3284 N. Greenwald Way Kissimmee, FL 34741 **Phone:** 407-343-4700 **Fax:** 407-343-8500

Name_____ Date_____ Marital Status_____

Social Security#_____ **HomePhone**_____**Birthdate**_____

Home Address_____

City _____ **State** ____ **Zip**_____ Sex: M or F

Employer_____ Occupation_____

Work Address and ph#_____

Cell Phone_____ **Emergency Contact and ph#**_____

E-mail Address_____

Local Preferred Pharmacy Name and Location_____

Insurance Company_____ Insured/Primary Social Sec #_____

Insured Name_____ Insured Birthdate_____

Insurance ID #_____ Group#_____

If the patient is Married or Partnered. ***Please*** *complete the information on your spouse/partner.*

Name_____ Relation_____

Address_____

Employer and Address_____ Business Phone/Ext_____

Patient Acknowledgment: I understand I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. "Advance Directive" refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply:

- ☐ I Have Not executed an Advance Directive
- ☐ I Have executed an Advance Directive Location of Form_____
  - ☐ Living Will
  - ☐ Durable Power of Attorney
  - ☐ Do Not Resuscitate (DNR) Order
  - ☐ Designation of health care surrogate form Designee/Guardian_____

Signature_____Witness: _____ **Date**_____

Insurance Assignment Release Form: I Hereby authorize my Insurance Benefits to be paid directly to G & G Medical Group, Inc. I also authorize the physician to release any information required and/or requested by my insurance carrier.

Office Policy: I understand that I am responsible for insurance deductibles, co-pays and percentages as per my insurance policy. I understand all fees are due at the time services are rendered. I understand that there is a $35 charge for confirmed appointments cancelled without 24 hours prior notice or failure to show up for a scheduled and confirmed appointment. I also understand that G & G Medical Group, Inc files claims to the insurance company as a courtesy, and that I am responsible for any services the insurance company does not pay for.

Signature_____ **Date**_____

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Date _____ D.O.B. _____ Age _____ Patient Name _____

PAST MEDICAL HISTORY (Have you had these?) Please do a checkmark (√).

Yes	No		Yes	No		Yes	No	
___	___	High Blood Pressure	___	___	Peptic Ulcer	___	___	Arthritis
___	___	Gallbladder Disease	___	___	Diabetes	___	___	Bowel/Colon disorder
___	___	Pneumonia	___	___	Liver disease	___	___	Thyroid disease
___	___	Kidney stones	___	___	High cholesterol	___	___	Kidney disease
___	___	Asthma/emphysema	___	___	Stroke	___	___	Heart disease
___	___	Epilepsy/seizures	___	___	Bleeding disorder	___	___	Cataracts
___	___	Radiation treatment	___	___	Gout	___	___	Tuberculosis
___	___	Anemia	___	___	Cancer	___	___	Bladder infections/UTI
___	___	Glaucoma	___	___	Depression	___	___	Psychiatric disorder
___	___		___	___		___	___	

FAMILY MEDICAL HISTORY (Have any blood relative ever had?) Please do a checkmark (√).

Yes	No		Who	Yes	No		Who
___	___	Diabetes	_____	___	___	Cancer	_____
___	___	Thyroid disease	_____	___	___	Hepatitis	_____
___	___	High blood pressure	_____	___	___	HIV	_____
___	___	Heart disease	_____	___	___	Abnormal bleeding	_____
___	___	High cholesterol	_____	___	___	Dementia	_____
___	___		_____	___	___		_____

SOCIAL HISTORY. Please do a checkmark (√).

Married ____ Single ____ Divorced ____ Widowed ____ Separated ____

Have you used tobacco? Yes___ No___ # of packs/day _____ For how many years? _____
Have you used alcohol? Yes___ No___ How much/daily_____ For how many years? _____
Have you used any drugs? Yes___ No___ What kind? _____ For how many years? _____

- If yes, have you ever received any counseling or entered a Rehab. Program.
- Program Name/Location Date
- _____

Do you use caffeine? Yes___ No___ Coffee/day _____ Cola/day _____ Tea/day _____
Do you exercise regularly? Yes___ No___ Are you on a regular diet? _____
Is sex satisfactory? Yes___ No___ Recent changes in sex life? _____

LIST OF CURRENT MEDICATIONS

Name of Medication	Dose/ frequency	Reason for taking medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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D.O.B. _____ Patient Name _____

ALLERGIES: Yes ____ No ____ Medications: Penicillin ____ Sulfa _____ Aspirin _____
Any other allergies? _____

PREVIOUS SURGICAL HISTORY
_____ Date_____ _____ Date _____
_____ Date_____ _____ Date _____

REVIEW OF SYSTEMS (In last 6 months) Please do a checkmark (√).

GENERAL

Weight change	Yes___	No___
Extreme fatigue	Yes___	No___
Fainting	Yes___	No___
Dizziness	Yes___	No___
Excessive brusing	Yes___	No___
Impaired sight	Yes___	No___
Nose bleeds	Yes___	No___
Anxiety	Yes___	No___

SKIN

Dry	Yes___	No___
Moist	Yes___	No___
Rash	Yes___	No___
Normal	Yes___	No___
Open wounds	Yes___	No___

CARDIAC/RESPIRATORY

Shortness of breath	Yes___	No___
Chest pain	Yes___	No___
Heart palpitations	Yes___	No___
Persistent cough	Yes___	No___
Edema	Yes___	No___

GASTROINTESTINAL

Ulcers	Yes___	No___
Liver disease	Yes___	No___
Diarrhea	Yes___	No___
Constipation	Yes___	No___
Blood in stool	Yes___	No___
Nausea/vomiting	Yes___	No___

NEUROLOGICAL

Severe headaches	Yes___	No___
Confusion	Yes___	No___
Tingling	Yes___	No___
Numbness	Yes___	No___

ENDOCRINOL.

Excessive thirst	Yes___	No___
Increased urination	Yes___	No___
Rising to void more than once a night	Yes___	No___

FEMALE REPRODUCTIVE
Age of menstruation ____ Is it regular? Yes___ No___
No. of pregnancies _____ Children born alive _____
Date last menstrual period _____
Date of last pap-smear_____
Last breast exam _____

MALE REPRODUCTIVE

Prostate problems	Yes___	No___
Testicular Mass	Yes___	No___
Impotence	Yes___	No___

If taking any medications for impotence list below:
_____

KIDNEYS

Stones	Yes___	No___
Kidney infections	Yes___	No___
Bladder infections	Yes___	No___
Blood in urine	Yes___	No___

VACCINATIONS

PNEUMONIA	YES___	NO____
TETANUS (last 10 yrs)	YES___	NO____
FLU	YES___	NO____

Completed by: Patient_____ Office nurse/M.A_____ Physician_____

Patient Signature _____ Date reviewed by Md with patient ____/____/_____

Physician Signature _____

AUTHORIZATION FOR RELEASE
OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize

G & G Medical Group, Inc.
3284 N. Greenwald Way
Kissimmee, Florida 34741
Tel: (407) 343-4700 Fax: (407) 343-8500

Permission to release and/or request:

_____ Copy of the most recent Office notes, labs, ultrasounds and/or scans from the organization listed below.

_____ Complete chart which includes all office notes, labs, diagnostic test, psychiatric drug/alcohol and AIDS information.

_____ Speak/Write a letter to the person/organization listed below:

_____

(Name of hospital, agency, or individual receiving information)

_____

(Address, phone and/or fax number)

I understand that my records are protected under the Notice of Privacy Act. My records cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time by so informing the above name parties in writing: however such written revocation will have no effect on actions taken prior to the revocation. If I do not revoke this release, it will expire one year from the date of signature.

Patient's Signature: _____

Date: _____

Date of Birth: _____

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HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- Protected health information may be disclosed or used for treatment, payment or health care Operation
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practice
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restriction
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

This Consent was signed by:_____
Printed Name - Patient or Representative

_____**Date**:_____
Signature

Relationship to Patient (if other than patient):_____

Witness: _____
Printed Name - Practice Representative

_____**Date**:_____
Signature