

Treasure Coast Urgent and Family Care

Michele Libman, MD
Board Certified in Emergency Medicine
And Internal Medicine

1050 S.E. Monterey Road ~ Suite 101 ~ Stuart, FL 34994 ~ (772) 419-0560 ~ FAX (772) 419-0557

Welcome to Our Office New Patient Information

Today's Date _____

Patient's Name (Please Print) _____

SSN _____ Date of Birth _____

Marital Status _____ Gender _____
S M W D Sep M F

Parent's Name (If patient is a minor) _____

SSN _____ Date of Birth _____

Father Mother
Other (please specify) _____

Insurance Name _____

Subscriber's Name and Date of Birth (Primary Cardholder's Name) _____

Reason for Visit _____

Permanent Street Address _____

City, State _____ Zip Code _____

(_____) _____
Local Phone #

(_____) _____
Cell Phone #

Secondary Address (if applicable) _____

City, State _____ Zip Code _____

(_____) _____
Home Phone # (if different from previous)

Employer's Name _____

(_____) _____
Work Phone #

Is Visit due to an Accident? Yes No

If an Accident, is it: Worker's Comp Auto

I request that payment of authorized Medicare/or other Insurance Carrier of benefits be made either to me or on my behalf to **Treasure Coast Urgent and Family Care** for any services furnished to me by that party. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me, to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare/Other Insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts the assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.

Please Note:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT'S ACCOUNT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIERS PAYMENTS; HOWEVER, IF INSURANCE IS DENIED, THE PATIENT/GUARDIAN IS RESPONSIBLE FOR ALL FEES. IT IS CUSTOMARY TO PAY APPLICABLE CO-PAY/CHARGES WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER.

FOR INSURANCES, UNDER WHICH WE ARE CREDENTIALLED AS PRIMARY CARE, APPOINTMENTS CAN BE SCHEDULED FOR OUR PATIENTS' CONVIENENCE. IN ORDER TO BETTER SERVE ALL OF OUR PATIENTS, IF A SCHEDULED APPOINTMENT NEEDS TO BE CHANGED/CANCELLED, PLEASE CONTACT THE OFFICE 24 HRS IN ADVANCE; OTHERWISE A \$25.00 NO-SHOW CHARGE WILL BE APPLIED TO YOUR ACCOUNT.

Signature _____

Date _____

**Treasure Coast Urgent and Family Care
1050 SE Monterey Rd. Suite 101
Stuart, Florida 34994
(772) 419-0560**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
& PERMISSION TO SHARE HEALTH INFORMATION**

I have received a copy of the Treasure Coast Urgent and Family Care Notice of Privacy practices.
Yes ___ No ___ Treating Physician _____

PATIENT SIGNATURE: _____ (PRINT NAME) : _____

AUTHORIZED REPRESENTATIVE (TITLE) _____

DATE _____

Agrees but refuses to sign _____

NOTIFICATION OF FAMILY AND FRIENDS

I Hereby authorize _____ to disclose my health information to the following
Persons.

Persons to be notified (name, address, phone #)

1. _____

2. _____

3. _____

PATIENT SIGNATURE _____

AUTHORIZED REPRESENTATIVE (Title) _____

Date _____

RESTRICTIONS ON THE USE & DISCLOSURE OF YOUR HEALTH INFORMATION

As further described in the Treasure Coast Urgent and Family Care Notice of Privacy Practice, I understand that I may request certain restrictions on the use and disclosure of my health information. I request the following restrictions. The practice is not required to agree to my requests.

1. _____ Yes ___ No ___
2. _____ Yes ___ No ___

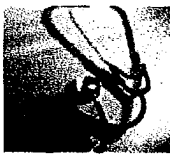
PATIENT SIGNATURE _____

AUTHORIZED REPRESENTATIVE (TITLE) _____

DATE _____

REVIEWED BY _____

APPROVAL DATE _____



Treasure Coast Urgent and Family Care

Michele Libman, MD
Board Certified in Emergency Medicine
And Internal Medicine

1050 S.E. Monterey Road - Suite 101 - Stuart, FL 34994 - (772) 419-0560 - FAX (772) 419-0557

Patients Name: _____

Family Physician: _____

PAST HISTORY:

Have you previously been treated for: (Please CIRCLE)

- | | | |
|---------------------|------------------|-----------------|
| High Blood Pressure | Diverticulosis | Diabetes |
| Heart Attack | Liver Disease | Thyroid Disease |
| Angina | Kidney Disease | Cancer |
| Emphysema | Kidney Stones | Arthritis |
| Asthma | High Cholesterol | Blood Disease |
| Depression | Gout | Stomach Ulcer |
| Anxiety | Back Problems | Neck Problems |

Any other previous medical problems you feel should be noted?

1. _____

2. _____

Please List All Prior Surgeries:

MEDICATIONS (Please list drug name, dosage, and frequency of use, as well as prescribing physician)

Do You Have any allergies or adverse drug reactions (please list drug and side effect)

Family History

| | Age (if living) | Age (at death) | Illness, cause of death |
|----------|-----------------|----------------|-------------------------|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |

LIFESTYLE AND PREVENTIVE CARE

Do You Drink? Y/N How much _____

Do You Smoke? Y/N Packs per day _____

Do You Exercise? Y/N How much _____

Year of last physical exam _____

colonoscopy _____

mammogram _____

PAP smear _____

Bone Density _____

Tell me about your hobbies, marital status, and social interests:
