NEW PATIENT MEDICAL HISTORY

LAST NAME **FIRST NAME** **MIDDLE/MAIDEN NAME**

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

DATE OF BIRTH ____________________________ GENDER ☐ M ☐ F MARITAL STATUS ☐ S ☐ M ☐ OTHER EMAIL______________________

:

HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) AREA CODE/TELEPHONE NUMBER

NAME OF POLICY HOLDER EMPLOYER

IS THIS AN HMO/PPO/MANAGED CARE PLAN? YES NO

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

FAMILY & PERSONAL HEALTH HISTORY *(Please print in black ink) to be completed*

Has any person, related by blood, had any of the following?

	Yes	No	Relationship
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clotting disorder			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Cancer (type):			
Alcohol/drug problems			
Psychiatric illness			
Suicide			

HEIGHT______________ WEIGHT ____________

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year
High blood pressure			
Rheumatic fever			
Heart disease			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Head or neck radiation treatments			
Tumor or cancer (specify)			
Malaria			
Thyroid disease			
Diabetes			
Serious skin disease			
Mononucleosis			

	Yes	No	Year
Hay fever			
Allergy injection therapy			
Arthritis			
Serious head injury			
Frequent or severe headache			
Dizziness or fainting spells			
ADD			
Paralysis			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			
Frequent vomiting			
Gall bladder trouble or gallstones			

	Yes	No	Year
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia			
Inherited blood disorder (Specify)			
Eye trouble besides need glasses			
Bone, joint, or other deformity			
Knee problems			
Recurrent back pain			
Neck injury			
Back injury			
Broken bone (specify)			
Kidney infection			
Bladder infection			

	Yes	No	Year
Kidney stones			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Sexually transmitted disease			
Blood transfusion			
Alcohol use			
Drug use			
Anorexia/Bulimia			
Smoke 1+ pack cigarettes/week			
Regularly exercise			
Wear seat belt			
Other (specify)			

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

MEDICATIONS *(Please print in black ink) to be completed*

☐ I am not taking any medications.

☐ I brought a list of my medications from home. [You do not need to write them in the list]

List all medications including over the counter, alternative, herbal, and prescriptions.

Name________________________________Use________________Dosage_____________Name__________________________Use__________________Dosage________________
Name________________________________Use________________Dosage_____________Name__________________________Use__________________Dosage ________________
Name________________________________Use________________Dosage_____________Name__________________________Use__________________Dosage________________
Name________________________________Use________________Dosage_____________Name__________________________Use__________________Dosage ________________
Name________________________________Use________________Dosage_____________Name__________________________Use__________________Dosage________________
Name________________________________Use________________Dosage_____________Name__________________________Use__________________Dosage ________________

Local Pharmacy: __________________________ Phone Number:________________________________
Mail Order Pharmacy: ________________________ Phone Number:________________________________

ALLERGIES *(Please print in black ink) to be completed*	
Medication/Food/Environmental	Reaction

HEALTH MAINTENANCE *(Please print in black ink) to be completed*		
Have you had these vaccines?	**Yes (Date)**	**No**
Flu		
Pneumonia		
Tetanus		
Shingles		
Coronavirus – Type?		
Have you had these tests?	**Yes, date (month/year)**	**No**
Bone Density Screening		
Colorectal Cancer Screening		
Dental Exam		
Diabetic Eye Exam		
Eye Exam		
Mammogram		
Pap Smear		

SPECIALISTS *(Please print in black ink) to be completed*	
Please list any other doctors you see	**Specialty**

FAMILY & PERSONAL HEALTH HISTORY-CONTINUED *(Please print in black ink) To be completed*

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet).

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

IMPORTANT INFORMATION….PLEASE READ AND COMPLETE

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself that may be advised or recommended by Garry Millien M.D.

Print Full Name **Signature** **Date**

Signature of Parent/Guardian, if student under age 18 **Date**

Garry D. Millien, M.D., P.A.

1501 FOREST HILL BLVD. SUITE #103 | WEST PALM BEACH, FL 33406
Phone: (561) 432-5090 | **Fax (561) 433-1565** | info@drgarrymillienmd.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (ROI)

RE:

Patient Name: ____

Date of Birth: ______________ Social Security Number: XXX-XX- __________

I here give permission to:

____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

____
Street Address

____
City, State and Zip Code

Release a copy of the specific information/documents listed:

____

____

____

___ *(Initial Here)* Drug Abuse ___ *(Initial Here)* Psychiatric/Psychological
___ *(Initial Here)* HIV/AIDS ___ *(Initial Here)* Alcohol Abuse

___ *(Initial Here)* I hereby release the facility from any liability which may arise as a result of the use of the information contained in the records released.

____ ______________
Print Full Name **Signature** **Date**

____ ______________
Signature of Parent/Guardian, if student under age 18 **Date**

____ ______________
Signature of Witness **Date**

To Receiving Agency: Prohibition of Redisclosure! This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the patient provides specific written consent for the subsequent disclosure of this information

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FINANCIAL RESPONSIBILTY

Patient Name: ____________________

Date of Birth: ____________ Social Security Number: ____________

Primary Number: ____________ Other: ____________

Address: ____________________
ADDRESS CITY STATE ZIP CODE

INSURANCE POLICY HOLDER

Insurance Name: ____________ Policy #: ____________

Group #: ____________ Phone #: ____________

Insured Name: ____________ Relation: ________ DOB: ______

Address: ____________________
ADDRESS CITY STATE ZIP CODE

PLEASE PRESENT CURRENT INSURANCE CARD AT TIME OF SERVICE
FULL PAYMENT OR COPAY IS EXPECTED AT EACH VISIT

AUTHORIZATION AND CONSENT: I hereby authorize Garry Millien M.D. to examine and treat my child or myself. I also authorize such treatment and procedures, as deemed necessary, by physician, including and not limited to, the taking of such blood samples, urine samples, and other therapies as deemed necessary. I am aware that the practice of medicine is not an exact science and I acknowledge no guarantee of assurance has been made or implied to me as to the results that may be obtained by examination and treatment.

I hereby authorize and request my insurance company to pay directly to the above physician benefits due me for his services. I understand I am financially responsible for charges, co-payments and my applicable deductible not covered by this authorization.

I hereby authorize the physician and/or supplier to release any information required to process this claim form.

You will allow us to bill your insurance for service rendered. If for any reason service is not covered because of non-eligibility, loss of coverage, assignation a different primary care doctor, etc... and the insurance denies payment, you ae responsible ultimately for the bill.

I certify that I understand the above authorization. The signature below is acknowledgment that I have received and understand the Notice of Privacy Practices and Guidelines.

____________________ ____________
Patient Print Full Name / Policyholder **Signature** **Date**

____________________ ____________
Signature of Parent/Guardian, if student under age 18 **Date**

____________________ ____________
Signature of Witness **Date**

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Financial Policy/Assignment of Benefits/Consent to Treatment

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late- cancellations delay the delivery of health care to other patients, some who are quite ill.

A "No Show" is missing a scheduled appointment. A "Late Cancellation" is canceling an appointment without calling us to cancel 24 hours in advance of an office visit. We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

Payment for services is due at the time services are rendered. Methods of payment: Cash, American Express, MasterCard, Visa and Discover. (Returned check fee is $25.00).

We are happy to assist you in processing your insurance claim, however insurance coverage is a contract between you and your insurance company and you are ultimately responsible for payment of your bill.

I understand that I may be billed for any out of pocket or reasonable collection fees if my account is not paid in a timely fashion. If it becomes necessary to pursue legal action to attempt to collect any outstanding balances, I agree that I am responsible for any and all attorney fees, court costs and any and all other costs deemed reasonable and customary and/or that may be allowed by the Court.

I hereby authorize and direct my insurance company to make payment to my physicians, providers and/or associates for services rendered and acknowledge that I am financially responsible for all non-covered services. I also authorize my provider to release to my insurance company any information necessary to process my claims. A photocopy of this assignment shall be considered as effective as the original.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctor's office of any changes in my medical status. I hereby authorize the healthcare staff to perform the necessary services I may need.

I certify that I have read and understand the foregoing "Financial Policy/Assignment of Benefits/Consent to Treatment" and agree to all terms and conditions as stated above. I understand it is my sole responsibility to verify my medical coverage with the insurance company, HMO or PPO, Medicare/Medicaid or other benefits programs and that I am ultimately responsible for payment in full of any outstanding balances.

A charge of $25.00 will be assessed for each no show or late cancellation office visit appointment if less than 24 hours notice is given.

______________________________ ______________
Patient Print Full Name / Policyholder **Signature** **Date**

______________________________ ______________
Signature of Parent/Guardian, if student under age 18 **Date**

______________________________ ______________
Signature of Witness **Date**