Medical Physicians Group PLLC
8563 Argyle Business Loop Suite #2, Jacksonville Florida 32244
531 South 6th St. Suite #1, Macclenny Florida 32063
https://medicalphysiciansgroup.com
admin@medicalphysiciansgroup.com
Phone # 863-874-0898
Fax # 833-728-7733

Health Insurance Portability and Accountability Act (HIPPA) Acknowledgement

I have received the HIPAA information. I understand that Medical Physicians Group PLLC and Dr. Leung will make all attempts to protect patient's medical information

_____
Print

_____ _____
Sign **Date**

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Cancellation Policy and Payment Policy

I understand that there is a $25 for any cancellation less than 24 hours prior to the appointment. I understand if insurance does not pay for your benefits and/or if your benefits have expired, then it is the patient's responsibility to pay for the office visit and/or the procedure, vaccination, and/or any medical services rendered.

_____
Patient's name

_____ _____
Patient's Signature **Date**

Medical Physicians Group PLLC New Patient Information Form

Patient's Legal Name: _____
Guardian/Responsible Party (if any):_____
Patient's Date of Birth: _____
Patient's Social Security Number: _____
Patient's spouse and/or person who is primary on the insurance and that person's date of birth
_____
Patient's Address:
_____
_____
Patient's Telephone Number: _____
Emergency Contact Name and Relation to Patient: _____
Emergency Contact's Phone Number: _____
Date of Last Physician Visit (Known or Approximate): _____
Name of Last Physician Seen: _____
Physician Phone Number: _____
Reason for Last Office Visit: _____
Primary Care Physician's Name (if different from above): _____
Primary Care Physician's Phone Number: _____
Date Last Seen by Primary Care Physician: _____
Patient's Primary Pharmacy Address: _____
Primary Pharmacy Telephone: _____

Allergy and Drug Information- New Patient

Do you currently have any known allergies? Yes No
What is the reaction?
If so, please list all known allergies (food allergies included) and reaction
_____

For females, when was your last menstrual period?
For females, is there a chance that you can be pregnant?

Please list all medications taken. Include name of medication (including strength), physician's name who prescribed the medication, date of last refill, and how often you take this medication. This includes prescription medication, medical supplements (both physician and non-prescription prescribed), and any recreational drugs. Please include drug name, dosage, and frequency and what time periods the drug was taken.

_____
_____
_____
_____

By completing the above information, you acknowledge the following: All prescribed and non-prescribed medications taken, including their current dosages and strengths, have been truthfully stated on this form. Should our physician prescribe medication which could cause a reaction with any unknown substances at the time of prescription, the patient agrees to hold harmless said physician.

If there is any change in medication taken from another provider, or another provider issues a new or change of prescription, it is up to the patient to notify us to update this change in his/her medical records and advise patient regarding any possible drug interactions.

Signature of Patient or Patient's Representative: _____

Date Signed: _____
Reason for Today's Visit:
_____

Please Circle and Elaborate if You Have Seen a Physician For or Have Been Diagnosed with Any of the Following:
Arthritis_____
Blurry Vision_____
Cancer_____
Chest Pain_____
Circulation Issues_____
Diabetes_____
Digestive Issues_____
Dizziness_____
Fatigue_____
Female Health/Gynecological _____
Heart Conditions_____
High Cholesterol _____
High Blood Pressure _____
Hormonal Issues_____
Incontinence_____
Insomnia_____
Low Blood Pressure _____
Male Health_____
Mental Health Conditions _____
Migraines_____
Pain (describe location) _____
Paralysis_____
Respiratory Conditions (including Asthma and Shortness of Breath)
_____
Substance Abuse/Chemical Dependency _____

When was last menstrual period? _____
Are you in Menopause?_____
Is there a chance you can be pregnant? _____

Do you currently use any medical devices? This includes assistive devices used as needed or prescribed regular use equipment. Some examples can include a nebulizer, CPAP machine, walker/cane, oxygen system, etc. If so, please list below:
_____
_____

I hereby attest to the best of my knowledge, all above statements regarding my previous known health conditions have been disclosed and answered truthfully.

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

Surgical History

Please list all Surgeries (both Inpatient and Outpatient), and Their Dates

_____

_____

_____

Social History

Do you using tobacco products? If so how much packs per day and for how many years? _____
Do you drink alcohol? If so, how much do you drink and how often? _____
Do you use any illicit drug use including marijuana? _____

Family History

What medical conditions does your mother have? Is she alive?
What medical conditions does your father have? Is he alive?
What medical conditions does your siblings have? Are they alive?

Insurance Information

Primary Insurance Company's Name_____
Group Number: _____ **Policy Number:**_____
Policy Holder's Name_____
Policy Holder's SSN: _____
Relation to Patient: _____

Policy Holder's Place of Employment:_____
Phone Number:_____
Policyholder's Address:

_____

Secondary Insurance Company Name: _____
Group Number: _____ **Policy Number:**_____
Policyholder's Name: _____

I hereby attest that all insurance information is truthful and current. If insurance information is unable to be verified at time of appointment, or a company rejects any claim, it is up to the patient or patient' representative to pay via cash and perform a self-claim filed with their own insurance company for self-reimbursement.

Patient or Patient's Representative Signature_____
Date_____