Nature Coast Health Care

New Patient General Information
7562 W. Gulf to Lake Hwy, Crystal River FL 34429//820 S Bea Ave., Inverness FL 34453

Patient Last Name:_____ Patient First Name:_____ DOB:_____

***Instructions:* Complete all items. Indicate N/A if not applicable**

☐ ***Driver License*** ☐ ***Insurance Card***

Today's Date: _____ How did you hear about our office? _____

Patient Name: _____ DOB: _____
Last First MI

Phone (Day): _____ Phone (Evening, Cell): _____

Mailing Address: _____ City: _____ State: _____ Zip:_____

SS#: _____ - _____- _____ Gender: M F Other Marital Status: Single Married Divorced Widowed
(Please Circle One) (Please Circle One)

(Please Circle One

Primary Language: English, Spanish, refused to report, Other: _____
Race: Native American, Indian, Alaskan Native, Asian, African American, Caucasian, Refused to Report, Other: _____
Ethnicity: Hispanic or Latino, Non-Hispanic or Latino, refused to report, Other: _____

Email Address: _____

Employer: _____ Phone Number: _____

Primary Insurance Carrier: _____ Policy ID: _____

Type of Plan: HMO PPO POS Other Insurance Carrier Phone #: (___)_____
(Please Circle One)

Second Insurance Carrier: _____ Policy ID: _____

EMERGENCY CONTACT INFORMATION
Name: _____
Relationship: _____
Phone: _____

MEDICAL RELEASE INFORMATION
Can we discuss your medical condition or test result(s) with your family member(s)? □ Yes □ No
can be shared with _____
Can we leave a message on your answering machine at: Home? □ Yes □ No Cell? : □ Yes □ No
Fax a copy of your result(s) to another physician if need be: □ Yes □ No

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Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, don't answer it. Add any notes you think are important.

Past Medical History (Please check all that apply

☐ AIDS/HIV +	☐ Depression	☐ Hypertension	☐ Stroke
☐ Anemia	☐ Diabetes	☐ Kidney Disease	☐ Thyroid Problem
☐ Anxiety	☐ Eating Disorder	☐ Liver Disease	☐ TB
☐ Arthritis	☐ Emphysema/COPD	☐ Migraines/Headaches	☐ Ulcers
☐ Asthma	☐ Epilepsy	☐ Mononucleosis	☐
☐ Bleeding Disorder	☐ Glaucoma	☐ Multiple Sclerosis	☐
☐ Breast lump	☐ Gout	☐ Pneumonia	☐
☐ Bronchitis	☐ Heart Disease	☐ Prostate Problem	☐
☐ Cancer	☐ Hepatitis	☐ Rheumatic Fever	☐
☐ Cataracts	☐ Hernia	☐ Sexually transmitted disease	☐
☐ Chicken Pox	☐ High Cholesterol	☐	☐
☐ Other:			

_____

_____

Past Surgical History

Date: _____ Reason: _____ Hospital: _____

_____ _____ _____

Hospitalizations:

Date: _____ Reason _____ Hospital: _____

_____ _____ _____

Have you ever had a blood transfusion? □ Yes □ No If so, when? _____Blood Type? _____
Have you ever had a cardiac stress test? □ Yes □ No If so, when? _____
Do you have a history of drug addiction? □ Yes □ No

Allergies

Are you allergic to any medications: □ Yes □ No
List anything that you are allergic to (medications, food, bee stings etc.) and how each affects you.

Allergy	Reaction
1._____	_____
2._____	_____
3._____	_____

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Immunization History ✓ ***any vaccine received and date***

	Date: (if known)				
□ Chickenpox	_____	□ Meningococcus	_____	□Typhoid	_____
□ Flu shot	_____	□ MMR (Measles, Mumps, Rubella)	_____	□Smallpox	_____
□Gardasil/HPV	_____	□ Pneumonia	_____	□Pneumococcal	_____
□ Hepatitis A	_____	□ Tdap (tetanus and pertussis)	_____	□ COVID-19	_____
□ Hepatitis B	_____	□ Tetanus	_____	□ Zostavax (Shingles)	_____

Personal Habits:

1) Have you ever smoked? □ Yes □ No If Yes, are you a regular smoker now? □ Yes □ No Have you used chewing tobacco? □ Yes □ No If Yes, number of yrs. _____ If No, when did you quit? _____
2) Do you regularly drink alcohol? □ Yes □ No If Yes, how often: _____
3) Have you ever used any of the following? □ Marijuana □ LSD □ Heroin □ Cocaine □ Speed □ Other: _____

Exercise/Activity

Exercise Level □ None □ Occasional exercise □ Moderate exercise □ High level exercise
Current Activity / Frequency _____
Physical Limitations: _____

Nutritional History

Current Weight: _____Lbs. Height: _____Ft. _____In Weight Change in the past 6 mo.? □ Yes □ No
Current Diet Plan?

_____ _____
Patient/Guardian/Parent Signature Date

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Patient Last Name:_____ Patient First Name:_____ DOB:_____

Family Health History:

Relation	Alive	Age	Significant Health Problems
Grandmother (Maternal)	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Osteoporosis □ Heart Disease □ Hypertension □ Stroke
Grandfather (Maternal)	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Stroke
Grandmother (Paternal)	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Osteoporosis □ Heart Disease □ Hypertension □ Stroke
Grandfather (Paternal)	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Stroke
Father	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Stroke
Mother	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Osteoporosis □ Heart Disease □ Hypertension □ Stroke
Brother (any)	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Stroke
Sister (any)	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Osteoporosis □ Heart Disease □ Hypertension □ Stroke
Other	Y N		□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Stroke

Social Lifestyle / History:

Education - □ Less than 8th grade □ High school □ 2 Year college □ 4-year college □ Postgraduate
□ Employed Occupation_____ □ Unemployed □ Retired □ Disabled

Is there someone that lives in your residence? □YES □NO If yes, please list name and relationship:

Type of Residence □ Apartment □ Mobile Home □ House: □ One Story □ Two Story
□ Assisted Living Name: _____

Durable Medical Equipment? □YES □NO □ Wheelchair □ Oxygen □ Walker □ Cane
□ Nebulizer □ CPAP/BIPAP Other: _____

Can you afford medications? □YES □NO If no, explain:

Do you have a cognitive issue? □ Memory problems □ Dementia □ Learning disability

Do you drive? □YES □NO If no, explain:

Do you live in a safe environment? □YES □NO If no, explain:

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Patient Last Name:_____ Patient First Name:_____ DOB:_____

Obstetric and Gynecological History (Women only)

Last PAP exam: _____ Date of last Mammogram: _____
Age of first menstrual Period: _____ Date of last menstrual period or age of menopause: _____
Number of pregnancies: _____ Births: _____ Living: _____ Miscarriages: _____ Abortions: _____
Cesarean section: if yes, then number: ____

□ Bleeding between periods □ Heavy period Extreme menstrual pain □ Vaginal itching, burning or discharge
□ Hot Flashes □ Breast lump or nipple discharged. □ Self breast exam □ wake in the night to go to the bathroom

Sexual History:

Are you sexually active:	□ Yes	□ No
Current sexual partner:	□ Female	□ Male □ Multiple partners
Do you use condoms:	□ Yes	□ No
Interested in being screened for STD'S?	□ Yes	□ No

Activities Of Daily Living

Do you require assistance to bathe or groom?	□Yes □No	If Yes, Explain:
Do you require assistance for your toilet needs?	□Yes □No	If Yes, Explain:
Do you require assistance to eat?	□Yes □No	If Yes, Explain:
Do you have hearing loss?	□Yes □No	
Do you wear hearing aids?	□Yes □No	
Do you have vision loss?	□Yes □No	
Do you receive regular Dental Care	□Yes □No	

Screenings: *if you have a copy or name of provider completed- please list*

	Date:	Provider/where was this done?	
Annual Wellness Visit	_____	_____	□Normal □Abnormal
Eye Exam	_____	_____	□Normal □Abnormal
Colonoscopy or iFOBT kit	_____	_____	□Normal □Abnormal
Labs	_____	_____	□Normal □Abnormal
Electrocardiogram	_____	_____	□Normal □Abnormal
Blood Pressure	_____	_____	□Normal □Abnormal
Mammogram	_____	_____	□Normal □Abnormal
Bone Density (DEXA)	_____	_____	□Normal □Abnormal

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I, the undersigned voluntarily give consent to Nature Coast Health Care medical professional to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Signature: _____ Date: _____ DOB: _____
Patient Printed Name _____Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You may refuse to sign this acknowledgement

I have received/reviewed a copy of Nature Coast Health Care's Notice of Privacy Practices and the Florida Patient Bill of Rights.

Signature: _____ DATE: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign
□ Communication barriers prohibited obtaining the acknowledgment
□ An emergency situation prevented us from obtaining acknowledgement
□ Other (Please Specify): _____

_____ _____
Signature of Employee Date

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List of Providers

Please list all physicians you are currently being treated by or have seen in the last 2 years.
* Please include last primary care physician

Physician Name	Specialty	City/State	Phone Number	Mo/Yr Last Seen

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List of Medications

Please list all medications you are currently taking, including inhalers, oxygen, chemotherapy, prescription drugs, over the counter drugs, and vitamins.

Preferred Pharmacy Name: _____ City: _____

Drug	Dosage	How often	Date started
Example: Vitamin C	500mg	Daily	

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HIPAA NOTICE OR PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Nature Coast Health Care uses an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy and insurance company through a secure electronic prescription connection which improves the timely and accurate transmission of your medication information. To optimize the use of this electronic capability, and coordinate your care between us and your specialists, this will allow us to access your medication history through the pharmacies and insurance companies' electronic database.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that relates to your past, present, or future physical or mental health or condition and related health services.

1. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

a. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

b. Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

c. Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, research, criminal activity, military activity, and national security, workers' compensation, inmates. Required uses and disclosures: under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. **Other permitted and required uses and disclosures** will be made only with your consent, authorization, or opportunity to object unless required by law. **You may revoke this authorization at any time**, in writing, except to the extent that you physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient Last Name:_____ Patient First Name:_____ DOB:_____

2. Your Rights: Following is a statement of your rights with respect to your protected health information.

a. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

b. You have the right to request a restriction of you protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

c. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure or your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

d. You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

e. You have the right to obtain a paper copy of this notice from us, upon request, if you have agreed to accept this notice alternatively i.e. electronically.

f. You may have the right to your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

g. You have the right to receive an accounting of certain disclosures we have made, if any, or your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact or your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy or, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:
Print Name: _____
Signature: _____ Date: _____

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Florida Patient's Bill of Rights and Responsibilities
Florida Statutes Chapter 381(026)

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Nature Coast Health Care

PATIENT SELF-DETERMINATION QUESTIONNAIRE - YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance.

- Declaration to Decline Life-Prolonging Procedures (Living Will)

  □ I have □ I have NOT made a Living Will

- Health Care Surrogate

  □ I have □ I have NOT designated a Health Care Surrogate

- Durable Power of Attorney

  □ I have □ I have NOT appointed a Durable Power of Attorney for Health Care Decisions

If you have signed an advance directive outlining your wishes, we will gladly make a copy and place it in your chart. If you have not created an advance directive, we will gladly provide you with a packet of information and forms.

PATIENT PRIVACY QUESTIONNAIRE

Please list the family members or other persons, if any, whom we may verbally inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____ Relationship: _____ Phone: _____

Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: _____ Relationship: _____ Phone: _____

I understand that all correspondence from our office will be sent in a sealed envelope marked "CONFIDENTIAL"

Confidential messages (i.e., appointment reminders) □ May □ May NOT be left on answering machine or voicemail.

Please print the phone number where you want to receive calls about your appointments:

_____

*I am fully aware that a cell phone is not a secure and private line. _____ (**initals**)*

Please print patient name date of birth _____

_____ *legal representative relationship to patient*

_____, 20_____

signature of patient or legal representative today's date

Nature Coast Health Care

AUTHORIZATION TO RELEASE/REQUEST HEALTHCARE INFORMATION

Patient Information

Patient's Name _____ Date of Request _____ Home Phone _____

Address _____ Date of Birth _____ Cell Phone _____

Last 4 of Social Security _____ Email _____

*Authorized Representative (if other than the patient) _____

*Authority of Authorized Representative ☐ Guardian ☐ Health Care Power of Attorney ☐ Health Care Surrogate ☐ Parent of Minor

☐ Representative of Deceased Patient ☐ Other _____

Information to be Released

☐ Specified Records for Date(s) of Service: ____ / ____ / ____ *to* ____ / ____ / ____

☐ Provider Name(s) _____

☐ Last History & Physical Exams ☐ Last Emergency Room Records ☐ Last Operative Reports/Consults ☐ Last Imaging Reports/Films

☐ Last Physician Progress Notes ☐ Other Records (specify) _____

This section to be completed if records will be requested or released to or from another medical facility/practice/provider to Nature Coast Health Care.

Medical Facility Practice/ Provider Name _____ Contact Name _____ Phone _____

☐ Mail Address _____ City _____ State _____ Zip Code _____

☐ Fax _____

Records to be sent to: Nature Coast Health Care Attn: Medical Records

7562 W Gulf to Lake Hwy Crystal River 34429 | (Phone) 352-436-4328 (Fax) 352-260-0960

Purpose of Disclosure: ☐ Continuing Medical Treatment/Continuity of Care ☐ Other (Please Specify) _____

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulations. Release of such records requires specific consent. I hereby grant such specific consent as initialed below. **I UNDERSTAND** that these records are protected under federal and state regulations and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, If applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

In addition to any records checked above, the following initialed records may be released:

☐ Behavioral/Mental Health Information _____ (please initial)

☐ Substance Abuse Information _____ (please initial)

☐ Sexually Transmitted Disease Information _____ (please initial)

☐ Immune deficiency syndrome (AIDS), or Human Immunodeficient Virus (HIV) _____ (please initial)

Right to Revoke Authorization: I may revoke this authorization in writing at any time to the practice, except to the extent that the information has been released in the execution of this authorization. I further understand that I have a right to receive a copy of this authorization upon request.

Authorization: I hereby authorize the use or disclosure of my individually identifiable health information as described. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment, or eligibility of benefits may not be conditioned on my signing this authorization except as provided by law. I understand that information released in response to this authorization could potentially be re-disclosed and may no longer be protected by federal privacy regulations. I understand that in compliance with Florida Law, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records. I understand that this authorization will **expire one year from the signature date below**.

_____ _____

Signature of Patient or Patient's Authorized Representative Date