



# Treasure Coast Urgent and Family Care

Michele Libman, MD

Board Certified in Emergency Medicine

1050 S.E. Monterey Road ~ Suite 101 ~ Stuart, FL 34994 ~ (772) 419-0560 ~ FAX (772) 403-2379

## Welcome to Our Office

### New Patient Information

Today's Date: \_\_\_\_\_

### Please Print Clearly

\_\_\_\_\_  
Patient Name Last First Middle

Mr.  Mrs.  Ms.  Other: \_\_\_\_\_

Suffix (if any): \_\_\_\_\_

\_\_\_\_\_  
Nick Name/Preferred Name

\_\_\_\_\_  
Maiden Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Birthday Female  Male

\_\_\_\_\_  
SSN S  M  W  D  Sep   
Marital Status

Race: American  Indian  Asian  African American  Pacific Island  White/Caucasian   
Other: (please specify) \_\_\_\_\_

\_\_\_\_\_  
Ethnic Group

\_\_\_\_\_  
Preferred Language

### \*Guardian/Parent Information (if patient is a minor)

\_\_\_\_\_  
Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
SSN

\_\_\_\_\_  
Relationship to patient

### \*Employment Information (required if visit is for Worker's Comp)

\_\_\_\_\_  
Employer/Company Name

### How did you hear about this practice? (Please check one)

- Friend/Family Member
- Internet (Website/Search Engine)
- Newspaper
- Flyer/Brochure at: \_\_\_\_\_
- Health Fair
- Hospital/ER staff

- Insurance Company
  - Other Physician
- Name: \_\_\_\_\_

### Reason for Visit

\_\_\_\_\_

### Contact Information

\_\_\_\_\_  
Primary Mailing Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Permanent Street Address (if different from Primary)

\_\_\_\_\_  
City, State, Zip Code Please Check Best Contact

( ) \_\_\_\_\_   
Home Number

( ) \_\_\_\_\_   
Work Number

( ) \_\_\_\_\_   
Cell Number

\_\_\_\_\_  
\*E-mail Address (please print clearly)\*

### Primary Care Physician

\_\_\_\_\_  
Name

( ) \_\_\_\_\_  
\*Phone Number\*

( ) \_\_\_\_\_  
Fax Number (if available)



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## Insurance Information

\_\_\_\_\_  
**Insurance Carrier**

\_\_\_\_\_  
**Name of Primary Cardholder**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date of Birth of Primary Cardholder**

If coverage is through Worker's Comp or an Auto Insurance Plan, additional information is needed

|                       |                       |
|-----------------------|-----------------------|
| Date of Accident:     | Date of Accident:     |
| Supervisor/Contact :  | Adjuster/Claim Rep.:  |
| Contact Phone Number: | Contact Phone Number: |

### **All Insurance and Self Pay Patients:**

#### **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 OR INSURANCE INFORMATION IS NOT RECEIVED AT THE TIME OF SERVICE THE PATIENT/ GUARDIAN IS RESPONSIBLE FOR ALL APPLICABLE FEES. IT IS CUSTOMARY TO PAY APPLICABLE CO-PAY/CHARGES WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMNETS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER.

\*

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date

*If visit is to be submitted to an insurance company, please read and initial the following:*

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. \* *Please Initial:* \_\_\_\_\_

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.3801-3212 provides penalties for withholding this Information) \* *Please initial:* \_\_\_\_\_

**IN ORDER TO BETTER SERVE ALL OF OUR PATIENTS, APPOINTMENTS CAN BE SCHEDULED IN ADVANCE. 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.**



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## Hippa Health Information Privacy and Portability Act

### Privacy Form

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

I understand that my medical records are protected by federal law and that the information can only be released as per the Health Information Privacy and Portability Act. (A copy is available upon request at the front desk)

\*

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name

Acknowledges but refuses to sign: \_\_\_\_\_ (Please X the line)

#### NOTIFICATION OF FAMILY AND FRIENDS

I hereby authorize **Treasure Coast Urgent and Family Care** to disclose my health information to the following persons.  
*Please List all persons that are authorized to obtain information of patient: (include **Name& Phone Number**)*

1. \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name Phone Number
2. \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name Phone Number
3. \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name Phone Number

#### NOTIFICATION OF PHYSICIANS

I hereby authorize **Treasure Coast Urgent and Family Care** to disclose my health information to the following physicians.  
*Please note, if you would like your notes sent to your primary care physician, please include their names below. (Name, Phone Number & Fax Number if available)*

4. \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name Phone Number Fax Number
5. \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name Phone Number Fax Number

\*

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
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
3. \_\_\_\_\_  Yes  No

\*

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date



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## NEW PATIENT MEDICAL HISTORY FORM

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Allergies: \_\_\_\_\_

Problem(s) you are seeking help with:

Major Medical Problems/Conditions/Diseases:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Surgeries/Operations (Please list all prior surgeries, dates of surgery, name of surgeon, and City/State of surgery):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physicians (please list physicians you have treated with in the past 10 years, including those you are currently treating with)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medicines/Dosage/Frequency: (if longer than space allows, please write on back)

Vitamins/Herbal Supplements/OTC Medicines:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Health Habits:

Check which substances you use and quantity:

- \_\_\_ Tobacco  
    Have you ever smoked    Yes  No   
    If yes, how long ago did you quit \_\_\_\_\_
- \_\_\_ Alcohol
- \_\_\_ Drugs
- \_\_\_ Caffeine

### Stress Levels:

Please rate your stress levels for each category (0-10)

- Job: \_\_\_\_\_
- Home life/relationship: \_\_\_\_\_
- Children: \_\_\_\_\_
- Other (specify): \_\_\_\_\_



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Please check each symptom/condition that applies to you:

### General

- Anxiety
- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Night sweats
- Numbness
- Sleep Disturbance

### Cardiovascular

- Chest Pain
- High Blood Pressure
- Irregular Heart Beat
- Low Blood Pressure
- Poor Circulation
- Rapid Heart Beat
- Swelling of Ankles
- Varicose Veins

### Eye, Ear, Nose, Throat

- Bleeding gums
- Blurred vision
- Difficulty swallowing
- Earache
- Ear discharge
- Hay Fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems

### Gastrointestinal

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion

- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting Blood

### Genito-Urinary

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination
- Penile discharge
- Vaginal discharge

### Skin

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sores that do not heal

**Female Only:** (Males skip to next section)

*Pregnancies: (years, genders & complications)*

*Number of children, ages, genders:*

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*Last menstrual period:* \_\_\_\_\_

*Last pap smear:* \_\_\_\_\_

*Last mammo:* \_\_\_\_\_

*Is it possible that you are pregnant?* \_\_\_\_\_

*Have you had:*

*Abnormal Pap Smears* \_\_\_\_\_

*Bleeding between periods* \_\_\_\_\_

*Breast lumps* \_\_\_\_\_

*Extreme menstrual pain* \_\_\_\_\_

*Hot flashes* \_\_\_\_\_



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### Family Medical History:

|            | Age   | State of Health | Age of Death | Cause of Death |
|------------|-------|-----------------|--------------|----------------|
| Father:    | _____ | _____           | _____        | _____          |
| Mother :   | _____ | _____           | _____        | _____          |
| Brother's: | _____ | _____           | _____        | _____          |
| Sister's:  | _____ | _____           | _____        | _____          |

### Has any blood relative of yours had:

Cancer (type): \_\_\_\_\_  
Diabetes: \_\_\_\_\_  
Heart Disease: \_\_\_\_\_  
Hypertension: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_