

DAVID P.M. HARRIS, M.D.

WE WILL NEED A COPY OF YOUR DRIVER'S LICENSE, INSURANCE/MEDICARE CARD(S)

Patients' Name _____ Date of Birth: _____ Age: _____

Address _____

City, State, Zip _____

Out of state address, if applicable _____

Social Security Number: _____

Marital status: ___ Single ___ Married ___ Widowed ___ Spouse's Name _____

Notify in case of emergency _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer of patient _____ Phone _____

Address of employer _____

Insurance Information: _____

Secondary insurance (if applicable) _____

I hereby authorize David P. M. Harris, M.D. to provide to insurance carriers or others, as directed, information regarding my medical treatment.

I understand that I am responsible for all charges due at the time of service.

Name _____ Date _____

Name _____ Age _____ Birth date _____ Phone _____

Why are you seeing the doctor today? _____

Referred by: _____

DETAILS OF YOUR PROBLEM:

Symptoms _____

How long have you had this problem? _____

What makes the symptoms better? _____

What makes the symptoms worse? _____

PAST MEDICAL HISTORY (please check either yes or no)

	Yes	No		Yes	No		Yes	No
High blood pressure			Lung disease			Sinus problems		
How many years?			Emphysema			Breast problems		
Diabetes			Bronchitis			Fibrocystic disease		
How many years?			Asthma			Nipple discharge		
Controlled by insulin, pills or diet			Ulcers			Arthritis		
Stroke(s)			Kidney disease			Thyroid problems		
Dates(s)			Prostate problems			Gout		
Seizures			Kidney stones			Dentures		
How many years?			Kidney infections			Hiatal hernia		
Date of last seizure			Hepatitis			High cholesterol		
Heart problems			Pancreatitis			Cataracts		
Heart attack(s)			Jaundice			Glaucoma		
Dates:			Cancer			Migraines		
Do you get chest pain			Intestinal problems			Blood vessel disease		
What brings it on?			Skin disease			Depression		
What makes it better?			Skin cancer			Blood clots in leg(s)		
Do you use nitroglycerin?								

PAST SURGERIES (include all operations such as tonsillectomy, appendectomy, cataracts, C-section, etc.)

	Operation	Date	Hospital/City	Surgeon
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Any significant complications from any of these operations?
 If so, please explain: _____

PLEASE FILL OUT OTHER SIDE

INJURIES

	Type	Year	Hospital / City
1.	_____	_____	_____
2.	_____	_____	_____

HABITS

1. Do you smoke? YES NO 1. Did you smoke in the past? YES NO

If yes: Packs per day _____ If yes: How many years _____
 Number of years smoking _____ Packs per day _____
 When did you stop smoking? _____

ALCOHOL

Drinks per day _____ Beer Wine Liquor

Number of years drinking? _____

ALLERGIES / SENSITIVITIES (i.e. penicillin, sulfa, iodine)

	Name of medication	Reaction to medication
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Blood transfusion(s)? Yes No If yes, when _____

MEDICATIONS (include birth control, water pills, herbal supplements, hormones, aspirin, etc)

	Medication	Dose	Frequency		Medication	Dose	Frequency
1.	_____	_____	_____	2.	_____	_____	_____
3.	_____	_____	_____	4.	_____	_____	_____
5.	_____	_____	_____	6.	_____	_____	_____
7.	_____	_____	_____	8.	_____	_____	_____
9.	_____	_____	_____	10.	_____	_____	_____

SOCIAL HISTORY

Place of birth (city and state) _____

Married Divorced Single Widow(er)

Occupation: _____ If retired, previous occupation _____

Education: _____ Hobbies _____

Do you live alone? Yes No If No, who lives with you? _____

FAMILY HISTORY

	Alive	Deceased	Current age/age at death	Medical Problems	If deceased / cause of death
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Sister (s)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Son(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Daughter(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

GULF COAST MEDICAL SPECIALISTS FINANCIAL POLICY
We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

- 1) Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Visa/Mastercard/Checks/Cash.
- 2) Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
- 3) We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.
- 4) If you are insured by a plan that we do not participate in, we will prepare and send the claim; however, you will be responsible for the full amount due at the time of service and we will refund any monies sent to the office.
- 5) Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office or billing company.
- 6) If your visit is related to an auto accident or work-related injury, this information must be provided prior to seeing the physician and all claim and billing information must be furnished prior to the appointment.
- 7) We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.
- 8) Patients who do not keep their appointments or fail to cancel scheduled appointments **without a 24 hour advance notice** may be subject to a administrative fee from \$30.00 to \$60.00 depending upon the length of the scheduled appointment and a minimum fee of \$100.00 for procedures, such as ultrasounds, cardiac stress tests, and DEXA bone density tests.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient or responsible party

Date

Printed name

GULF COAST MEDICAL SPECIALISTS, PLLC

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, Gulf Coast Medical Specialists, PLLC may use and disclose protected health information (“PHI”) about me to carry out treatment, payment and healthcare operations (“TPO”). Please refer to Gulf Coast Medical Specialists, PLLC’s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Gulf Coast Medical Specialists, PLLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Gulf Coast Medical Specialists, PLLC Privacy Officer at [*Street Address, City, State Zip*].

With my consent, Gulf Coast Medical Specialists, PLLC may call my home or other designated 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 call pertaining to my clinical care, including laboratory results among others.

With my consent, Gulf Coast Medical Specialists, PLLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Gulf Coast Medical Specialists, PLLC may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Gulf Coast Medical Specialists, PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Gulf Coast Medical Specialists, PLLC’s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Gulf Coast Medical Specialists, PLLC may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient’s Name

Date

Print Name of Patient or Legal Guardian