721 S COLORADO AVE.
STUART, FL 34994
T: (772) 888-2545 | F: (772) 888-2742

7805 NW BEACON SQ BLVD #103
BOCA RATON, FL 33487
T: (561) 318-4757 | F: (561) 314-3541

5700 STIRLING RD. #100
HOLLYWOOD, FL 33021
T: (954) 357-0889 | F: (954) 329-0004

CHECK ONE: □ Health Insurance □ Worker's Compensation □ Auto Accident

Today's Date: ________________

Name: _____________________________________ Age: _____ Date of Birth: ____________________

Address: __________________________________ City/State: _______________ Zip: _____________

SS#: ________________________ Home Phone: _______________ Cell Phone: __________________

Work Phone:________________ Email: ___________________________ Marital Status: □ M □ S □ D □ W

Sex: Male: ___ Female: ___ Number of Children: ___ Email Address: _______________________________

Spouse's Name: ____________________ Your Occupation: ___________________________________

Employer: __________________________________ Work Number: ___________________________

Emergency Contact: __________________ Relation: ___________ Contact Number: __________________

Primary Care Physician: _________________________ Telephone Number: ________________________

Explain the Main Reason for your visit today (Describe Pain /Location): _______________________________

____

____

____

Start Date of current problem: _______________________

Have you seen another physician for this condition? □ Yes □ No if yes, Physician Name: ____________________

Is this condition due to: Auto Accident: ____ Work Injury: ____ Sports Injury: _____ Unknown: ____________

Please Explain: ____

____

Is it possible you are pregnant? □ Yes □ No If yes, when are you due ______________________________

Were you referred to us by anyone? If so who: ____

Patient Health History

Please check if you have ever had any of the disease(s) and or condition(s) listed below:

____ Disc Herniation ____ Heart Attack ____ Alcohol/Drug Abuse ____ HIV+/AIDS ______

____ Spinal Surgery ____ Congenital Heart Defect ____ Heart Surgery/Pacemaker _____ Heart Murmur

____ Neurological Surgery ____ Frequent Neck Pain ____ Low Back Problems ____ Artificial Bones

____ Arthritis ____Severe Frequent Headaches _____ Anemia ____ Diabetes ____ Artificial Valves

____ Emphysema/Glaucoma ____ Asthma/Difficulty Breathing _____ Sinus Problems ____ Ulcers/Colitis

____ High/Low Blood Pressure ____ Kidney Problems _____ Psychiatric Problems ____ Venereal Disease

____ Shingles ______ Hepatitis _____ Fainting/Seizures/Epilepsy ____ Chemotherapy ____ Cancer

____ Rheumatic Fever ____ Tuberculosis

Any known Allergies ☐ Yes ☐ No

What are you allergic to and what is your reaction:____

____

COMPREHENSIVE
FAMILY HEALTH

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Family Health History - Mother

Please check if your mother ever had any of the disease(s) and or condition(s) listed below:

___ Disc Herniation ___ Heart Attack ___ Alcohol/Drug Abuse ____ HIV+/AIDS _____

___ Spinal Surgery ___ Congenital Heart Defect ___ Heart Surgery/Pacemaker ____ Heart Murmur

___ Neurological Surgery ___ Frequent Neck Pain ___ Low Back Problems ___ Artificial Bones

___ Arthritis ___Severe Frequent Headaches ____ Anemia ___ Diabetes ___ Artificial Valves

___ Emphysema/Glaucoma ___ Asthma/Difficulty Breathing ____ Sinus Problems ___ Ulcers/Colitis

___ High/Low Blood Pressure ___ Kidney Problems ____ Psychiatric Problems ___ Venereal Disease

___ Shingles _____ Hepatitis ____ Fainting/Seizures/Epilepsy ___ Chemotherapy ___ Cancer

___ Rheumatic Fever ___ Tuberculosis

Family Health History Father

Please check if your father ever had any of the disease(s) and or condition(s) listed below:

___ Disc Herniation ___ Heart Attack ___ Alcohol/Drug Abuse ____ HIV+/AIDS _____

___ Spinal Surgery ___ Congenital Heart Defect ___ Heart Surgery/Pacemaker ____ Heart Murmur

___ Neurological Surgery ___ Frequent Neck Pain ___ Low Back Problems ___ Artificial Bones

___ Arthritis ___Severe Frequent Headaches ____ Anemia ___ Diabetes ___ Artificial Valves

___ Emphysema/Glaucoma ___ Asthma/Difficulty Breathing ____ Sinus Problems ___ Ulcers/Colitis

___ High/Low Blood Pressure ___ Kidney Problems ____ Psychiatric Problems ___ Venereal Disease

___ Shingles _____ Hepatitis ____ Fainting/Seizures/Epilepsy ___ Chemotherapy ___ Cancer

___ Rheumatic Fever ___ Tuberculosis

Past Surgical / Hospitalization History

List any prior surgeries and reason for surgery**.**

____ Date: ___________

____ Date: ___________

____ Date: ___________

List all Medications you are Currently Taking

Medication/Dose ____

Medication/Dose ____

Medication/Dose ____

Medication/Dose ____

Pharmacy Name: _________________________ Phone # __________________

Pharmacy Address:____

FOR WOMEN: Are you currently on any form of birth control? ☐ Yes ☐ No

If yes, What kind: ____

Current Height: ______ft ______inches

Current Weight: _______lbs

****

Do you smoke? ☐ Yes ☐ No If yes how many packs a week? ____________

Have you ever smoked? ☐ Yes ☐ No

If yes how long did you smoke for? ____________

Do you drink? ☐ Yes ☐ No If yes, number of drinks per week. __________

Is Alcohol use a problem for you? ☐ Yes ☐ No

Any drug abuse history please list here ☐ Yes ☐ No _________________

Are you sexually active? ☐ Yes ☐ No

How is your sleep pattern? _____________________

Do you exercise? ☐ Yes ☐ No How often per week? _____________

Please check all Past/Present Medical Problems (Show Month and Year)

□ Abdominal Pain: ____

□ Allergies: ____

□ Anemia:____

□ Anorexia:____

□ Arthritis: ____

□ Cancer: ____

□ Chest Pain: ____

□ Diabetes: ____

□ Dizziness:____

□ Eye Problems: ____

□ Headaches: ____

□ Sinus Problems: ____

Please list any additional medical problems that have not been addressed above. Make sure to include the month and year.

____

____

____

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Health Insurance Information

MEDICAL ONLY

Primary Insurance Company: ______________________ Policy # ____________ Group # ____________

Insured Name: ________________ SS# ______________ Date of Birth: _________ Employer: __________

Insured Address: ________________________________ City/State: ___________ Zip: ________________

Secondary Insurance Company: ___________________ Policy # _____________ Group # _____________

Insured Name: ________________ SS# ______________ Date of Birth: _________ Employer: __________

Insured Address: ________________________________ City/State: ___________ Zip: ________________

Do you have a deductible? □ Yes □ No

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Worker's Compensation Insurance Information

WORKERS COMP. ONLY

Insurance Company: ______________________________ Policy # ____________ Claim # ______________

Adjuster's Name: ________________________________ Adjuster's Phone # __________________________

Do you have a deductible? □ Yes □ No Is this insurance in your name: □ Yes □ No

If no, please fill out the next section:

Insured Name: _________________________________ SS# ________________ Date of Birth: __________

Insured Address: ________________________________ City/State: ___________ Zip: ________________

Date of Injury: __________________Employer: ____

Auto Accident Insurance Information

AUTO ACCIDENT ONLY

Date of Accident: _____________________ Time of Accident: ________________ Attorney: □ Yes □ No

If Yes, Attorney Name: ________________ Attorney Phone: __________________ Fax: _________________

Insurance Company: ____________________________ Policy # ____________ Claim # ________________

Adjuster's Name: ______________________________ Adjuster's Phone # ___________________________

Do you have a deductible? □ Yes □ No If yes, Deductible amount_________ Has it been met □ Yes □ No

Are you the policy holder?: □ Yes □ No If no, please fill out the next section

ACCOUNT INFORMATION: Please check the payment method you will be using for todays visit

______ Cash, Check, Credit Card _____ Medical Insurance ____ Auto Insurance

CONSENT FOR TREATMENT

This form is provided to patients of the Comprehensive Family Health. (the “Clinic”). We want to let you know about the care and treatment that you will receive from the Clinic, and to obtain your consent to allow us to provide your care. In the case of patients under the age of 18, or other individuals who may not be capable of making informed choices about their healthcare, we provide this form to their parents, guardians or caregivers to evaluate and sign on behalf of the patient.

General Consent and Conditions of Treatment: I consent to the treatment that will be provided by the Clinic primary care providers, as well as their assistants and other Clinic staff members. I understand that a medical record will be prepared and maintained about me by the Clinic, and that I am entitled to obtain a copy of my medical record by signing a Medical Records Authorization Form provided by the Clinic for that purpose.

Student Participation: I understand that the Clinic participates in the education of students in healthcare. I can decline their participation in my care at any time.

Communication With Health Care Providers: To safeguard my health information, I understand that the Clinic’s practice is to convey test results to patients in person. I understand that the Clinic’s policies do not permit discussions about my health information, or transmission of my test results via email, since email is generally not a secure method of communication. I understand that I always have the option to call the Clinic, view my results via the secure Patient Portal or make an appointment to come in to discuss my test results or health issues with a provider.

Emergency Situations: I understand that in emergency situations, it may be necessary or advisable for the Clinic to perform services and/or procedures that may not be fully discussed with me (or my parent or caregiver) in advance. I consent to these services and/or procedures under those circumstances.

Work-Related Injuries or Disabilities: I understand that if I receive treatment for a work-related injury or illness, some of my information will be shared with my employer or its workers’ compensation insurance carrier, in connection with evaluation of my claim, and in order to help my employer address any safety issues at the workplace. I also understand that if I request special accommodations based upon a disability, a limited amount of my medical information may be shared with my employer, to the extent warranted to evaluate or confirm my disability.

Authentication: I understand that the Clinic will require patients to provide identification in connection with visits to the Clinic or in connection with any telephone calls in which personal information may be requested. This helps the Clinic ensure that it is not divulging personal information nor treating an unauthorized person. If I cannot provide the necessary identification, I may not be able to receive treatment or receive the information that I am seeking from my medical record until I am able to satisfy the Clinic’s authentication requirements. Such documents will include my valid driver’s license and/or a picture I.D.

Personal Belongings: I understand that the Clinic takes steps to ensure that the waiting room and other areas of the Clinic are safeguarded. However, I understand that I am solely responsible for any personal belongings that I bring with me to the Clinic, including jewelry and other valuables.

Notice of Privacy Practices: By signing this form, I acknowledge receipt of the Clinic's Notice of Privacy Practices.

Validity of Consent: I understand that this Consent Form shall be valid as long as I am a participant of the Comprehensive Family Health as an active patient. I have the right to withdraw my consent at any time. If I choose to do so, I must provide that withdrawal in writing, to the Clinic.

The withdrawal of consent will only apply after it is received, and not to any information for which I previously provided consent.

I HAVE READ OR HAD READ TO ME THIS CONSENT FORM, AND UNDERSTAND AND ACCEPT ITS TERMS.

Patient's Signature ____Date ____________

Guardian's Signature ____Date ____________

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ____

DOB:___________________________Account Number:______________Ph Number: __________

Address: ____

I Authorize: ____

To release copies of my medical records to the following providers: Dr. Paul Gambino, Sarah Hartford APRN, Dan Miller APRN, Bradley Rhatigan APRN, Nicole Barlett APRN, and Thomas Rawson PA-C. I authorize release of information in regards to the following portions of my medical record:

___Mental Health ___Test Results ____HIV/AIFS

___Substance Abuse ____Communicable Disease ____All

Only the Following listed below:

____

Pursuant to Florida law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, the record may be given only to the person designated and it may be used only for the purpose listed on this form. I understand now that my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. I understand that I may revoke this authorization at any time, in writing, to this office.

Patient Signature (or legal representative)

____

Relationship to Patient:_______________________________________ Date: _________________

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