



4

ADULT

PLEASE TELL US ABOUT YOURSELF
(PLEASE PRINT)

PATIENT NAME				M	F	DATE	
ADDRESS				S	M	W	D
CITY	STATE	ZIP CODE	RACE	SOCIAL SECURITY NUMBER			
HOME PHONE NUMBER	WORK PHONE NUMBER		DATE OF BIRTH	EMAIL ADDRESS			
HOW DID YOU HEAR ABOUT US? <input type="checkbox"/> SIGN <input type="checkbox"/> TIMES-UNION <input type="checkbox"/> WELCOME WAGON <input type="checkbox"/> DR. SCHNEIDER <input type="checkbox"/> INSURANCE PLAN <input type="checkbox"/> FRIEND <input type="checkbox"/> FCP EMPLOYEE <input type="checkbox"/> HEALTH SOURCE MAGAZINE <input type="checkbox"/> INTERNET <input type="checkbox"/> JOB <input type="checkbox"/> PHYSICIAN REFERRAL <input type="checkbox"/> RETURNING PATIENT							
EMPLOYER				OCCUPATION			
EMPLOYER ADDRESS					ZIP CODE		
NAME OF SPOUSE AND PHONE WHERE MAY BE REACHED				HOME PHONE NUMBER	WORK PHONE NUMBER		
IN CASE OF EMERGENCY NOTIFY							
RELATIONSHIP				HOME PHONE NUMBER	WORK PHONE NUMBER		
Do you have a living will? (Advance Directives) YES <input type="checkbox"/> NO <input type="checkbox"/>							

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		
POLICY NUMBER	GROUP NUMBER	
POLICY OWNER'S NAME	RELATIONSHIP TO YOU	
PLACE OF EMPLOYMENT		
POLICYHOLDER'S DATE OF BIRTH	POLICYHOLDER'S SOCIAL SECURITY NUMBER	

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY		
POLICY NUMBER	GROUP NUMBER	
POLICY OWNER'S NAME	RELATIONSHIP TO YOU	
PLACE OF EMPLOYMENT		
POLICYHOLDER'S DATE OF BIRTH	POLICYHOLDER'S SOCIAL SECURITY NUMBER	



PRINTED NAME OF PATIENT	DOB
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PATIENT CONFIDENTIALITY:

THE FAMILY CARE PARTNERS OF ARLINGTON AND ITS EMPLOYEES ARE BOUND BY FLORIDA STATUTE 395.017 WHICH PROVIDES THAT PATIENT MEDICAL RECORDS ARE PRIVILEGED AND CONFIDENTIAL AND MAY NOT BE DISCLOSED WITHOUT THE CONSENT OF THE PATIENT. NO PATIENT INFORMATION SHALL BE GIVEN TO ANYONE TELEPHONING OR INQUIRING ABOUT A PATIENT OR FORMER PATIENT, INCLUDING SPOUSES, FAMILY MEMBERS, RELATIVES, FRIENDS, EMPLOYERS, FORMER PATIENTS, UNLESS A VALID PATIENT CONSENT HAS BEEN OBTAINED.

- NO, I DO NOT CONSENT TO RELEASE THE INFORMATION IN MY MEDICAL RECORD.
 YES, I HEREBY CONSENT TO RELEASE ANY AND ALL INFORMATION FROM MY MEDICAL RECORD TO:

NAME	RELATIONSHIP
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AUTHORIZATION:

I HEREBY AUTHORIZE THE OFFICES AND EMPLOYEES OF THE FAMILY CARE PARTNERS OF ARLINGTON OR ITS CONTRACTED SERVICE COMPANIES TO RELEASE INFORMATION NECESSARY TO PROCESS CLAIMS WITH MY INSURANCE COMPANIES, AND FURTHER AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO SAME.

FINANCIAL RESPONSIBILITY:

UPON ACCEPTANCE OF TREATMENT IN THIS OFFICE, I ASSUME FINANCIAL RESPONSIBILITY FOR PAYMENT OR FEES.

OUR ADDITIONAL SERVICES TO YOU:

AS COURTESY TO OUR PATIENTS, WE ARE HAPPY TO FILE INSURANCE FORMS AND WILL ACCEPT ASSIGNMENT OF INSURANCE BENEFITS.

FEES NOT COVERED BY INSURANCE:

DEDUCTIBLES AND CO-PAYMENT (THE PORTION OF OUR FEES NOT COVERED BY INSURANCE) **MUST BE PAID AT THE TIME TREATMENT IS RENDERED.** THIS MAY BE IN THE FORM OF CASH, CHECK, VISA OR MASTERCARD. YOU WILL BE RESPONSIBLE FOR ANY RETURNED CHECK FEES THAT MAY BE INCURRED.

NON-PAYMENT:

IN THE EVENT IT SHOULD BECOME NECESSARY TO PLACE YOUR ACCOUNT IN THE HANDS OF AN ATTORNEY OR COLLECTION AGENCY, YOU WILL BE RESPONSIBLE TO PAY ALL COSTS OF COLLECTION, INCLUDING ATTORNEY'S FEES.

PATIENT OR GUARDIAN SIGNATURE	
PRINTED NAME OF SIGNER (IF DIFFERENT FROM PATIENT NAME)	DATE

Acknowledgement of Receipt of Privacy Notice

Family Care Partners

I hereby acknowledge that I have received a copy of Family Care Partners' Notice of Privacy (NPP). NPP Pub Date: 4/14/2003, revised June 2006.

Signed: _____ Date: _____

Print Name: _____ DOB: _____ Phone: _____

If not signed by the patient, please indicate the relationship:

_____ Guardian or conservator of an incompetent patient

_____ Beneficiary or personal representative of deceased patient

Name of patient: (Please Print) _____ DOB: _____

Patient Contact

All calls regarding your health care test results and appointments will be made to your patient voice-mail (Phone Tree) or to your home phone number. If you would like us to contact you at an alternative phone number, please indicate this number.

(_____) _____ Location: _____

_____ I hereby authorize this medical practice to contact by phone and if I am not present, you may leave a message on my answering machine.

_____ I prefer that you do NOT leave messages on my answering machine.

For office use only:

Signed form received by (Please Print): _____ Initials: _____

_____ Patient refused to sign acknowledgement:

Efforts to obtain signature:

Reasons patient refused:



PATIENT AND FAMILY MEDICAL HISTORY

NAME _____ DATE OF BIRTH _____ SEX _____

MEDICATIONS OR SUBSTANCES YOU ARE ALLERGIC TO OR HAVE DISAGREED WITH YOU? _____

WEIGHT: USUAL _____ RECENT GAIN _____ RECENT LOSS _____ /DATE OF LAST CHEST X-RAY _____ DATE OF LAST TETANUS BOOSTER _____

FAMILY MEDICAL HISTORY

HAVE YOU OR ANY BLOOD RELATIVE EVER HAD	YOU		BLOOD RELATIVE		RELATION TO YOU (MOTHER, FATHER, ETC.)	DECEASED		IF YES, AGE
	YES	NO	YES	NO		YES	NO	
ALLERGIES, ASTHMA								
ANEMIA								
BLEEDING TENDENCIES								
HEART TROUBLE								
HIGH BLOOD PRESSURE OR STROKE								
CANCER								
GLAUCOMA								
DIABETES								
ARTHRITIS/GOUT								
PEPTIC ULCER								
KIDNEY OR BLADDER PROBLEM								
ALCOHOL OR DRUG PROBLEM								
EMOTIONAL PROBLEMS/NERVOUS BREAKDOWN								

HABITS

TOBACCO: CIGARETTES _____ PIPES _____ CIGARS _____ AMOUNT / DAY _____ NO. OF YEARS SMOKING _____ NO. OF YEARS STOPPED _____
 ALCOHOLIC BEVERAGES: USUALLY DAILY _____ WEEKENDS _____ NEVER _____ TYPE _____ WEEKLY AMOUNT _____ HOW LONG _____
 COFFEE/CAFFEINATED BEVERAGES: CUPS/GLASSES PER DAY _____ EXERCISE: TYPE _____ FREQUENCY _____

SURGICAL PROCEDURES AND HOSPITAL ADMISSIONS

SURGICAL PROCEDURES - CHECK ANY YOU HAVE HAD

TONSILLECTOMY _____ DATE _____	GALL BLADDER _____ DATE _____	LIST OTHER SURGERY YOU HAVE HAD: _____	DATE _____
APPENDECTOMY _____ DATE _____	STOMACH SURGERY _____ DATE _____	_____	_____
HYSTERECTOMY _____ DATE _____	HEMORRHOIDECTOMY _____ DATE _____	_____	_____
VASECTOMY _____ DATE _____	PLASTIC SURGERY _____ DATE _____	_____	_____

OTHER HOSPITAL ADMISSIONS:

REASON _____ DATE _____	REASON _____ DATE _____	REASON _____ DATE _____
_____	_____	_____

WOMEN

BIRTH CONTROL PILLS: PAST _____ PRESENT _____ IUD: PAST _____ PRESENT _____ HOW LONG _____ PREGNANCIES: NUMBER _____ LIVE BIRTHS _____
 PERIODS: FREQUENCY _____ DATE OF LAST PAP SMEAR _____ BREASTS: SELF EXAM? YES _____ NO _____ DATE LAST MAMMOGRAM _____

IMMUNIZATIONS

DATE	DATE	DATE	DATE	DATE
D 1. _____	T 1. _____	P 1. _____	O RUBELLA: _____	TINE: _____
P 2. _____	D 2. _____	O 2. _____	T MUMPS: _____	PNEUMOVAX: _____
T 3. _____		L 3. _____	H MEASLES: _____	INFLUENZA: _____
4. _____		I 4. _____	E HIB: _____	HEPTAVAX: _____
5. _____		O 5. _____	R	

OTHER FACTS

PLEASE DESCRIBE ANY OTHER FACTS YOU FEEL MAY BE IMPORTANT TO YOUR HEALTH HISTORY: (USE BACK OF FORM IF NECESSARY)

ACKNOWLEDGMENT

TO THE BEST OF MY KNOWLEDGE THE PRECEDING INFORMATION IS ACCURATE AND COMPLETE.

 (SIGNATURE) DATE _____



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PEDIATRICS

PLEASE TELL US ABOUT YOURSELF
(PLEASE PRINT)

PATIENT NAME			M	F	DATE
ADDRESS					
CITY		STATE	ZIP CODE		RACE
HOME PHONE NUMBER	DATE OF BIRTH	SOCIAL SECURITY #		EMAIL ADDRESS	
NAME OF MOTHER			NAME OF FATHER		
EMPLOYER			OCCUPATION		
EMPLOYER ADDRESS				WORK PHONE NUMBER	
HOW DID YOU HEAR ABOUT US? <input type="checkbox"/> SIGN <input type="checkbox"/> TIMES-UNION <input type="checkbox"/> WELCOME WAGON <input type="checkbox"/> DR. SCHNEIDER <input type="checkbox"/> INSURANCE PLAN <input type="checkbox"/> FRIEND <input type="checkbox"/> FCP EMPLOYEE <input type="checkbox"/> HEALTH SOURCE MAGAZINE <input type="checkbox"/> INTERNET <input type="checkbox"/> JOB <input type="checkbox"/> PHYSICIAN REFERRAL <input type="checkbox"/> RETURNING PATIENT					ZIP CODE
OTHER CHILDREN: NAME					AGE
NAME					AGE
NAME					AGE
IN CASE OF EMERGENCY NOTIFY					
RELATIONSHIP			HOME PHONE NUMBER	WORK PHONE NUMBER	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY					
POLICY NUMBER			GROUP NUMBER		
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TO: Family Care Partners of Arlington
6484 Ft. Caroline Road
Jacksonville, Florida 32277
904-744-7300

Patient Name: _____

Patient D.O.B.: _____

Please make record of the fact that in any case of our unavailability, we would wish you to care for our minor child/children:

Name: _____ D.O.B.: _____

Medication/Allergies: _____

Name: _____ D.O.B.: _____

Medication/Allergies: _____

Name: _____ D.O.B.: _____

Medication/Allergies: _____

should medical need arise. You are authorized to perform or arrange for whatever treatment you may consider necessary.

The child/children will be left in the care of:

Name: _____

Address: _____

Phone #: _____

Should prescription medication be required, our preference is:

Drug store: _____

In addition to ourselves, please notify:

Name: _____

Phone #: _____

of the advisability of treatment, if any is to be performed under this authorization. This authorization, unless extended in writing expires on _____.

Signed: _____ Witness: _____

_____ Date: _____

We may be located in an emergency at the following address(es):



PRINTED NAME OF PATIENT	DOB
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