QUALITY MEDICAL CARE
2014 Patient Information Sheet

- ***Please complete entire form, regardless if information has changed or not.***

Name: ______________________ Date: ______________________

DOB: ______________ Soc. Sec.: XXX - XX - ______ Marital Status: M S W D

Address: ____

Driver's License: ______________________ State: ______________

Cell Ph#______________ ______________________________

Home Phone: ______________ Business Phone: ______________

Spouse's Name: ______________ Spouse's SS#: XXX-XX ________

Primary Insurance Policy Information

Insurance Name: ______________

ID#: ______________

Group#: ______________

Address: ______________

City, State, Zip: ______________

Secondary Insurance Policy Information

Insurance Name: ______________

ID#: ______________

Group#: ______________

Address: ______________

City, State, Zip: ______________

Emergency Contact______________Phone #: ______________

Relation to Patient: ______________________________

- **Please Note:**

Quality Medical Care will submit claims to your insurance provider. In the event that your insurance does not pay all or a balance remains on your account after 30 days, for services rendered, you will be billed. **If your insurance coverage has a deductable, QMC will collect the appropriate amount at the time of service**, and as a courtesy we will submit claims to your insurance company to reflect that you have met some or all of your deductible.

- ***Balances and Co-Pays must be paid at the time of service.***

Signature: ______________________________Date: ______________

Continue on reverse side

My signature below indicates that I hereby give my consent to Quality Medical Care to provide medical treatment to myself or the named patient.

INSURANCE AUTHORIZATION

My signature below indicates that I authorize QMC to release any pertinent medical or health information to the Social Security Administration or its intermediaries, carriers of Medical claims or to my insurance carrier or its representative, any information necessary to process an insurance claim. I permit a copy of this authorization to be used in place of its original and request that payment of medical insurance benefits be made to Quality Medical Care. Regulations pertaining to Medicare Assignments of benefits apply.

QUALITY MEDICAL CARE'S STATEMENT ON HIPPA

The Health Insurance Portability Accountability Act (HIPPA) was enacted to protect and enhance the rights of patients by providing them with access to their health information and controlling the inappropriate use of that information to reduce fraud and abuse, and to improve the quality of health care by restoring trust in the healthcare system. QMC will maintain your personal health information in the strictest confid3ence. QMC will not sell, transfer, copy, distribute or share your personal and health information with any7 other persons not directly involved in the continuity of your health care without written consent to do so in accordance with HIPAA guidelines. QMC is committed to implementing measures to comply and adhere to the rules set forth by this act.

APPOINTMENT POLICY

Appointments are reserved especially for you. QMC makes every effort to schedule times that accommodate your needs. Every effort is made to see all patients on time, barring any unforeseen emergencies. QMC asks that you make the same effort to keep your appointment, and that if issues arise that conflict with you rescheduled appointment, you call us to reschedule. Multiple missed appointments without notification make it impossible for our providers to maintain a treatment plan for the patient. Multiple "no-show, no-call" for appointments may also result in a $45.00 "no show fee" applied directly to your account. My signature bellow indicates that I have read and agree to abide by the terms of QMC's Appointment Policy.

FINANCIAL POLICY

Quality Medical Care strives to maintain a high level of professional care while keeping the costs as fair as possible. Payment is expected at the time of treatment. We accept Check or Credit Card with proper identification such as a valid drivers' license. We always accept cash. Most Health Insurance is accepted, provided that we can verify your eligibility for treatment by QMC, either before or at the time of your visit. All CO-PAYS and/or DEDUCTIBLES are collected at time of service. If a patient does not have the appropriate co-pay or payment amount, the appointment will be rescheduled to such time as the patient can make the appropriate payment. Patient is 100% responsible for all fees incurred for services rendered. We will send a claim to your chosen insurance carrier for services rendered. If your insurance carrier does not make payment within 30 days from the date of treatment, the balance of your account will be shifted to the patient or responsible party for payment in full within 14 days. Failure to make payment or payment arrangements within 14 days may result in further collections processing. **My signature below indicates that I have read and agree to abide by the terms of QMC's Financial Policy.**

____

Patient or Responsible Party Signature Date

PATIENT CONSENT FORM

Quality Medical Care

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Quality medical Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices (NOPP) provided by Quality Medical Care describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Quality Medical Care/Brevard Medical Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer, QMC, P.O. Box 1980, Melbourne, FL 32902.

With this consent, Quality Medical Care may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Quality Medical Care may mail to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and confidential."

With this consent, Quality Medical Care may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request in writing that Quality Medical care restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Quality medical Care to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Quality Medical Care may decline to provide treatment to me.

Signed By: ______________________________ ______________ ________________

Signature of Patient or Legal Guardian | Date | Relationship to Patient

______________________________ ______________________________

Print Patient's Name | Print Name of Legal Guardian, if applicable

QUALITY MEDICAL CARE, P.A.
HEALTH HISTORY

Patient Name: ____ **DOB**: ______ /_______ / ______

Past Medical History (Please check those items which you current have or have had in the past):

- ❑ Dizziness / Fainting
- ❑ Headaches
- ❑ Convulsions / Seizures
- ❑ Depression
- ❑ Anxiety
- ❑ Paralysis / Numbness
- ❑ Sinus trouble
- ❑ Frequent colds
- ❑ Lung disease
- ❑ Shortness of breath
- ❑ Persistent cough
- ❑ Pneumonia / Bronchitis
- ❑ Asthma / Hay fever
- ❑ Eye infections / Disorders
- ❑ Thyroid disease
- ❑ Endocrine problems
- ❑ Pancreatitis
- ❑ Tuberculosis
- ❑ Night Sweats
- ❑ Heart trouble / chest pain
- ❑ Rheumatic fever
- ❑ Swelling of ankles
- ❑ High blood pressure
- ❑ Abdominal pain
- ❑ Liver disease/jaundice
- ❑ Stomach ulcer
- ❑ Hernia / Rupture
- ❑ Hemorrhoids
- ❑ Lactose intolerance
- ❑ Gallbladder disease
- ❑ Bowel irregularity
- ❑ Kidney / Bladder problems
- ❑ Difficulty Urinating
- ❑ Sexual / Menstrual dysfunction
- ❑ Skin disease
- ❑ Hives / Eczema
- ❑ Arthritis / Joint pain
- ❑ Childhood hyperactivity
- ❑ German measles
- ❑ Mononucleosis
- ❑ Measles
- ❑ Mumps
- ❑ Polio
- ❑ Scarlet fever
- ❑ Malaria
- ❑ Diabetes
- ❑ Cancer
- ❑ Tumor
- ❑ Venereal disease
- ❑ Anemia / Blood disorder
- Injury to:
  - ❑ Head
  - ❑ Neck
  - ❑ Spine
  - ❑ Knees
  - ❑ Arms / Legs
  - ❑ Hands / Feet
  - ❑ Other: _____________

Surgeries:

	Year
Appendectomy	______
C-Section	______
Gallbladder	______
Ulcer	______
Tonsillectomy	______
Prostatectomy	______
Cataract Surgery	______

Immunizations:

	Year
Tetanus	______
Flu	______
Pneumovax	______
Other:	

____
____
____

Allergies:

Please circle or write in your allergies

Aspirin Codeine
Penicillin Erythromycin
Sulfa Iodine Seafood Dye
Other:
____
____
____

Please fill in any other past medical information you think your doctor should know about you: (Include significant injuries, illnesses, other surgeries, and any other hospitalizations):

Problem / Surgery	**Date**	**Problem / Surgery**	**Date**

Medications (please list all medications you take including aspirin, laxatives, birth control, vitamins, eye drops, creams, etc.)

Name of Drug	Strength	Frequency taken	Name of Drug	Strength	Frequency taken

Family History (Check those that apply)

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❑	❑	❑	❑	❑	❑
High blood Pressure	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	❑	❑
Bleeding disorder	❑	❑	❑	❑	❑	❑
Kidney disease	❑	❑	❑	❑	❑	❑
Thyroid disease	❑	❑	❑	❑	❑	❑
Mental illness	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑

Social History:

Circle one: Married Divorced Single Widowed If any, religious preference ____________________

Occupation: ______________________________ Do you work? ❑ Unemployed ❑ Retired ❑ Part-Time ❑ Full-Time ❑

Number of Children: ______ Number of children living: ______ Highest level of education: ____________________

Hobbies: ____

Number (other than yourself) living in your current household: ______________________________

Are all household members healthy Yes No Please explain: ______________________________

Types of pets in household: None dog(s) cat(s) Other: ______________________________

Do you have a living will (advanced directive)? Yes No If yes, location: ______________________________

Diet / Habits / Sleep

Ever smoked? Yes No Packs daily: _______ For how long? ___________ When stopped: _______________

Exercise Routine: Light Moderate Heavy Explain: ______________________________

Alcohol: Type/Amount: __________________________ Have you ever used drugs socially? _______________

Sleep Habits: # hours / night: __________ Snoring? ____________ Difficulty falling asleep? _______________

Do you toss and turn? __________ Early morning awakening? _________ Daytime drowsiness? ___________

Diet: Do you follow a special diet? Yes No Please describe: ______________________________

Use Salt? ___________ Eat fatty foods? _____________ # cups of caffeinated beverages/day? ______________

Wear dentures? _______________ Gum disease? _______________

Vision: Do you wear glasses or corrective lenses? ______ Any eye problems? ____________________________

Signature: ____ **Date:** ________ / ________ / _________