GMS FLORIDA WEST COAST, INC.

FAMILY IDENTIFICATION & BUSINESS INFORMATION: DATE _____

Patient Name _____ Birth Date _____ Age___
Spouse/Parent/Guardian _____ Birth Date _____ Age___
Address _____ City _____ ST _____ Zip _____
Alternate Address _____ City _____ ST _____ Zip _____
Social Security #: _____ Marital Status:( )Married ( )Divorced ( )Widow ( )Single
Phone #: _____ Cell #: _____

Patient's Employer: _____ Occupation: _____
Phone Number: _____
Spouse's Employer: _____ Occupation: _____
Phone Number: _____

Referred By: _____

Emergency Contact: _____ Relationship: _____
Phone Number: _____ Alternate Phone Number: _____

Primary Insurance: _____ Secondary Insurance: _____
ID #: _____ ID #: _____
Covered by ( )Self ( )Spouse ( )Parent Covered by ( )Self ( )Spouse ( )Parent
Policy Holders Name: _____ Policy Holders Name: _____
Policy Holders Date of Birth: _____ Policy Holders Date of Birth: _____
Policy Holders Address: _____ Policy Holders Address: _____

Do you have Medicare? ( )Yes ( )No If Yes, Policy #: _____

You may release my medical information to:

_____ _____ _____
Name and relation Name and relation Name and relation

I give my permission to leave test results or other medically related communications on my answering machine or voice mail. ( )Yes @ #:_____ ( )No

_____
SIGNATURE OF PATIENT

PLEASE PRESENT ALL INSURANCE CARDS, COPAYMENTS AND RESIDUAL BALANCES TO THE RECEPTIONIST EACH TIME YOU COME IN TO BE SEEN.

I UNDERSTAND THAT ALL CHARGES (INCLUDING THOSE NOT PAID BY INSURANCE), COLLECTION FEES, BANK AND RETURNED CHECK FEES, LEGAL FEES, FAILURE TO KEEP APPOINTMENT FEES AND LATE FEES ARE THE FINANCIAL RESPONSIBILITY OF THE PATIENT (OR THE PARENT/GUARDIAN IN THE CASE OF A MINOR). I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ALL INFORMATION CONCERNING MY ILLNESS(ES) AND TREATMENT TO MY INSURANCE CARRIERS/HEALTH PLANS. IN THE EVENT THAT THIS OFFICE PARTICIPATES WITH MY INSURANCE CARRIER/ HEALTH PLAN, I HEREBY ASSIGN ALL AVAILABLE BENEFITS AND PAYMENTS DIRECTLY TO THEM FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL AMOUNTS NOT COVERED BY MY INSURANCE CARRIER/HEALTH PLAN, AND I AUTHORIZE THIS OFFICE TO CHARGE MY CREDIT/DEBIT ACCOUNT FOR THE FULL AMOUNT OF ANY UNPAID BALANCE. I ACKNOWLEDGE NOTIFICATION OF HIPAA'S PRIVACY RULE AND PRACTICES AND UNDERSTAND THAT I MAY REQUEST A COMPLETE COPY AT ANY TIME.

_____
SIGNATURE DATE

DO YOU HAVE A LIVING WILL OR WISH TO DISCUSS ONE? ( )HAVE ONE ( )DISCUSS ( )NOT INTERESTED

GMS FLORIDA WEST COAST, INC. - PATIENT HISTORY FORM

DATE: _____ DATE OF BIRTH: _____

NAME: _____ AGE: _____

Family History: For each family member below mark an "x" for all that apply to that person's health.

	HEALTH			Cause of death	Allergies/ Asthma	Stress/ depression	Kidney problems	Diabetes	High blood pressure	Heart trouble	Anemia Bleeding Issues	Cancer /Tumor
	Good	Poor	Deceased									
Father:												
Mother:												
Sibling:												
Sibling:												
Sibling:												
Sibling:												

Your Health History

Do you smoke? ( )Yes ( )No ( )Quit-When_____ How many packs per day? _____ How many years? _____

Do you drink alcohol/beer? ( )Yes ( )No How many drinks per day? _____ How many years? _____

Additional Illnesses: Mark an "X" in the boxes of the illnesses that you have or have ever had.

☐ eczema	☐ bronchitis	☐ pancreatitis	☐ mononucleosis	List Others Below:
☐ asthma	☐ measles	☐ liver disease	☐ german measles	☐
☐ malaria	☐ pneumonia	☐ neuritis	☐ kidney trouble	☐
☐ mumps	☐ hemorrhoids	☐ chicken pox	☐ yellow jaundice	☐
☐ polio	☐ emphysema	☐ scarlet fever	☐ venereal disease	☐
☐ hives/ rash	☐ diverticulosis	☐ thyroid disease	☐ rheumatic fever	☐

Have you ever been turned down for life insurance, military service or employment because of your health? ☐ yes ☐ no

Major Hospitalizations: If you have ever been hospitalized for any serious medical illness or operation write them below starting with the most recent. (Do not include normal pregnancies.) ☐ Check this box if you have had more than three hospitalizations.

	Year hospitalized	Operation or illnesses	Name of hospital	City and state
1)				
2)				
3)				

Allergies / Reaction:

_____

_____

_____

_____

Current Medical Problems

_____

_____

_____

_____

_____

Current Medications (Including Strength and Dosage):

_____

_____

_____

_____

_____