Bay Medical Center
Sacred Heart Health System

Samantha Chapman, ARNP
489 N. Tyndall Parkway
Panama City, FL 32404
Phone: (850)770-3290 Fax: (850)770-3295

PATIENT INFORMATION **Date _____**

Name_____ Maiden Name_____
Last First MI

Sex: M_____ F_____ Age_____ Birthdate_____ SSN_____-_____-_____ Martial Status_____

Address_____

City_____ State_____ Zip_____ Home Phone _____
Cell Phone _____Email Address _____ Contact preference: _____

Race_____ Preferred Language_____ Hispanic ☐ Non-Hispanic ☐ Other ☐

Smoker: Yes ☐ No ☐ **Student Status:** Full Time ☐ Part Time ☐ Not A Student ☐ **Veteran:** Yes ☐ No ☐

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

In case of emergency who should be notified? _____ Relationship_____ Phone _____

How did you hear about us? _____

PERSON RESPONSIBLE FOR ACCOUNT

Name_____
Last First MI
Relationship to Patient_____ Birthdate_____ Soc. Sec. #_____

Address (if different from patient's) _____Phone_____

City_____ State_____ Zip_____

Person Responsible Employed by_____ Occupation_____

Business Address_____ Business Phone_____

PRIMARY INSURANCE

Insurance Company_____ Policy #_____ Group#_____

Policy Holder's Name_____ Relation to Patient_____ Birthdate_____ SS#_____

Policy Holder Employed by _____ Business Phone_____

ADDITIONAL INSURANCE

Insurance Company_____ Policy #_____ Group#_____

Policy Holder's Name_____ Relation to Patient_____ Birthdate_____ SS#_____

Policy Holder Employed by _____ Business Phone_____

ASSIGNMENT AND RELEASE

I the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Brian Shaheen, M.D., insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Patient Signature Date

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Patient Name_____ **Date**_____

What brings you in today?_____

Current Medications:

List medications and dose that you take.
Please list prescription as well as Over-The-Counter (OTC) medications, vitamins, supplements and herbs.

Name of current Medication	How much? (dose)	How often? (frequency)	For treatment of:	Prescribed by:
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Medication Allergies: ☐ I do not have any known allergies to medication.
☐ Codeine ☐ Penicillin ☐ Sulfa ☐ Other _____
Reaction:_____

Preferred Pharmacy/Mail Order: _____
For Chronic Medications: ☐ 30 Day Supply ☐ 90 Day Supply

Secondary Pharmacy (short term meds): _____

CONSENT FOR TREATMENT

I consent to treatment ordered and performed by these physicians and/or their practitioners under the physician's direction within this office. I understand that treatment will be explained fully to me before the treatment is performed. This consent shall be in effective until I notify Bay Medical Sacred Heart Family Medicine of its cancellation.

_____ _____

Patient or Patient or Authorized Person's Signature **Date**

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Patient Name _____DOB_____Date_____

Patient Medical and Social History Questionnaire

 What doctors have you seen in the past 3 years (list name – specialty)?
_____
_____
_____

Medical History: Please mark next to any medical conditions or symptoms that you have now or have had in the past (use the space provided for details: how long, etc.):

Heart Disease (if yes, explain below):
No Yes Abnormal EKG _____
No Yes Chest Pain or Angina _____
No Yes Heart Attack or positive stress test _____
No Yes Angioplasty _____
No Yes Heart or Valve Surgery _____
No Yes Rheumatic/Scarlet Fever _____
No Yes Palpitations _____
No Yes Congestive Heart Failure or swelling of legs_____
No Yes Heart Murmur _____
No Yes High Blood Pressure _____
No Yes High Cholesterol _____
Other _____

Respiratory Disease (if yes, explain below):
No Yes Asthma _____
No Yes Bronchitis _____
No Yes Pneumonia _____
No Yes Emphysema _____
No Yes COPD _____
No Yes TB /Tuberculosis _____
No Yes Sleep Apnea and CPAP _____
No Yes Shortness of Breath at rest or on exertion (Circle one if applies to you) _____
Other _____

Gastrointestinal or Kidney (if yes, explain below):
No Yes Acid Reflux/Heartburn _____
No Yes Gallbladder Disease or removed _____
No Yes Hiatal Hernia _____
No Yes Stomach Ulcers _____
No Yes Pain or trouble swallowing _____
No Yes Change in appetite _____
No Yes Weight loss or gain _____
No Yes Chronic Diarrhea or Constipation (Circle ones that apply) _____
No Yes Hepatitis or Liver Disease_____
No Yes Urinary track, Kidney infections, Kidney stones (Circle ones that apply) _____
No Yes BPH (enlarged prostate) or Trouble urinating _____
No Yes Urinary frequency, hesitancy, urgency, incontinence (Circle ones that apply) _____
No Yes Dialysis or Chronic renal insufficiency _____
Other _____

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Patient Name _____DOB _____Date_____

Neurological or Musculoskeletal Disease (if yes, please explain below):

No Yes Stroke/TIA/Paralysis _____
No Yes Seizures or Epilepsy _____
No Yes Tremors _____
No Yes Carpal Tunnel Syndrome _____
No Yes Chronic Headaches or Migraines (if yes, frequency) _____
No Yes Vision problems _____
No Yes Neuropathy _____
No Yes Fainting Spells_____
No Yes Loss of Memory _____
No Yes Speech Disorder _____
No Yes Arthritis _____
No Yes Gout _____
No Yes Lupus _____
No Yes Muscular dystrophy _____
Other _____

Miscellaneous

No Yes **Diabetic** (if yes, controlled with) ____A. Diet ____B. Insulin ____C. Oral Medication
No Yes **Thyroid Disorder** (if yes, what type) _____
No Yes **Glaucoma or Cataracts** (Circle ones that apply) _____
No Yes **Bleeding disorder** (if yes, please explain) _____
No Yes **Blood Clots** (if yes, please explain) _____
No Yes **Use of any recreational drugs?** (if yes, what type)_____
No Yes **Mental Health Disorder** (if yes, explain) _____
No Yes **Could you be pregnant?** *(Women only)*_____
No Yes **Reactions to Anesthesia** (please describe) _____

Women Only

No Yes Could you be pregnant? _____
No Yes Pre-Menopause: _____
No Yes Hot Flashes/Sleep problems: (Please specify which ones): _____
No Yes Irregular/Heavy periods: (Please specify which ones): _____

Preventative Health Maintenance:

Screening	Date	Result
Pap		
Mammogram		
Colonoscopy		
PSA		
Digital Rectal Exam		
Labs (Where done)?		
Diabetic Eye Exam (if applicable)		
DEXA Scan		
EKG (for Blood Pressure, Diabetes or Coronary Artery Disease		
Monthly Self Breast or Testicular Exams		
Tetanus Vaccine		
Pneumonia Vaccine		
Shingles Vaccine		
Flu Vaccine		
Hemoccult		

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Patient Name _____DOB_____Date_____

Family History: Please check any medical illness or history that runs in your family:

- ☐ Attention Deficit
- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Attack before 50
- ☐ Cancer (type)_____
- ☐ Stroke
- ☐ Depression
- ☐ Diabetes
- ☐ Bleeding Disorder
- ☐ Eczema
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Migraines
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Vascular Disease
- ☐ Pain disorder
- ☐ Seizures
- ☐ Kidney Disease
- ☐ Asthma

Surgical History:
Please list any surgery you have had in the past and the approximate date of your surgery.

Surgery	Date	Physician	Facility

If back/neck surgery: Fusion or Laminectomy or Discectomy?
Back: Lumbar or Thoracic?
Was it due to an accident? Yes No

Social History:
Marital Status: Single Married Divorced Separated Widowed

No Yes I never smoked cigarettes or used any tobacco products.
No Yes I smoke cigarettes, cigars, or chew tobacco. (Circle one if applies to you)
No Yes I currently smoke _____ packs a day for _____ years.
No Yes I quit smoking _____ years ago and used to smoke _____ packs a day for _____ years

Do you currently or have a history of alcohol use? _____ / What type?_____Frequency?_____
Do you use drugs or have a history of drug use?_____/ What type?_____Frequency?_____

What is /was your occupation? _____
☐ I am currently working: Full time part time limited duty I am unable to work
I have been on disability since _____

Please mark your highest level of education:

- ☐ Did ***not*** complete high school (HS)
- ☐ Completed HS
- ☐ Some college
- ☐ Bachelor's degree
- ☐ Advanced degree
- ☐ Other_____

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1. Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____Zip: _____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

2. *This information may be disclosed to the following individual.*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____

_____

Signature of patient or legal representative Date: _____

2. Notice of Privacy Practices (HIPAA)

The undersigned certifies that he/she has received a copy of the Notice of Privacy Practices.

If you did not received these documents, or have misplaced them, please ask for another copy. This signature page is in reference to the Federal HIPAA privacy Regulations requirements.

The HIPAA Notice of Privacy Practices document can also be found at www.baymedical.org

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Signature of patient or legal representative Date

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Authorization for Use and/or Disclosure of Protected Health Information

Patient Identification
Printed Name: _____ Date of Birth:_____
Address: _____
_____
Social Security #:_____ Telephone:_____

Information To Be Released - Covering the Periods of Health Care
From (date)_____ to (date)_____
From (date)_____ to (date)_____

Please check type of information to be released:

- **Entire medical record · Pathology report · Discharge summary · History and physical exam · Consultation reports · Progress notes**
- Laboratory test results/reports · X-ray reports · X-ray films / images
- Operative report · Emergency room record · Itemized bill
- Other, (specify) _____

Purpose of Request

- Treatment or consultation · At the request of the patient · Billing or claims payment
- Other, (specify) _____

Person Authorized to Receive Information
Name:_____
Address:_____
_____

Drug and/or Alcohol Abuse and/or Psychiatric, and/or HIV/AIDS Records Release
I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check One:** · Yes · No
_____ Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. **Check One:** · Yes · No
_____ Initials

Time Limit and Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Bay Medical Center Sacred Heart Health System 615 N Bonita Ave Panama City FL 32401. Unless revoked, this authorization will expire on the following date or event _____ .

Re-disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that Bay Medical Center Sacred Heart Health System may not condition my treatment on whether I sign this authorization from unless specified above under Purposes of Request. I can inspect or copy the protected health information to be used or disclosed.
I authorize _____ **to use and disclose the protected health information specified above.** (Name of Facility or Provider)

Signature _____: Date: _____

Authority to Sign if not patient: _____

Identity of Requestor Verified via: · **Photo ID** · **Matching Signature** · **Other, specify**
_____

Verified by:_____