2 _____ Date: _____

FAMILY MEDICAL HISTORY (Refer to Patient Past Medical History for Diseases)

	Age	Name	Diseases	If Deceased, Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				
Children				

IMMUNIZATION HISTORY

Flu Vaccine (Date): _____ Pneumovax Vaccine (Date): _____ Last Tetanus (Date): _____ Hepatitis Vaccine (Date):_____

Covid Vaccine (Date):_____ Covid Boosters (Date): _____ Shingles Vaccine (Date): _____

SOCIAL HISTORY

How often do you smoke? □ Never □ Former/Date Quit _____ □ Current Smoker ____Packs per day For how long?_____

How often do you drink alcohol? □ Socially □ Weekly □ Daily □ Beer/Wine □ Liquor □ Never

Have you ever used recreational drugs? □ Yes □ No Do you have a Medical Marijuana Card? □ Yes □ No

ARE YOU PREGNANT? □ Yes □ No Due Date_____

Name:_____Date of Birth: _____

REVIEW OF SYSTEMS

Please check below if any of the following symptoms are current or recent.

CONSTITUTIONAL

Good General Health Lately ..... □ Yes □ No
Frequent Fever ..... □ Yes □ No
Fatigue ..... □ Yes □ No

EYES

Sensitive to Lights ..... □ Yes □ No
Changes in Vision ..... □ Yes □ No
Wear Glasses/Contact Lenses ..... □ Yes □ No

EARS/NOSE/MOUTH/THROAT

Hearing Loss or Ringing ..... □ Yes □ No
Earaches or Drainage ..... □ Yes □ No
Nasal Stuffiness/Sneezing ..... □ Yes □ No
Frequent Nosebleeds ..... □ Yes □ No
Mouth Sores… ..... □ Yes □ No
Bad Breath or Bad Taste ..... □ Yes □ No
Sore Throat or Change in Voice ..... □ Yes □ No
Swelling in Neck/Enlarged Tonsils ..... □ Yes □ No

CARDIOVASCULAR

PACEMAKER/DEFIBLATOR ..... □ Yes □ No
Low Exercise Tolerance ..... □ Yes □ No
Chest Pain or Angina Pectoris ..... □ Yes □ No
Rapid Heartbeat/Skipped Beats ..... □ Yes □ No
Shortness of Breath with Activity or Lying Flat… ..... □ Yes □No
Swelling of Feet, Ankles, or Hands ..... □ Yes □ No
Varicose Veins ..... □ Yes □ No
Discolored/Cool Extremities ..... □ Yes □ No

GASTROINTESTINAL

Loss of Appetite… ..... □ Yes □ No
Abdominal Pain or Heartburn ..... □ Yes □ No
Change in Bowel Habits ..... □ Yes □ No
Regular Use of Laxatives… ..... □ Yes □ No
Rectal Bleeding or Blood in Stool ..... □ Yes □ No

RESPIRATORY

Chronic or Frequent Coughs ..... □ Yes □ No
Coughing up Blood ..... □ Yes □ No
Wheezing ..... □ Yes □ No

NEUROLOGY

Frequent or Recurring Headaches… ..... □ Yes □ No
Lightheaded or Dizzy ..... □ Yes □ No
Convulsions or Seizures… ..... □ Yes □ No
Tremors ..... □ Yes □ No
Speech Problems ..... □ Yes □ No
Balance Problems ..... □ Yes □ No
Memory Loss of Confusion ..... □ Yes □ No
Numbness or Tingling Sensations ..... □ Yes □ No

ONCOLOGY

Have you ever been diagnosed with Cancer ..... □ Yes □ No
Where:_____
Treatment:_____

Do you have any metal implants ..... □ Yes □ No
Where:_____

GENITOURINARY

Frequent/Burning/Painful Urination □ Yes □ No
Blood in Urine ..... □ Yes □ No
Change in Force of Stream When Urinating ..... □ Yes □ No
Incontinence or Dribbling ..... □ Yes □ No
Male – Penile Discharge or Sores… ..... □ Yes □ No
Male – Testicle Pain or Lumps ..... □ Yes □ No
Sexual Difficulty ..... □ Yes □ No
Female - Pain with Periods ..... □ Yes □ No
Female - Irregular Periods ..... □ Yes □ No
Female - Vaginal Discharge ..... □ Yes □ No
Female - # of Pregnancies: _____
Female - # of Miscarriages: _____
Female - Date of Last PAP Smear: _____
Female - Date of last Menstrual Period: _____

MUSCULOSKELETAL

Joint Pain /Stiffness/Swelling ..... □ Yes □ No
Weakness of Muscles or Joints ..... □ Yes □ No
Muscle Pain or Cramps ..... □ Yes □ No
Back Pain ..... □ Yes □ No
Use of Assistive Device ..... □ Yes □ No

INTEGUMENTARY

Rash or Itching ..... □ Yes □ No
Change in Moles ..... □ Yes □ No
Change in Hair or Nails… ..... □ Yes □ No
Breast Pain/Lumps/Discharge ..... □ Yes □ No

PSYCHIATRIC

Nervousness or Anxiety ..... □ Yes □ No
Sleep Poorly ..... □ Yes □ No
Often Depressed ..... □ Yes □ No
Change in Moods ..... □ Yes □ No
Lifestyle Change (Divorce, Death, Loss of Job) ..... □ Yes □ No
Considered/Attempted Suicide ..... □ Yes □ No
Violence in Your Home ..... □ Yes □ No

HEMATOLOGICAL / LYMPHATIC

Slow to Heal After Cuts ..... □ Yes □ No
Bleed or Bruise Easily ..... □ Yes □ No
Past Transfusion ..... □ Yes □ No
Enlarged Glands ..... □ Yes □ No

ENDOCRINE

DIABETIC ..... □ Yes □ No
Last A1c:_____
Night Sweats… ..... □ Yes □ No
Excessive Thirst or Urination ..... □ Yes □ No
Heat or Cold Intolerance ..... □ Yes □ No
Skin Becoming Drier ..... □ Yes □ No

Last Colonoscopy:_____

Last Mammogram:_____

Patient Name:_____ Date of Birth: _____