Do you have access to our Patient Portal?

Please provide your email address so that you can have access to:

Request Appointments

Request prescription refills

Ask non emergent medical questions

View medical history/medications

Review lab reports (once reviewed by the Dr.)

Request billing information

Email Address (Please Print Clearly): ______________________________

You can also download the Healow App to access the Portal on your mobile device anywhere, anytime!

1. Download the app
2. Enter practice code
3. Enter portal username and password

Practice Code: DGIGCA

Use above practice code to easily link healow app with our practice

How Did You Hear About Us?

THANK YOU FOR CHOOSING FM MEDICAL CENTERS, WE WOULD APPRECIATE YOU TAKING THE TIME TO COMPLETE THIS FORM.

PLEASE SELECT ONE OF THE FOLLOWING:

Did you hear about us in one of the following ways?

- Newspaper Advertisement ____
- Drove by _____
- Facebook ____
- Attorney ____
- Television Advertisement ___
- Internet Search/Web site ___
- Yellow Pages ___
- Employer/Friend/Insurance ___
- Another Physician ____ Who: ______________________
- Other _______________

Your Name (please print): ________________________________

FM MEDICAL CENTERS

ST AUGUSTINE
165 Southpark Blvd
St. Augustine, FL 32086
Ph: 904-823-8833
Fax: 904-823-9394

PALATKA
700 Reid St.
Palatka, FL 32177
Ph: 386-328-4043
Fax: 386-328-4141

ST AUGUSTINE BEACH
3560 A1A S
St. Aug. Beach, FL 32080
Ph: 904-460-2827
Fax: 904-429-9873

Patient Registration

Last Name			Primary Care Physician/Referring Physician
First Name		MI	Email Address
Previous Name	Date of Birth (mm/dd/yyyy)		Social Security Number
Address			Gender □ Male □ Female
City			Marital Status □ Single □ Divorced □ Married □ Widowed
State	Zip	County	Race : □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Other Pacific □ Black or African American □ White □ Hispanic □ Other □ Refuse to report
Home Phone	Cell Phone		Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Refuse to report
Work Phone	Ext.		Preferred Pharmacy

Responsible Party or Guarantor (If under 18 years of age)

Last Name		Relation		
First Name	MI	Address		
Home Phone	Cell Phone	City	State	Zip

Patient Employer Information

☐ Employed ☐ Retired ☐ Full-time Student ☐Part-time Student ☐ Disabled ☐ Unemployed

Employer Name		Occupation		
Address	City	State	Zip	Work Phone

Insurance Information

Primary Insurance Company Name	Subscriber's Name	Subscriber's Date of Birth
Subscriber's Social Security/ID Number	Subscriber's Address	Subscriber's Home Phone
Secondary Insurance Company Name	Subscriber's Name	Subscriber's Date of Birth

Patient Request for Confidential Communications

This is a request for confidential communications of my protected health information (PHI). When the doctor, nurse or other members of your office want to contact me please use the following guidelines. I understand that you will do your best to adhere to the following requests.

Please check all that apply to this request:

_____ Please do not phone me at home. Use the following alternative phone number to contact me:________________

_____ Please do not phone me at work. Use the following alternative number to contact me:______________________

_____ Please do not contact me by email.

_____ Other request(s) (describe in detail): ____

____

_____ When contacting me by phone it is ok to leave messages and discuss my health information with:

Name:______________________________________Relationship__________________

Name: ______________________________________Relationship _________________

May we speak with the above named person(s) regarding your billing/payment information? ______________________

________ **(Please initial) I understand that the physician or provider to whom I am making this request will make reasonable efforts to accommodate this request. I further understand that in some emergency situations, my PHI may be released. I authorize my medications from the Pharmacy Data Base be released to this office.**

Advanced Directive Planning

Do you have an Advanced Directive? ☐ Living Will ☐ Power of Attorney ☐ DNR ☐ I do not have an Advanced Directive

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by this office and its' associated physicians, clinicians and other personnel. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantee has been made as to the result of treatments or examinations.

Assignment of Benefits and Patient Responsibility

I certify that the information on these forms is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay bills at time of service unless other arrangements are made. I authorize my insurance claim to be paid directly to the clinic. I further understand my health care insurance carrier or payor of my health benefits may pay less than the actual bill for services, and all second opinion and pre-admission review requirements are ultimately my responsibility.

Signature of Patient (or patient's personal representative):____

Relationship of representative to patient: ____

Date: _________________________________

Financial Policy

I have read and understand the Financial Policy and agree to all provisions outlined. (On attached laminated paper)

Signature of Patient (or patient's personal representative):____ Date:_________

Please sign that you have read and acknowledged these items on the laminated paper on clipboard.

1. Notice of Privacy Pactices Acknowledgement Form HIPAA: ____________________________

2. Consent for Purposes of Treatment, Payment and Health Care Operations: ____________________________________
3. Medicare Lifetime Consent & Medicaid (If Applicable): ________________________________

Patient Name: ____

MEDICATIONS:

START DATE	Medication name	Dose	Times taken per day	Quantity	STOP DATE

ALLERGIES:

ALLERGY	REACTION: HIVES, ANAPHYLAXIS, VOMITING ETC

SOCIAL HISTORY:

Smoker? Yes ____ No ____	# of packs per day ________	How many years? ________
Drink alcohol? Yes____ No____	# of drinks per day ________	How many years? ________

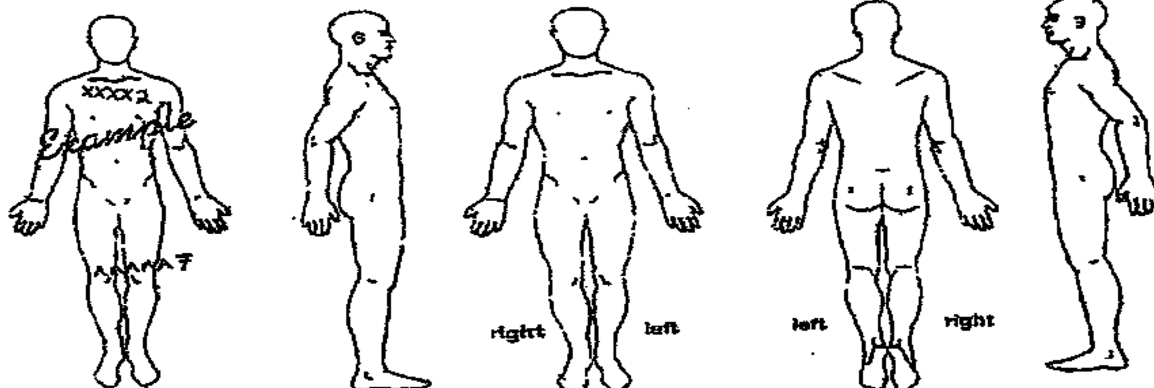
FAMILY HISTORY:

MOM	DAD	SIBLINGS	MATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	1ST COUSIN

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort as shown in the example below with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description:	**NUMBNESS**	**PINS & NEEDLES**	**BURNING**	**ACHING**	**STABBING**	**DULL**
Symbol:	NNN	PPP	BBB	AAA	SSS	DDD



Patient Name: ____________________

PAST MEDICAL HISTORY

Please check if you have ever had any of the following:

☐ Diabetes ☐ Diabetes Insipidus ☐ Obesity ☐ Over Weight ☐ High Blood Pressure ☐ Heart Disease ☐ High Cholesterol ☐ Hyperlipidemia ☐ Coronary Artery Disease ☐ Hepatitis A ☐ Hepatitis B or C ☐ Tuberculosis ☐ Blood Disorder ☐ Thalassemia ☐ Sickle Cell ☐ Turners syndrome ☐ Klinefelters Syndrome ☐ G6PD ☐ Congenital Heart Defect ☐ Anemia ☐ Gastroparesis ☐ Essential Tremor ☐ Rheumatoid Arthritis ☐ Vitamin D Deficiency	☐ PMS ☐ Lupus ☐ Scleroderma ☐ Reflux Disease ☐ Peptic Ulcers ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Kidney Stones/Disease ☐ Lung Cancer ☐ Stomach Cancer ☐ Colon Cancer ☐ Breast Cancer ☐ Skin cancer ☐ Leukemia ☐ Other Cancer ☐ Raynaud's ☐ Sleep Apnea ☐ Thyroid Disease ☐ Diverticulitis ☐ Gallbladder Disease ☐ Asthma ☐ COPD	☐ Emphysema ☐ Pleurisy ☐ Rib Fractures ☐ Conns Disease ☐ Cushing's Disease ☐ Rib Fractures ☐ Hemorrhoids ☐ HIV/AIDS ☐ Appendicitis ☐ Preeclampsia ☐ Gestational Diabetes ☐ Migraine headaches ☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella Shingles ☐ Chicken Pox ☐ Urinary tract Infection ☐ Fibroids ☐ Endometriosis ☐ Polio ☐ Eczema ☐ Parkinson's Disease ☐ Pulmonary Fibrosis	☐ Depression ☐ Back Pain ☐ Cystic Fibrosis ☐ SLE Lupus ☐ Scleroderma ☐ Psoriasis ☐ Brain Injury ☐ Bells' Palsy ☐ Stroke ☐ TIA ☐ Normal pressure Hydrocephalus ☐ Seizure Disorder ☐ Myasthenia Gravis ☐ Cerebral Palsy ☐ Temporal/Giant cell Arteritis ☐ Polio ☐ Anxiety ☐ Schizophrenia ☐ Bed Wetting ☐ Night Terrors ☐ Narcolepsy ☐ Alcoholism ☐ Drug Addiction ☐ Personality Disorder ☐ ADD or ADHD ☐ PAD ☐ Empyema Disease

SURGICAL HISTORY: List all surgeries below

PROCEDURES/OPERATIONS	YEAR

ST AUGUSTINE
165 Southpark Blvd
St. Augustine, FL 32086
Ph: 904-823-8833
Fax: 904-823-9394

PALATKA
700 Reid St.
Palatka, FL 32177
Ph: 386-328-4043
Fax: 386-328-4141

ST AUGUSTINE BEACH
3560 A1A S
St. Aug. Beach, FL 32080
Ph: 904-460-2827
Fax: 904-429-9873

FM Medical Centers
MEDICAL RELEASE FORM

To ensure that your medical records are held in the utmost confidentiality, please be as explicit as possible as to where you want them sent.

Patient Name: ____D.O.B _____/_____/______

Address: ____ PH # (_____) _________________

PLEASE TRANSFER MY MEDICAL RECORDS AS FOLLOWS:

FROM: _________________________________ TO: Circle the appropriate location at top of page

____

Records to be released:

All medical records _____ Abortion care ______ Birth Control ______ Labs/X-ray _____

Annual exam and pap smear/prostate _____ OTHER: ___________________________________

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding those listed below cannot be released without my written consent.

Please initial below if you DO NOT want any of the following records released. All applicable records will be released if nothing is initialed.

______Drug and/or alcohol abuse ______HIV/AIDS testing and/or treatment

______Psychiatric care and/or treatment ______ Confirmed sexually transmitted infection test results and/or treatment.

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 1 year.

___________________________________ _________________________________
SIGNATURE WITNESS

____
INTERPRETER, IF NECESSARY