|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| In an effort to ensure all your information is correct in your file, please fill out the information below. ***PLEASE PRINT*.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s Date: | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | | | | | | | | | | | First: | | | | | | | Middle: | | | | | ❑ Mr.  ❑ Mrs. | | | | | ❑ Miss  ❑ Ms. | | | | Marital status (circle one): | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid | | | | | | |
| Birth date: | | | | | Age: | | | | | | | Sex: | | | | | | | | | Social Security #: | | | | | | | | | | | | | | | | | | | | Cell Phone #: | | | | |
| / / | |  | | |  | | | | | | | ❑ M ❑ F | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | |  | |
| Street address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Home Phone #: | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | | |
| P.O. Box: | | | | | | | | | | City: | | | | | | | | | | | | | | | | | | | | | | | State: | | | | | | | ZIP Code: | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | |
| Occupation: | | | | | | | | | | Employer: | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer Phone: | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Please give your insurance card to the receptionist.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person responsible for bill: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Occupation: | | | | | | | Birth date: | | | | | | | | | | Address (if different): | | | | | | | | | | | | | | | | | | | | | Home phone #: | | | | | | | |
|  | | | | | | | / / | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | |
| Is this patient covered by insurance? | | | | | | |  | | | | Employer: | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | |
| ❑ Yes | | | | Employer address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone #: | | | | | | | | | | | | | |
| ❑ No | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | | | | |
| Subscriber’s name: | | | | | | | | | | | | |  | | Primary Insurance: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | ❑ Medicare | | | | | | | | | | | | ❑BCBS | | | | | | | | ❑ United Healthcare | | | | | | | | | ❑ Secure Horizons | | | | | | ❑ Aetna | | |
| ❑ Tricare | | | ❑ Humana | | | | | | ❑ Self-Pay ❑ Cigna | | | | | | | | | | | | | | | ❑ Other | | | | |  | | | | | | | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | Subscriber’s S.S. #: | | | | | | | | | | | | | | | Birth date: | | | | | | | | Group #: | | | | | | | Policy #: | | | | | | | Co-payment: |
|  | | | | | | | |  | | | | | | | | | | | | | | | / / | | | | | | | |  | | | | | | |  | | | | | | | $ |
| Patient’s relationship to subscriber: | | | | | | | | | | | | | | ❑ Self | | | | | | | ❑ Spouse | | | | ❑ Child | | | | | | ❑ Other | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | Subscriber’s name: | | | | | | | | | | | | | | | | | | | | | | Group #: | | | | | | Policy #: | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | |
| Name of local friend or relative (not living at same address): | | | | | | | | | | | | | | ❑ Self | | | | | | | ❑ Spouse | | | | ❑ Child | | | | | | Phone: | | | | | Relationship to patient: | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Chet Anthony, D.O. or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | | | | |  | | | | | | | | | | |
| Signature | | | | | |  | | | | | | | | | | Date | | | | | | | | | | |
|  |

🞏 I authorize Dr. Chet Anthony and the office staff to obtain my protected health information as needed from any of the following:

* *Previous Doctors/Medical Offices*
* Urgent Care/Clinics
* *Hospitals*
* *Pharmacies*
* *Imaging Centers*
* *Assisted Living Facilities/Nursing Homes*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Witness

**Medical History**

Current Medications—Including dosage and directions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­

Allergies:

**Social history**

Marital Status: Children: Lives with: \_\_\_\_\_\_\_\_\_\_ Pets:

Occupation: Years in FL: States prior to FL:

Nutrition: (Poor, average, good, excellent or vegetarian)

Exercise: Sexual Activity: Contraceptive:

Smoking: \_\_\_\_ If so, how many packs per day?­ Tobacco exposure:

Alcohol? \_\_\_\_\_\_ If so, how many drinks per day? \_\_\_\_\_\_\_ Seatbelt:

**Past/Recent Hospitalizations or Surgeries: Year:**

*Has it been more than a year since your last mammogram?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Has it been more than 5 years since your last colonoscopy?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Have you had recent blood work (In the past 90 days)?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Please note any family history:

Mother (alive/deceased):

Reason for Mother’s passing:

Father (alive / deceased):

Reason for Father’s passing:

Siblings (alive / deceased): **\_\_\_\_\_\_**

Reason for Sibling’s passing:

**Doctor Anthony is currently looking at shuttle options to potentially offer a free transportation to patients in need. Would this be a service you would utilize? Yes / No**

**Preference in seeing Dr. Anthony or Allison?**

**If so, circle one: Dr. Anthony / Allison / No Preference**

**Notice of Privacy Practices**

By signing here, I hereby acknowledge that (1) I have received a copy of HIPPA privacy practices for Dr. Chet Anthony, D.O. or (2) I have been offered a copy but declined to accept a copy.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) Leave a message on my answering machine with detailed information

( ) Leave a message on my answering machine with call-back number ONLY

( ) Cellular Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) Leave a voicemail message with detailed information

( ) Leave a voicemail message with call-back number ONLY

( ) Written Communication

( ) Mail to home address

( ) Mail to work address

At times it may be necessary to discuss medical information with someone other than yourself. In the space provided below please list anyone we might be able to discuss information with (spouse, friend, family member). If you do not wish to list anyone, please indicate “nobody” below:

**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to patient:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to patient:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to patient:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**( ) NOBODY**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Date of Birth

NOTICE: Uses and disclosures for TPO may be permitted without prior to consent in an emergency.