DR. JAMES F. CONNOR, P.A

PATIENT INFORMATION

(PLEASE PRINT)

PATIENT INFORMATION			
PATIENT NAME	MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MARRIED		SEX
PATIENT ADDRESS (STREET)	CITY	STATE	ZIP CODE
S.S. #	DATE OF BIRTH	HOME PHONE #	WORK PHONE #
CELL PHONE #	RELATIVE OR FRIEND NAME AND PHONE NUMBER		
REFERRED BY?			
EMAIL ADDRESS:			

INSURANCE INFORMATION			
PRIMARY INSURANCE	PHONE # ( )		
INSURANCE ADDRESS	GROUP #		
CITY, STATE, ZIP			
INSURED NAME	RELATION TO THE PATIENT?	DATE OF BIRTH	S.S.# OR I.D.#
OFFICE USE ONLY DEDUCTIBLE $_____ SATISFIED $_____ Percent %_____			
SECONDARY INSURANCE	PHONE # ( )		

I hereby authorize payment of medical benefits to the above named physician for all services rendered. I understand that I am financially responsible for any balance not covered by my insurance carrier. I authorize the above named physicians office to mail, copy, or request medical records from health care providers, agencies and insurance carriers as needed.

Copies of this signature are as valid as the original.

X_____ _____

PATIENT SIGNATURE DATE

Patient Interview Form Date: ____/____/____

Name: _____ DOB: _____ Age: _____ Height: _____

Reason for today's visit: _____

Advance Directive:

Living Will: ☐ Yes ☐ No **DNR:** ☐ Yes ☐ No **Power of Attorney:** ☐ Yes ☐ No ☐ **NONE**

Race

☐ White/Caucasian ☐ Black or African American ☐ Asian ☐ Hispanic or Latino ☐ Others: _____

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to provide information

Preferred Language

☐ English ☐ Spanish ☐ Others: _____

Contact Preference

☐ Cell Phone ☐ Home Phone ☐ Work Phone

Social History

Occupation: _____ Who else lives with you? _____ # of Children: _____

1) Do You Smoke? ☐ Yes ☐ No How Much? _____
2) Do you drink? ☐ Yes ☐ No How Much? _____

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

☐ Aspirin (Tartrazine Only) ☐ Latex ☐ Penicillin's ☐ Valium ☐ Iodine-Iodine Containing
☐ Codeine Sulfate ☐ Sulfa (Sulfonamide Antibiotics) ☐ Morphine

Current Medications

☐ None

Name	Dose	How Taken?

Pharmacy Name:

_____ _____

Signature ***Date***

MEDICAL HISTORY

(PLEASE PRINT) **DATE:**_____

NAME:_____ **AGE**_____ **HEIGHT:**_____

ALLERGIES:_____

PRIOR MEDICAL PROBLEMS:_____

_____

_____

_____

SURGERIES: _____

_____

SOCIAL HISTORY	**YES**	**NO**	**HOW MUCH?**
1) Do you smoke?	( )	( )	_____
2) Do you drink alcohol?	( )	( )	_____

3) Occupation? _____

4) Who else lives with you? _____

MEDICATIONS? _____

_____

_____

HAS ANYONE IN YOUR FAMILY EVER HAD?	**YES**	**NO**	**WHO?**	**WHAT KIND?**
1) Cancer?	( )	( )	_____	_____
2) Colon polyps?	( )	( )	_____	
3) Stroke?	( )	( )	_____	
4) Heart Attack?	( )	( )	_____	

What health problems have your parents had?

Mother:_____

Father:_____

		YES	**NO**	**DO YOU GET?**	**YES**	**NO**
Have you had blood transfusion?		( )	( )	5) Chest pains, tightness,		
DO YOU GET?	1) Blood in your stools?	( )	( )	squeezing, pressure or		
	2) Stomach cramps?	( )	( )	indigestion		
	3) Altered bowel habits?	( )	( )	w/ increased activity?	( )	( )
	4) Snoring regularly?	( )	( )	Jaw, neck, or arm pain		
				w/ increased activity?	( )	( )

ADDITIONAL MEDICAL INFORMATION:_____

_____

_____

X _____

PHYSICIAN REVIEWED

I hereby request and consent to examination and treatment by physicians at:

Dr. James F. Connor Professional Association
1851 Old Moultrie Rd., Suite A
St. Augustine, FL 32086

SIGNATURE: _____ DATE:_____

DR. JAMES F. CONNOR, PROFESSIONAL ASSCOCIATION

Notice Of Privacy Practices

As your personal physician, we keep your personal health information in the utmost confidence. Your medical record is actually the property of the medical office. You may obtain copy of that information with your signed release and the usual copying fee.

Your doctor, medical assistant and clerical assistants have access to your records for your treatment. We maintain physical, electronic and procedural safeguards that comply with federal standards to protect your personal information. We do not disclose information except as permitted by law.

Your legal rights under the privacy rule

Under the terms of the HIPAA privacy rule:

- **Patients have an enforceable legal right to review and copy their medical records,** base on the theory that access is the cornerstone of patient privacy policy and fair information practices. (45 CFR 164.524). Within 30 days of request, a covered entity must allow an individual to review records. If the information is not accessible onsite, the covered entity has 60 days to comply, though an extension can be given if the covered entity provides a written statement of the reasons for delay and the specific date by which it will comply.
- **Patients have the right to amend incorrect data in their medical records** (45 CFR 164.526). Within 60 days of request, a covered entity must amend a patient's information (with limited exceptions) as indicated and provide the amendment to all entities know to have received the objectionable information. Similar to the Fair Credit Reporting Act, if a request to amend or supplement information is denied, the HIPAA privacy rule gives the individual the right to file a statement disagreeing with the denial, which will be included in the records.
- **Patients have the right to an accounting to all disclosures of their personal information** to third parties by a covered entity (45 CFR 164.528).
- **Patients have the right to a written summary of their health condition**. At the individual's request, a provider must write a summary or explanation of the individual's health condition.
- **Exceptions:** A patient may be denied access to records if a provider believes such access could endanger the physical safety of the individual or others. Also patient access may be denied for some psychotherapy notes, for information complied for a lawsuit, or for certain other limited circumstances. All denials of patient access are subject to review and appeal.
- The content of most patient records falls within the definition of Protected Health Information (PHI).
- The office of Civil Rights enforces compliance of the HIPAA privacy rule and has full responsibility for correcting and/or punishing violations.

We are permitted to disclose information about you to:

- Pharmacist
- Laboratory
- X-Ray facilities
- Consulting Specialists
- Your insurance company
- Your employer if the employer pays for the visit
- Your spouse, children or those who help care for you
- Report a communicable disease to the Health Department
- Report child abuse
- Report elder abuse
- Court orders or subpoenas
- Government medical quality audits
- Collections agencies

I acknowledge the above

_____	_____	_____
PRINT NAME	**SIGNATURE**	**DATE**