Today's Date: ____________________

Patient Information

Name_______________________________________ Date of Birth_____/_____/________ Gender ☐M ☐F

Address____ City________________ State_____ Zip___________

Social Security Number ______-_____-______ E-mail _____________________________ Marital Status ______

Best phone number (____)_______-________ ◯ Home ◯ Mobile ◯ Work Alternate phone number (____)_______-________ ◯ Home ◯ Mobile ◯ Work

Veteran ☐Yes ☐No Student ☐Yes ☐No Employment status ☐Employed ☐Retired ☐Other___________

Pharmacy ____________________________________ Phone number ________________________________

Address/Side Streets ____

Employer:____ ☐Full Time ☐Part Time

Primary Language: ☐English ☐Spanish ☐Other: _______________________

Ethnicity: ☐Hispanic ☐non-Hispanic ☐Prefer Not to Disclose

Race: ☐White ☐Black/African-American ☐Asian ☐American Indian or Native Alaskan

☐Native Hawaiian/Pacific Islander ☐Hispanic ☐Prefer Not to Disclose

Primary Care Physician____________________________ Referring Physician _____________________________

Insurance Info (If your Insurance is Family Coverage, Complete This for the Primary Insured)

Name_______________________________ Date of Birth____/____/______ Relationship to Patient ____________

Primary Insurance: __________________________ Secondary Insurance: ___________________________

Emergency Contact

Name____ Relationship _______________________________

Best phone number (____)_______-________ ◯ Home ◯ Mobile ◯ Work Alternate phone number (____)_______-_______ ◯ Home ◯ Mobile ◯ Work

Patient Name: ____________________________________

Insurance Authorization and Assignment Consent to Treat

I hereby authorize ForCare Medical Group to furnish information concerning this illness/accident to insurance carriers and/or audit/compliance agencies. I hereby irrevocably assign to ForCare Medical Group all payments for medical services rendered to dependents or myself. I understand that I am financially responsible for all charges whether or not covered by insurance. I also hereby request and consent to treatment and services reasonable and proper by today's standards provided by a physician or provider of ForCare Medical Group and any employee acting under my physicians' orders.

Patient (or Guardian) Signature: ___________________________________ Date __________________

Pathology services – I authorize ForCare Medical Group to send my tissue or other specimens to the Laboratory for microscopic slide processing and interpretation.

Medical Photography – I understand that photographs may be taken and added to my medical record. I understand that if I request release of my medical records these photographs may be included. I understand that these photographs may be used for the following purposes: education, training, medical or scientific publication, in which case my identity will be protected.

Financial policy – The physicians and staff at ForCare Medical Group appreciate the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

- **Payment is due in full at the time of service for any copays, unmet deductibles, co-insurances, self-pay patients, and cosmetic procedures.**
- Patients must provide proof of insurance ID number at the time of visit. If the patient's insurance card is not presented at the initial visit or when there is a charge in coverage, the patient will be responsible for full payment of service.
- Please provide at least 24 hours advance notice if you need to reschedule or cancel your appointment.
- ForCare Medical Group accepts cash, checks, and all major credit cards. If a check payment is returned by the bank, a $30.00 fee will be applied to the patient's account. Patients who have a returned check must use cash or credit card only for all future payments.

___________________________________ ______________________________ ___/___/_______

Patient or Responsible Party Signature Print Name Date

*We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. Our practice is very busy, and if you are unable to keep your appointment, we would like to offer that slot to another patient.*

Patient Name: ______________________________

Acknowledgement of Notice of Privacy Practices and Authorization to Release Information

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol treatment/abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.
- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, mobile voice mail, text mail, email or with a household family member. *I understand I may be charged for calls, texts or automated dialing systems by wireless carrier.*

◯ Please check here if you **DO NOT** want us to leave messages on your answering maching or with a household member

◯ Please check here if you **DO NOT** want us to leave a message on your mobile voie mail, text mail or email.

◯ **Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.**
Provide email address that we would send/receive information:

____

- **If you choose,** please list below the persons with whom we may share your healthcare of payment information.

Name: ______________________________ Relationship: ______________________

Name: ______________________________ Relationship: ______________________

- You may request a copy of and your have the right to read our *"Notice of Patient Provacy Practices"* prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

______________________ ______________________ ______________
Signature | Print name of person signing if other than patient | Date

Patient Name (please print):______________________________

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [ ] No [ ] RELATIONSHIP______________________

FOR OFFICE USE ONLY

Patient refused to sign the form. Reason: ______________________ Date: ____________

ForCare -West
4915 Ehrlich Rd
Tampa, FL 33624
P. 813.960.2400
F. 813.960.2410

Forcare -East
15416 N. Florida Ave.
Tampa, FL 33613
P. 813.960.2400
f. 813-960-2410

Please complete the following information:

Patient Name: ______________________________

Date of Birth: ___/___/____ Last 4 SSN: ____________

Please send the above listed record(s) **from**:

Provider: ______________________________

Address: ______________________________

Phone #: ______________ Fax #: ______________

I request a copy/summary of the following medical records:

- ▯ Complete Medical Record(s)
- ▯ Lab Report(s)
- ▯ Allergy Test/Treatment
- ▯ Other: ______________
- ▯ Biopsy Report(s)
- ▯ Consultation Report(s)
- ▯ Surgical Procedure(s)
- ▯ All

I authorize the records **to**:

Forcare Medical Center

4915 Ehrlich Road Or 15416 N. Florida Ave
Tampa FL 33624 Tampa, FL 33613

Phone #: (813)960-2400 Fax #: (813)960-2410

This authorization shall not be valid for greater than one year from the date of signature.

Print Name: ______________________________ Date: ____________

Patient Signature: __________________________ Date: ____________

Witness: ______________________________ Date: ____________

Today's Date: ____________________

FORCARE
MEDICAL CENTER

Patient Name: ______________________________ Date of Birth: ____________

Clinical Information

Do you wear Sunscreen? ◯ Yes ◯ No If, Yes, what SPF: ◯ 15 ◯ 30 ◯ 45 ◯ 50 ◯ unsure

Do you Tan in a Tanning Salon? ◯ Yes ◯ No

Do you have a Family history of Melanoma (Skin Cancer)? ◯ Yes ◯ No If yes, which relatives? ____________

Smoking: ◯ Never smoked ◯ Former Smoker ◯ Smoke less than daily ◯ Smoke Daily

Allergies (List): ____________ ____________ ____________

____________ ____________ ____________

Current Medications (include dosage)

____________ ____________ ____________

____________ ____________ ____________

Medical History (Check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Arterial fibrillation
- ☐ Benign Prostatic Hyperplasia (Enlarged Prostate)
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (High Blood Pressure)
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (High Cholesterol)
- ☐ Hyperthyroidism (Overactive thyroid)
- ☐ Hypothyroidism (Underactive thyroid)
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ Other: ____________
- ☐ **None**

Patient Name: ______________________________ Today's Date: ____________

FORCARE
MEDICAL CENTER

Past Surgical History (Check all that apply)

- [ ] Appendix Removed
- [ ] Bladder Removed
- [ ] Mastectomy : ___Right __Left __Bilateral
- [ ] Lumpectomy: ___Right __Left __Bilateral
- [ ] Breast Reduction
- [ ] Breast Implants
- [ ] Colectomy: Colon Cancer Resection
- [ ] Colectomy: Diverticulitis
- [ ] Colectomy: IBD
- [ ] Gallbladder Removal
- [ ] Coronary Artery Bypass
- [ ] PTCA (Angioplasty)
- [ ] Mechanical Valve Replacement
- [ ] Biological Valve Replacement
- [ ] Heart Replacement
- [ ] Joint Replacement Knee __Right __Left __Bilateral
- [ ] Joint Replacement Hip __Right __Left __Bilateral
- [ ] Joint Replacement within past 2 yrs
- [ ] Kidney Biopsy
- [ ] Kidney Removed ___Right ___ Left
- [ ] Kidney Stone Removal
- [ ] Kidney Transplant
- [ ] Ovaries Removed: Endometriosis
- [ ] Ovaries Removed: Cyst
- [ ] Ovaries Removed: Ovarian Cancer
- [ ] Prostate Biopsy
- [ ] TURP (Prostate Resection
- [ ] Skin Biopsy
- [ ] Basal Cell Cancer Surgery
- [ ] Squamous Cell Carcinoma
- [ ] Melanoma Surgery
- [ ] Spleen Removed
- [ ] Testicles Removed __Right __Left __Bilateral
- [ ] Hysterectomy: Fibroids
- [ ] Hysterectomy: Uterine Cancer
- [ ] **No Surgeries**

Skin History

- [ ] Acne
- [ ] Actinic Keratosis (AKs)
- [ ] Asthma
- [ ] Basal Cell Skin Cancer
- [ ] Blistering Sunburns
- [ ] Dry Skin
- [ ] Eczema
- [ ] Flaking or Itchy Scalp
- [ ] Hay Fever / Allergies
- [ ] Melanoma
- [ ] Poison Ivy
- [ ] Precancerous Moles
- [ ] Psoriasis
- [ ] Squamous Cell Skin Cancer
- [ ] **None**

Past Medical History

Have you ever had or been diagnosed with **Acid reflux** O Yes O No

Have you ever had or been diagnosed with **Alcohol abuse**? O Yes O No

Have you ever had or been diagnosed with **Anxiety**? O Yes O No

Have you ever had or been diagnosed with **Alzheimers**? O Yes O No

Have you ever had or been diagnosed with **Arthritis**? O Yes O No

Have you ever had or been diagnosed with **Artificial Joints**? O Yes O No

Have you ever had or been diagnosed with **Artificial Heart Valve**? O Yes O No

Have you ever had or been diagnosed with **Atrial Fibrillation**? O Yes O No

Have you ever had or been diagnosed with **Auto-immune disorders**? O Yes O No

Have you ever had or been diagnosed with **Bipolar disorder**? O Yes O No

Have you ever had or been diagnosed with any type of **Cancer**? O Yes O No

Have you ever had or been diagnosed with **COPD**? O Yes O No

Have you ever had or been diagnosed with **Depression**? O Yes O No

Have you ever had or been diagnosed with **Diabetes**? O Yes O No

Have you ever had or been diagnosed with **Heart Attack**? O Yes O No

Have you ever had or been diagnosed with **Hepatitis C**? O Yes O No

Have you ever had or been diagnosed with **High cholesterol**? O Yes O No

Have you ever had or been diagnosed with **High Blood Pressure**? O Yes O No

Have you ever had or been diagnosed with **Kidney Problems**? O Yes O No

Have you ever had or been diagnosed with **Liver Disease**? O Yes O No

Have you ever had or been diagnosed with **Osteoporosis**? O Yes O No

Have you ever had or been diagnosed with **Pre Diabetic**? O Yes O No

What brings you to the office today?

In the last 2 weeks have you had any of the following symptoms?

CONSTITUTIONAL

chills? O Yes O No

Fatigue? O Yes O No

loss of appetite? O Yes O No

undesired weight loss? O Yes O No

fevers? O Yes O No

CARDIOLOGY

chest pain? O Yes O No

dizziness? O Yes O No

palpitations? O Yes O No

RESPIRATORY

congestion? O Yes O No

cough? O Yes O No

shortness of breath? O Yes O No

GASTROENTEROLOGY

abdominal pain? O Yes O No

blood in stool? O Yes O No

diarrhea? O Yes O No

constipation? O Yes O No