Trinity Family Physicians

Consent and Authorization for Minors

By law, a healthcare provider must attempt to contact a birth / custodial parent or legal guardian prior to rendering treatment to a minor child (a person under the age of 18), except in those instances where the law recognizes the minor as having the capacity to consent to a specific medical procedure / treatment. It is the policy of Trinity Family Physicians to have a signed consent form by the birth parent / custodial parent or legal guardian of a minor in order for the minor to be seen by any of our physicians or nurses for medical treatment. If a minor is brought in to Trinity Family Physicians by someone other than the birth parent / custodial parent or legal guardian, the minor child must be accompanied by a note ("Authorization").

Authorization must include the date when it was written, name of the patient, name of the person bringing the child, what the child is being seen for, the birth / custodial parent or legal guardian's signature, copy of the birth / custodial parent or legal guardian's photo I.D., and a telephone number where the birth / custodial parent or legal guardian can be reached.

I, _____, (Circle your relationship to the patient) birth parent / custodial parent / legal guardian / grandparent
PLEASE PRINT NAME

give consent for the individual(s) identified below to bring the minor child to the Trinity Family Physicians for medical treatment. I hereby authorize the Trinity Family Physicians and other personnel, to render medical care to my minor child in accordance with the Authorization without obtaining additional consent from me.

_____
PRINT FULL NAME OF MINOR CHILD (PATIENT)

_____ _____
Print Name of person bringing minor in for appointment Relationship to minor

_____
Purpose of Visit (appointment for)

_____
Phone number where birth / custodial parent or legal guardian can be reached.

This consent is for (choose one):

1. Single time only. Date: _____

2. Specific period of time. From _____ to _____

3. Indefinite period of time. From _____ until revoked by me in writing.

_____ _____
Signature of Birth / Custodial Parent or Legal Guardian Date

_____ _____ _____
Print Witness Name Signature of Witness Date

Trinity Family Physicians

Let Our Family Care for Yours
Amir Shirmohammad, MD, MPH Stephanie Eldridge, MD, MPH
1817 Cypress Brook Drive, Suite 101
Trinity, FL 34655
Phone (727) 834 – 8377 fax (727) 834 – 8371

AUTHORIZATION TO OBTAIN / RELEASE MEDICAL RECORDS

I, _____ for _____
Name of Patient / Guardian Name of Patient

Date of Birth _____ Social Security Number _____

give authorization for Trinity Family Physicians to release to and / or obtain my protected health information / medical records from the following Physician and / or facility.

_____
(Name / Physician / Facility / Agency / Organization)

_____
(Complete Address)

_____
(Phone Number / Fax Number)

The purpose of the use or disclosure is (please check all that apply) :

_____ Continued Patient Care	_____ Attorney / Legal	_____ Social Service / Disability
_____ Insurance	_____ Personal Use	_____ Patient Transferring PCP
_____ Patient Moving	_____ Other:	_____ Other:

Please ONLY send LAST "2" years of the following records: OFFICE NOTES, PROBLEM LIST, IMMUNIZATION RECORDS, PERTINENT LABS, IMAGING and DIAGNOSTICS REPORTS

I acknowledge that the data released MAY INCLUDE material that is protected by law. My initials or check mark on the lines below authorize the release (if applicable) of information pertaining to:

(_____) Alcoholism and / or Drug Abuse
(_____) Mental Health and / or Rehabilitation
(_____) HIV / AIDS / Sexually Transmitted Disease & testing for other communicable diseases

I understand that this information will be used solely for professional purposes, will remain confidential and may not be discloses to third parties. This authorization may be revoked by me in writing at any time except to the extent that action has been taken in reliance thereon. I permit this authorization for a period not to exceed one year. I understand that a copy of this release is as valid as the original. In consideration of this consent, I hereby release the above parties from any and all liability arising there from.

_____	_____	_____
Print Patient Name	Signature of Patient/Guardian	Date
_____	_____	_____
Print Witness Name	Signature of Witness	Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Official for
Trinity Family Physicians
727-834-8377

Introduction

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

At Trinity Family Physicians, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal health information we collect, and how and when we use or disclose that information. This notice also describes your rights as they relate to your Protected Health Information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Acknowledgment of Receipt of this Notice

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Understanding Your Health Record/Information

Each time you visit Trinity Family Physicians, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, and serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Trinity Family Physicians, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request,
- Inspect and obtain a copy your health record as provided for in 45 CFR 164.524,
- Request to amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Trinity Family Physicians is required to:
1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
3. Abide by the terms of this notice,
4. Notify you if we are unable to agree to a requested restriction,
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location, and
6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Trinity Family Physicians, reserves the right to change our Privacy Information practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be available to you at this office during business hours, or by mail if requested. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.
Examples of How Trinity Family Physicians may use or disclose your health information:

For Treatment: Trinity Family Physicians, may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to those actions.

For Payment: Trinity Family Physicians, may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For health care operations: For example, Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
Appointments: Trinity Family Physicians may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Business associates: Some services provided in our organization are provided through Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, or a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we may use your name, if you have been transported to a hospital or other facility, and give your general condition, and religious affiliation for directory purposes. This information may be provided to family members or members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification, or communication with Family Members: Health professionals, using their best judgment, may use, or disclose information to notify or assist in notifying family relatives, personal representatives, close personal friends, or other people you identify; information relevant to that persons' involvement in your care or payment information related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant
Marketing: We may contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Required by Law: Trinity Family Physicians, may use and disclose information about you as required by law. For example, Trinity Family Physicians may disclose information for the following purposes:

For judicial and administrative proceedings pursuant to legal authority;
To report information related to victims of abuse, neglect or domestic violence; and
To assist law enforcement officials in their law enforcement duties.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

For More Information or to Report a Problem, or If you have questions and would like additional information, you may contact our practice's Privacy Official at:

Trinity Family Physicians
1817 Cypress Brook Drive
Suite 101
Trinity, FL 34655

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights - U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
866-OCR-PRIV (866-627-7748) or 886-788-4989 TTY

Acknowledgment of Receipt of this Notice

Trinity Family Physicians is concerned about the privacy of our patients health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for:
Trinity Family Physicians

Name of Patient (please print)_____

_____ _____

Signature of Patient or Authorized Representative Date

Trinity Family Physicians

1817 Cypress Brook Drive Trinity, Fl 34655
Office: 727-834-8377 Fax: 727-834-8371

HIPAA Consent & Notification

I hereby give my consent for **Trinity Family Physicians** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). **Trinity Family Physicians'** Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Trinity Family Physicians reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Trinity Family Physicians,** 1817 Cypress Brook Drive, Suite 101, Trinity, Florida 34655.

With this consent **Trinity Family Physicians** may call my home or 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 results among others.

With this consent, **Trinity Family Physicians** may discuss my medical records with:

Name:_____Relationship:_____Telephone:_____
Name:_____Relationship:_____Telephone:_____
Name:_____Relationship:_____Telephone:_____

With this consent, **Trinity Family Physicians** may mail to my home or other 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, **Trinity Family Physicians** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that **Trinity Family Physicians** restrict how it uses or discloses my PHI to carry out TPO. However, 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 **Trinity Family Physicians'** use and disclosure of 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, **Trinity Family Physicians** may decline to provide treatment to me.

____ **I have received a copy of Trinity Family Physicians' Notice of Privacy Practices.**
Initial

Signature of Patient or Legal Guardian: _____

Print Name of Patient or Legal Guardian: _____

Trinity Family Physicians

Let Our Family Care for Yours

Clinical Summary

Welcome to our practice. Please answer all the questions found below to the best of your ability.

Name: _____ **Date:** _____

Reason for today's visit: _____

Allergies to any medications: _____

Previous Hospitalizations/Surgeries/Procedures:	When:	Doctor:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had a colonoscopy: YES or NO If so, when: _____ Doctor_____

FOR WOMEN ONLY

1. Last Pap Smear: _____ Do you have a GYN: _____ If so, who_____
2. Are your periods normal: _____
3. Last menstrual period: _____
4. Number of pregnancies:_____ vaginal deliveries: _____C-Sections: _____
5. Last Mammogram: _____
6. Last Bone Density Screening: _____

_____

Initials

Trinity Family Physicians

Let Our Family Care for Yours

Medication List for: _____

Please list your current medications:

❑ **Currently, I am NOT on any medication.**

Name	Strength	Cap/Tab/Other?	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

_____
Initials

Trinity Family Physicians

Let Our Family Care for Yours

PATIENT HISTORY SHEET

Name: _____

PAST MEDICAL HISTORY:

- ☐ ABDOMINAL AORTIC ANEURYSM
- ☐ ABNORMAL PAP SMEAR (female)
- ☐ ATTENTION DEFICIT DISORDER
- ☐ ADOPTED
- ☐ ALLERGIC RHINITIS
- ☐ ANEMIA
- ☐ ANXIETY
- ☐ ASTHMA
- ☐ ATRIAL FIBRILLATION
- ☐ BACK PAIN
- ☐ BLOOD TRANSFUSION
- ☐ BENIGN PROSTATIC HYPERTROPHY
- ☐ BREAST LUMP
- ☐ BRONCHITIS
- ☐ CANCER: BLADDER
- ☐ CANCER: BONE
- ☐ CANCER: BREAST
- ☐ CANCER: COLON
- ☐ CANCER: LEUKEMIA
- ☐ CANCER: LUNG
- ☐ CANCER: LYMPHOMA
- ☐ CANCER: MELANOMA
- ☐ CANCER: MOUTH
- ☐ CANCER: OVARIAN (female)
- ☐ CANCER: PROSTATE (male)
- ☐ CANCER: RENAL CELL
- ☐ CANCER: SKIN
- ☐ CANCER: TESTICULAR (male)
- ☐ CANCER: THYROID
- ☐ CANCER: UTERINE (female)
- ☐ CARDIOMYOPATHY
- ☐ CARPAL TUNNEL
- ☐ CATARACTS
- ☐ CVA (STROKE)
- ☐ CHRONIC BLADDER INFECTIONS
- ☐ CHRONIC DIARRHEA
- ☐ CHRONIC PANCREATITIS
- ☐ CIRRHOSIS
- ☐ COLOSTOMY
- ☐ CONGESTIVE HEART FAILURE (CHF)
- ☐ COPD (Chronic obstructive pulmonary disease)
- ☐ CORONARY ARTERY DISEASE
- ☐ CONSTIPATION
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIVERTICULITIS
- ☐ DIVERTICULOSIS
- ☐ DNR (DO NOT RESUSCITATE)
- ☐ DVT (DEEP VENOUS THROMBOSIS)
- ☐ EDEMA
- ☐ EMPHYSEMA
- ☐ GALLBLADDER DISEASE

_____
Initials

Name: _____

☐ GERD
☐ GOUT
☐ HEAD OR NECK RADIATION
☐ HEADACHE
☐ HEART DISEASE
☐ HEART MURMUR
☐ HYPERTENSION (High blood pressure)
☐ HERNIA
☐ HYPOTHYROIDISM
☐ HYPERLIPIDEMIA (High cholesterol)
☐ INSOMNIA
☐ MACULAR DEGENERATION
☐ MIGRAINE HEADACHE
☐ MITRAL VALVE PROLAPSE
☐ OSTEOPENIA
☐ OSTEOPOROSIS
☐ PALPITATIONS
☐ PNEUMONIA
☐ POLIO
☐ PULMONARY NODULE
☐ PULMONARY EMBOLUS
☐ RHEUMATIC FEVER
☐ RHEUMATOID ARTHRITIS
☐ SEIZURES
☐ THYROID NODULE
☐ TIA (Transient ischemic attack aka mini-stroke)
☐ ULCERS
☐ URINARY INCONTINENCE
☐ UTERINE PROLAPSE (female)
☐ VERICOSE VEINS
☐ OTHER: _____
_____

☐ NONE OF THE ABOVE

SOCIAL HISTORY:

DO YOU SMOKE? ☐ YES ☐ NO

IF YES, PACKS PER DAY: ☐ ONE ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

IF YES, DRINKS PER DAY: ☐ ONE OR LESS ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

DO YOU USE RECREATIONAL DRUGS? ☐ YES ☐ NO

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO

DO YOU USE CAFFEINE? ☐ YES ☐ NO

IF YES, DRINKS PER DAY: ☐ ONE OR LESS ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

MARITAL STATUS:

☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

_____
Initials

Name: _____

FAMILY HISTORY:

MOTHER: ☐ ALIVE ☐ DECEASED

- ☐ AAA (ABDOMINAL AORTIC ANEURYSM)
- ☐ CHF (CONGESTIVE HEART FAILURE)
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ HYPERLIPIDEMIA (High cholesterol)
- ☐ CANCER
- ☐ COPD (Chronic obstructive pulmonary disease)
- ☐ DVT (DEEP VENOUS THROMBOSIS)
- ☐ GALLBLADDER DISEASE
- ☐ HYPERTENSION
- ☐ HYPOTHYROIDISM
- ☐ NONE OF THE ABOVE

FATHER: ☐ ALIVE ☐ DECEASED

- ☐ AAA (ABDOMINAL AORTIC ANEURYSM)
- ☐ CHF (CONGESTIVE HEART FAILURE)
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ HYPERLIPIDEMIA (High cholesterol)
- ☐ CANCER
- ☐ COPD (Chronic obstructive pulmonary disease)
- ☐ DVT (DEEP VENOUS THROMBOSIS)
- ☐ GALLBLADDER DISEASE
- ☐ HYPERTENSION
- ☐ HYPOTHYROIDISM
- ☐ NONE OF THE ABOVE

SIBLINGS: # BROTHERS ____ # SISTERS _____

- ☐ AAA (ABDOMINAL AORTIC ANEURYSM)
- ☐ CHF (CONGESTIVE HEART FAILURE)
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ HYPERLIPIDEMIA (High cholesterol)
- ☐ CANCER
- ☐ COPD (Chronic obstructive pulmonary disease)
- ☐ DVT (DEEP VENOUS THROMBOSIS)
- ☐ GALLBLADDER DISEASE
- ☐ HYPERTENSION
- ☐ HYPOTHYROIDISM
- ☐ NONE OF THE ABOVE

CHILDREN: # BOYS ____ # GIRLS _____

- ☐ AAA (ABDOMINAL AORTIC ANEURYSM)
- ☐ CHF (CONGESTIVE HEART FAILURE)
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ HYPERLIPIDEMIA (High cholesterol)
- ☐ CANCER
- ☐ COPD (Chronic obstructive pulmonary disease)
- ☐ DVT (DEEP VENOUS THROMBOSIS)
- ☐ GALLBLADDER DISEASE
- ☐ HYPERTENSION
- ☐ HYPOTHYROIDISM
- ☐ NONE OF THE ABOVE

_____
Initials

Name: _____

REVIEW OF SYSTEMS:

Which of the following symptoms have you had in the past **2 weeks**?

- ☐ FEVERS OR SWEATS
- ☐ UNDESIRED WEIGHT LOSS
- ☐ VISION WORSENING
- ☐ DOUBLE VISION
- ☐ HEARING LOSS
- ☐ DIFFICULTY SWALLOWING
- ☐ CHEST PAIN
- ☐ CHEST HEAVINESS
- ☐ SHORTNESS OF BREATH
- ☐ COUGHING UP BLOOD
- ☐ BLOOD IN STOOL
- ☐ VOMITING BLOOD
- ☐ BLOOD IN URINE
- ☐ URINARY DISCHARGE
- ☐ JOINT SWELLING
- ☐ MUSCLE WEAKNESS
- ☐ IRRITATED MOLES
- ☐ CHANGING MOLES
- ☐ CONVULSIONS
- ☐ FALLING
- ☐ LACK OF PLEASURE/FUN
- ☐ THOUGHTS OF SUICIDE
- ☐ HOT FLASHES
- ☐ CAN'T TOLERATE HOT/COLD TEMP
- ☐ BRUISING EASILY
- ☐ BLEEDING FREQUENTLY
- ☐ WHEEZING
- ☐ NASAL CONGESTION
- ☐ SEX LIFE COULD BE BETTER
- ☐ SNORING

☐ NONE OF THE ABOVE

_____
Initials

Trinity Family Physicians

Let Our Family Care for Yours

Amir Shirmohammad, MD, MPH Stephanie Eldridge, MD, MPH

1817 Cypress Brook Drive, Suite 101
Trinity, FL 34655
Phone: (727) 834 – 8377 Fax: (727) 834 – 8371

Name: _____ D.O.B: _____
Social Security #: _____ Email Address: _____
Home Address: _____City: _____ State: _____ Zip: _____
Employer: _____Occupation: _____
Home Phone: _____ Leave Message: Yes / No (call order___)
Cell Phone: _____ Leave Message: Yes / No (call order___)
Work Phone/ext: _____Leave Message: Yes / No (call order___)

Emergency Contact Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

Circle one for each category:
Do you reside in FL year round? Yes / No (If no, please fill in the following section)
Do you have an alternative PCP that takes care of your routine/yearly care? Yes / No
Alternative PCP Name: _____ Phone: _____
Home Address: _____City: _____ State: _____ Zip: _____
Months at the alternative Address: _____ to _____

Circle one for each category:
Sex: M / F **Employment Status**: FT / PT / Retired/Other **Student Status**: FT / PT
Marital Status: Married / Single / Divorced / Widowed / Legally Separated / Significant Other
Preferred Language: English / Spanish / Russian / Indian / Other
Ethnicity: Hispanic / Non-Hispanic
Race: Caucasian / African American / Hispanic / American Indian / Asian / Hawaiian / Other

Primary Insurance: _____Insured's Name: _____
Social Security #: _____ D.O.B_____ Relationship: _____
Policy / Subscriber #: _____ Group #: _____
Eligibility / Customer Service Phone: _____

Secondary Insurance: _____Insured's Name: _____
Social Security #: _____ D.O.B_____ Relationship: _____
Policy / Subscriber #: _____ Group #: _____
Eligibility / Customer Service Phone: _____

Local Pharmacy: _____Address:_____ Phone: _____

Mail Order Pharmacy: _____ Address: _____Phone:_____

Insurance Assignment & Release Form: I hereby authorize my Insurance Benefits to be paid directly to Trinity Family Physicians. I also authorize the physician to release any information required and/or requested by my insurance carrier.

Signature: _____Date: _____

Co-Pay or Payment is due upon the day services are rendered.
Cash, Check, Visa, MasterCard, Discover or American Express

INTERNAL USE: PCID: _____ Health Goal: ____

Identifying Your Wellness Care Plan

Name: _____ **Date:** _____ **Age:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Email Address: _____ **Phone:** _____ **Date of Birth:** ___/___/___

DIETARY INTAKE SUMMARY:

How many servings of fruit do you consume per day? _____

How many servings of vegetables do you consume per day? _____

How many servings of protein do you consume per day? _____

How many servings of bread/crackers/pasta do you consume daily? _____

Do you consume artificial sweeteners? __Yes __ No If yes, what brands? _____

Do you consume fast food? __ Yes __ If yes, what do you typically eat? _____

Do you eat breakfast? __ Yes __ No If no, what time is your first meal of the day? _____

Do you consume alcoholic beverages? __ Yes __ No If yes, how many per week? _____

Do you consume coffee? __ No __ Yes If yes, how many cups per day? _____

Do you consume dietary supplements? __ No __ Yes If yes, please list all of them below. Additionally, please bring them in so we can check for ingredients that are not healthful or may have contraindications with medications.

_____

Please indicate the areas of health that you want to improve:

____ Lose weight ___ More energy ___ Sleep better ___ Improve digestion

____ Improve blood work ___ Prevent problems ___ Anti-aging support ___ Improve general health

If you could improve ONE thing about your health, what is your priority?

_____

IDENTIFYING YOUR HEALTH GOALS:

To help our office understand your wellness goals and give you the type of care that you want, please use this chart to answer the questions below.

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
I have serious concerns about my overall health	I feel worried about my health	I have constant concerns that affect my health	I have health challenges that affect me on a daily basis	I have some minor complaints about my health	I feel okay about my health with no complaints	I feel good most days	I feel well on a daily basis	I feel energetic and healthy	I feel active, energetic and fit	I feel great and am proactive about my health

1. What number best describes how you feel about your health today? _____
2. What health goal do you want to achieve?: _____
3. Which type of health care do you prefer: __ Prescriptions __ Natural Alternatives __ Combination as needed

NOTE: In our commitment to your health, our office provides our patients with access to a free online resource for education, science and wellness support. We will create your login ID and provide access information. Please indicate which free wellness classes you wish to be informed of:

__ Health Reality Check __ Genetics & Your Health __ Why Diets Don't Work __ Other: _____