ACCIDENT PATIENT'S MEDICAL HISTORY

Date: ________ Name ____ Male ____Female ____DOB ____/____/_____

Marital Status ______ Race________ Weight ________ Height _______

Ethnicity (circle one): White-Caucasian African-American Asian Korean Hispanic Other_________

Primary Language Spoken__________________ Patient's Social Security # __________________________

Address____ City___________________________ ST_______

ZIP__________ Home # ___________________ Cell # _________________Emergency Contact #________________________

Email Address____

Preferred Pharmacy ______________________________Pharmacy Location __________________________

Medical History: Please check if you have / had any of the following. Give date of ailment. Advise any ailments afflicting biological parents.

	Self	Mom / Dad				Self	Mom / Dad	
Heart Attack					Migraine			
Heart Disease					Diabetes (Type 1 or Type 2)			
Atrial fibrillation					Asthma			
COPD					Arthritis			
High Blood Pressure					Cancer - What kind ?			
Gastroesophageal Reflux Disease					Other ________________________			
Splenectomy					Other ________________________			

List **ALL MEDICATIONS** you are currently taking, including prescription & over the counter. INCLUDE ASPIRIN, MOTRIN, IBUPROFEN & VITAMINS.

Drug	Dosage (if known)		Drug	Dosage (if known)

List **ALLERGIES TO MEDICATIONS** ____ **REACTIONS TO MEDICATIONS** _______________________

List **ALLERGIES TO ENVIRONMENTAL FACTOR** ______________________________________ **REACTIONS** ______________________________________

ALLERGIC TO LATEX ________ **ALLERGIC TO TAPE** __________ **ALLERGIC TO IODINE**__________ **DO YOU SMOKE?** ______ **DRINK ALCOHOL?** ______

List **ALL SURGERIES**____

Type of Accident: Work injury ____ Auto accident while working ____

Date of Accident: ___________________ Time of Accident ______ A.M./P.M.

Describe accident in detail: ____

____

Location of Injury/Pain: ____

Did you lose consciousness? _____Yes _____No Were you treated at a hospital? ______ Yes _____ No

If you were treated at a hospital, which one? ____

If this was a work injury, who is your employer?____

What are your normal job duties?____

If you were in an auto accident, in which state did it occur? _____Florida _____ Other State ____________________

Were you the: _____ Driver ______Front passenger______ Rear passenger

Wearing a seat belt? Yes / No Airbag deployed? Yes / No

I, the undersigned, certify that I have answered the above questions truthfully to the best of my abilities.

Patient's Signature **Date**

North Florida Medical Group

AUTHORIZATIONS AND ASSIGNMENT OF BENEFITS

I authorize my insurance company, attorney or any third-party payor to pay directly to North Florida Medical Group and its subsidiaries, Coastal Urgent Care and Plastic Surgery Institute and Spa all charges submitted for services rendered to me by staff members of the above listed clinics. I understand that I will be responsible for any and all charges not paid by my insurance company. Should my account become delinquent, I understand that it may be turned over to a collection agency, and additional fees and interest may be added. I authorize North Florida Medical Group to release all information necessary concerning my medical condition to my insurance carrier for the purpose of processing a claim. I further authorize the use of this signature on all insurance submissions. I authorize NFMG to release the medical records and/or information needed in order to facilitate any referrals and/or further medical care. This authorization and assignment of benefits will remain valid until I notify North Florida Medical Group in writing of its cancellation. A photocopy of this authorization shall be as valid as the original.

I authorize prescription history to be downloaded from other sources. ☐ YES ☐ NO
I give my permission for NFMG to leave a message for me on my phone: ☐ YES ☐ NO
I give my permission for NFMG to contact me by e-mail: ☐ YES ☐ NO

If yes, what is your e-mail address? ____

I request a patient portal web account to be created and a welcome email to be generated to the email provided above. ☐ YES ☐ NO

I give my permission for NFMG to discuss my medical care, appointments, financial information regarding my account, and any other issues related to my care with the following person(s):

NAME: ____ Relationship to me: ___________________

NAME: ____ Relationship to me: ___________________

I also acknowledge that I was given the HIPAA Notice Of Privacy Policy to read and I understand that if I want a copy, one will be provided to me. I also understand that this authorization will remain in effect unless terminated in writing by me.

Patient's Name:_____________________________________ Patient's Date of Birth: ______/______/______

Signature: ____ Date: ______/______/______

Relationship to patient: ________________________________