PELICANPRIMARYCARE
23421 Walden Center Dr. Ste. 100, Bonita Springs, FL 34134
Ph: (239) 514-2008 · Fax: (239) 593-0067 · www.PelicanPrimaryCare.com

PATIENT INFORMATION

Thank you for choosing **PELICAN PRIMARY CARE**. In order to properly serve you, we need the following information.

PATIENT INFORMATION

Name: (Last, First, MI) _____ Email: _____

Address: (Street) _____ (City, St, Zip) _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Social Sec#: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African Amer. ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Hispanic/Latino ☐ Other ☐ Decline

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Place of Employment: _____ Occupation: _____

Employer's Address: _____

Extended Information: (Choose One) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse or Parent: (Name) _____ (Relationship) _____ (Phone #) _____

Spouse/Parent's Employer: (Name) _____ (Work Phone #) _____

Emergency Contact: (Name) _____ (Relationship) _____ (Phone #) _____

IF SEASONAL RESIDENT: 2nd Address _____

DATES AT 2ND ADDRESS: From _____ **To** _____

Guarantor/Responsible Party: (Person Responsible for Payment of Your Service if different from Patient)

Name: _____

Date of Birth: _____ Relationship to Patient: _____

Address (if different from Patient): _____

INSURANCE INFORMATION

Name of Insured: _____ Date of Birth: _____ SS# _____

Insurance Co: _____ Policy #: _____ Group #: _____

Choose One: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ No ☐ Yes If Yes, please complete the following:

Insurance Co: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____ ☐ Self ☐ Spouse ☐ Parent ☐ Other:

PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services.

I give my permission to leave phone messages regarding my medical care/appointment confirmation: ☐ Yes ☐ No

☐ Check here to authorize us to contact you by email.

Signed (Patient or Guardian) _____ **Date** _____

All bills are ultimately the responsibility of the patient. We will file insurance claims as noted, however, if your insurance has not paid in 60 days, the bill is due and payment by you is expected immediately.

COMPREHENSIVE PATIENT HISTORY

Please complete the following two pages.

Patient Name: _____ Date of Birth: _____ Soc. Sec. #: _____

Occupation _____ List all previous occupations: _____

Birth place: _____ List all States/Countries visited: _____

Preferred Pharmacy: (Pharmacy Name) _____ (Phone #) _____

Address: (Street) _____ (City, St, Zip) _____

Describe the following (if applicable):

What is the reason for today's visit? _____ Today's Date: _____

Location of problem: _____ How long have you had this problem? _____

How severe is this problem? ☐ Mild ☐ Moderate ☐ Very How often are you having the problem? _____

What caused the problem? _____

Do you know of anything else that may have contributed to this problem? _____

Does anything else occur with this problem? _____

When was your last complete physical examination? _____ Where? _____

PERSONAL HISTORY:

ILLNESSES: Have you ever had:

Measles	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No
Chicken pox	☐ Yes ☐ No	Meningitis	☐ Yes ☐ No
Whooping cough	☐ Yes ☐ No	Anemia/jaundice	☐ Yes ☐ No
Scarlet fever	☐ Yes ☐ No	Migraine headaches	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
		Diabetes	☐ Yes ☐ No
		Asthma/emphysema	☐ Yes ☐ No

INJURIES: Have you ever had:

Broken bones	☐ Yes ☐ No
Sprains/dislocations	☐ Yes ☐ No
Lacerations (extensive)	☐ Yes ☐ No
Concussion/head injury	☐ Yes ☐ No
Ever been knocked out	☐ Yes ☐ No

SURGERY: List previous hospitalizations/serious injuries: When?

1 _____ _____
2 _____ _____
3 _____ _____
4 _____ _____
5 _____ _____

ALLERGIES: List any (food, drug, other):

1. _____
2. _____
3. _____
4. _____
5. _____

SOCIAL HISTORY:

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily: _____

Use of tobacco: ☐ Never ☐ Previously but quit ☐ Current packs per day: _____

Drug use: ☐ Never ☐ Type/Frequency: _____

Excessive exposure at home/work ☐ Fumes ☐ Dust ☐ Solvents ☐ Noise

Caffeine use: How many cups coffee/tea/soda per day? _____

Regular exercise: How often? _____

MEDICATIONS: List all regularly taken:

1. _____
2. _____
3. _____
4. _____
5. _____

Do you get regular flu shots? ☐ Yes ☐ No

Last Tetanus _____

Last Pneumonia _____

FAMILY HISTORY

Cancer	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Heart trouble	☐ Yes ☐ No
Acute Infections	☐ Yes ☐ No	Seizures	☐ Yes ☐ No	Bleeding Tendency	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No	Hereditary Defects	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Asthma/emphysem	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No
		Mental Illness	☐ Yes ☐ No	Congenital Deformities	☐ Yes ☐ No

Patient History Continued:

FAMILY HISTORY:	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Spouse			
Brother or Sister (circle)			
Brother or Sister (circle)			
Daughter or Son (circle)			
Daughter or Son (circle)			
Daughter or Son (circle)			
Daughter or Son (circle)			

PLEASE ANSWER ALL QUESTIONS ***Have you recently experienced any of the following?***

GENERAL HEALTH & WELL-BEING

Good general health lately	☐ Yes	☐ No
Recent weight change	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Headaches	☐ Yes	☐ No

EYES

Eye disease or injury	☐ Yes	☐ No
Wearing glasses/contact lens	☐ Yes	☐ No
Blurred or double vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

EARS, NOSE, THROAT, SINUS

Hearing loss	☐ Yes	☐ No
Ringing in the ears	☐ Yes	☐ No
Perforated (hole in) ear drums	☐ Yes	☐ No
Earaches or drainage		
Sinus problems	☐ Yes	☐ No
Seasonal nasal discharge (allergies)	☐ Yes	☐ No
Loss of smell	☐ Yes	☐ No
Nose bleed	☐ Yes	☐ No
Mouth sores	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Bad breath or bad taste	☐ Yes	☐ No
Sore throat or voice change	☐ Yes	☐ No
Swollen glands in neck	☐ Yes	☐ No

HEART & CIRCULATORY SYSTEM

Heart trouble	☐ Yes	☐ No
Chest pains	☐ Yes	☐ No
Palpitations or flutter of heart	☐ Yes	☐ No
Swelling of feet, ankles or hands	☐ Yes	☐ No
Shortness of breath that awakens you at night	☐ Yes	☐ No
Cramping in legs	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No

LUNGS

Frequent coughing	☐ Yes	☐ No
Spitting up blood	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Asthma or wheezing	☐ Yes	☐ No

GENITOURINARY

Frequent urination (voiding)	☐ Yes	☐ No
Burning or painful urination	☐ Yes	☐ No
Blood in urine or discoloration	☐ Yes	☐ No
Change in force or strain when urinating	☐ Yes	☐ No
Inability to control bladder or dribbling	☐ Yes	☐ No
Getting up at night to pass urine	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No
Male – testicle pain	☐ Yes	☐ No

GASTROINTESTINAL

Loss of appetite	☐ Yes	☐ No
Change in bowel movements	☐ Yes	☐ No
Nausea or vomiting	☐ Yes	☐ No
Heartburn or chronic indigestion	☐ Yes	☐ No
Frequent diarrhea	☐ Yes	☐ No
Painful bowel movements or constipation	☐ Yes	☐ No
Red blood cells in stool or tarry, black stools	☐ Yes	☐ No
Stomach pain	☐ Yes	☐ No
Hemorrhoids or rectal itching	☐ Yes	☐ No

BONES, JOINTS, MUSCLES

Joint pain, stiffness, or swelling	☐ Yes	☐ No
Weakness of muscles or joints	☐ Yes	☐ No
Muscle pain or cramps	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Cold extremities (legs)	☐ Yes	☐ No
Difficulty in walking	☐ Yes	☐ No

SKIN

Rash or itching	☐ Yes	☐ No
Change in skin color	☐ Yes	☐ No
Change in hair or nails	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No
Breast pain	☐ Yes	☐ No
Breast lump	☐ Yes	☐ No
Breast discharge	☐ Yes	☐ No

BRAIN & NERVOUS SYSTEM

Frequent or recurring headaches	☐ Yes	☐ No
Light headed or dizzy	☐ Yes	☐ No
Convulsions or seizures	☐ Yes	☐ No
Numbness or tingling sensations	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Temporary blindness	☐ Yes	☐ No
Loss of consciousness	☐ Yes	☐ No
Weakness of any extremity (leg or arm)	☐ Yes	☐ No

MENTAL HEALTH

Memory loss or confusion	☐ Yes	☐ No
Nervousness	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Sleep problems	☐ Yes	☐ No

ENDOCRINE

Glandular or hormone problem	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Excessive thirst or urination	☐ Yes	☐ No
Heat or cold intolerance	☐ Yes	☐ No
Dry skin	☐ Yes	☐ No
Change in hat or glove size	☐ Yes	☐ No

BLOOD & LYMPH

Slow to heal after cuts	☐ Yes	☐ No
Easily bruise or bleed	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Past transfusion	☐ Yes	☐ No
Enlarge glands	☐ Yes	☐ No

WOMEN ONLY:

Pain with periods	☐ Yes	☐ No
Irregular periods	☐ Yes	☐ No
Vaginal discharge	☐ Yes	☐ No

pregnancies: # miscarriages:

Date of last PAP smear? _____

Finding of last PAP: ☐ Normal ☐ Abnormal

Date of last period? _____

Date of last Mammogram? _____

Do you practice birth control? ☐ Yes ☐ No

If so, what type:

Patient's Signature: _____ **Date:** _____

☐ *I have reviewed and confirmed this information with the patient.* **Provider Signature:**

Today's Date _____ _____

PELICANPRIMARYCARE

MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT INFORMATION:

Name: (Last, First, MI) _____

Address: _____

Phone: _____ Date of Birth: _____ SS#: _____

AUTHORIZATION:

I hereby authorize (Physician, Clinic, Hospital or other Health Care Provider) to release medical records:

From (Name of Health Care Provider Office Releasing Records):

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Date of Services: _____ to _____

To (Name of Requesting Party):

Name: **PELICAN PRIMARY CARE**

Address: **23421 WALDEN CENTER DR STE 100, BONITA SPRINGS, FL 34134**

Fax #: **(239) 593-0067** Phone #: **(239) 514-2008** Email: **info@pelicanprimarycare.com**

PURPOSE OF RELEASE OF MEDICAL RECORDS:

- ☐ Change in family doctor
- ☐ Insurance claim processing
- ☐ Legal claim processing
- ☐ Specialty appointment
- ☐ Other (specify): _____

The Undersigned Hereby Releases PELICAN PRIMARY CARE from Any and All Legal Responsibility or Liability that could occur from this Action.

Patient Signature: _____ **Date:** _____

PELICANPRIMARYCARE

PAYMENT POLICY

Thank you for choosing PELICAN PRIMARY CARE as your primary care provider. We are committed to providing you with the best possible health care. In order to better serve you, we have adopted the following payment policy:

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. CO-PAYMENTS & DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

3. MEDICARE & SECONDARY INSURANCE. Whether or not your secondary payer is a crossover, you are expected to pay the 20% co-payment at the time of service. Upon receiving payment from your secondary insurance company, we will refund you the payment.

4. NON-COVERED SERVICES. Please be aware that some, & perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

5. PROOF OF INSURANCE. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. CLAIMS SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. COVERAGE CHANGES. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you and payment will be expected immediately.

8. NON-PAYMENT. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. A monthly interest rate will accrue to your patient balance for non-paid services. Partial payments will not be accepted unless otherwise agreed upon. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. MISSED APPOINTMENTS. If you fail to show up or cancel your appointment with less than a 24 hour advance notice, you will be charged a fee of **$25**, (**$50** for a physical). As a courtesy, a reminder call is made by our staff a day prior to your appointment, but in no way does this relieve the patient of the responsibility to fulfill their scheduled appointment.

10. PAYMENTS ACCEPTED. Cash, Check, American Express, Discover, Master Card, Visa. If your check is returned for insufficient funds, we reserve the right to add a penalty charge of **$35.00** to your account.

11. CHARGEABLE SERVICES. You will be charged for additional services you request including: medical form completion, phone and email consultations, and prescription refills (requested outside a scheduled visit).

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient (or Responsible Party) **Date**

PELICANPRIMARYCARE

PRIVACY PRACTICES ACKNOWLEDGEMENT & CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly or indirectly.**
- **Obtain payment from third-party payers (your insurance company).**
- **Conduct normal healthcare operations, such as quality assessments and physician certifications.**

I have received and reviewed a copy of the Notice of Privacy Practices (in office or printed out from website) containing a more complete description of the uses and disclosure of my health information. I understand that PELICAN PRIMARY CARE has the right to change its privacy notice and that I may contact PELICAN PRIMARY CARE any time to obtain a current copy of the Notice of Privacy Practices. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the PPC Privacy Officer, 1217 Piper Blvd, Suite 104, Naples, FL 34110.

I hereby give my consent for PELICAN PRIMARY CARE to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). With this consent, PELICAN PRIMARY CARE may call, mail, or email my home or other 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 test results, among others.

I prefer to be contacted/reminded regarding my appointment, billing, or medical care in the following manner:

☐ Home Phone: _____ ☐ *Check here if you ONLY want us to leave a call back phone #*

☐ Work Phone: _____ ☐ *Check here if you ONLY want us to leave a call back phone #*

☐ Cell Phone: _____ ☐ *Check here if you ONLY want us to leave a call back phone #*

☐ Email: _____

☐ Secure Online Patient Portal (Requires Registration)

☐ Mail/Written Communication ONLY (We will send all information to your home address, unless requested differently)

☐ Other (Please specify): _____

I authorize the following persons to be contacted regarding my appointments, billing, or medical care.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

By signing this form, I am consenting to allow PELICAN PRIMARY CARE to use and disclose my PHI to carry out TPO.

_____ _____

Signature of Patient (or Legal Guardian) Date

_____ _____

Print Patient's Name Print Legal Guardian's Name (if applicable)