evolution primary care

11264 Boyette Road Riverview, Florida 33569
P: 813.672.2014 F: 866.386.1733 | evolutionprimary.com

Patient name _____ DOB_____

The purpose of today's visit- please choose only 1

☐ **This is an annual physical (no concerns/symptoms):**

An appointment intended to prevent illnesses and detect health concerns early, before symptoms are noticeable. Preventive visits could be an annual physical, well-child exam, Medicare wellness exam or welcome to Medicare visit. Insurance companies are required to cover preventive care services at no cost to patients. During your appointment, your provider will review your overall health and well-being.

Depending on your age, services may include:

- Complete physical exam
- Routine bloodwork
- Pelvic exams, Pap smear
- Sexually-transmitted disease testing
- Alcohol, depression, obesity and tobacco counseling
- Select Immunizations

I am being seen today for an annual physical and **I do not have any complaints or concerns I wish to discuss.**

_____ _____
Patient signature Today's date

☐ **This is an office visit(concerns/symptoms):**

An appointment designed to discuss new or existing health problems or symptoms. To address these specific health concerns, your provider may order tests, prescribe medication, refer you to a specialist or provide advice and education. Office visits are billed to insurance and patient is generally responsible for a standard insurance co-pay or deductible.

I am being seen today for an office visit due to concerns/symptoms I am having and would like to discuss with the doctor. **I understand that this is considered an ordinary office visit and I will be responsible for any copay or deductible**.

_____ _____
Patient signature Today's date

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Today's Date: _____

PLEASE PRINT AND COMPLETE ALL SECTIONS				
PATIENT NAME (LAST - FIRST - MIDDLE INITIAL)		NICKNAME (if applicable)		PATIENT DATE OF BIRTH
PATIENT ADDRESS		CITY, STATE		ZIP
HOME PHONE	CELL PHONE	PATIENT SSN	PATIENT MARITAL STATUS ❑ Single ❑ Married ❑ Divorced ❑ Other_____	
PATIENT RACE ❑ White ❑ Black or African American ❑ American Indian ❑ Asian ❑ Chinese ❑ Other Race ❑ Decline to Specify		PATIENT ETHNICITY ❑ Hispanic ❑ Non-Hispanic ❑ Decline to Specify	PATIENT SEX ❑ Male ❑ Female	PATIENT PREFERRED LANGUAGE ❑ English ❑ Spanish ❑ Other_____
PATIENT EMAIL ADDRESS		PREFERRED PHARMACY & LOCATION		
EMERGENCY CONTACT NAME		RELATIONSHIP TO PATIENT	EMERGENCY CONTACT PHONE NUMBER	
PRIMARY INSURANCE POLICY HOLDER		Relationship to patient: ❑self ❑spouse ❑parent ❑guardian ❑other		
NAME (LAST - FIRST - MIDDLE INITIAL)		ADDRESS (if different from patient)		
HOME PHONE	CELL PHONE	DATE OF BIRTH	SSN	
SECONDARY INSURANCE POLICY HOLDER		Relationship to patient: ❑self ❑spouse ❑parent ❑guardian ❑other		
NAME (LAST - FIRST - MIDDLE INITIAL)		ADDRESS (if different from patient)		
HOME PHONE	CELL PHONE	DATE OF BIRTH	SSN	
FINANCIALLY RESPONSIBLE PARTY		Relationship to patient: ❑self ❑spouse ❑parent ❑guardian ❑other		
NAME (LAST - FIRST - MIDDLE INITIAL)		ADDRESS (if different from patient)		
HOME PHONE	CELL PHONE	DATE OF BIRTH	SSN	

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	**DATE**

INSURANCE ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	**DATE**

Patient Information Sheet

Patient Name: _____ **DOB:** _____ **Today's date:** _____

Purpose of today's visit:

- ❏ This is a routine annual physical, I currently have no complaints that I would like to discuss
- ❏ I would like to discuss the following complaints with the doctor:
  1- _____ 2- _____

Current Prescription Medications:

Name of Medication	Dosage	How often? (daily, weekly, etc)

Personal Medical History: (Please circle all that apply)

ADHD	Bladder problems	Emphysema/COPD	High cholesterol	Thyroid disease
Alcoholism	Irregular heart	Epilepsy	HIV/AIDS	Ulcers
Allergies	beat	Heart attack	Kidney disease	_____
Asthma	Glaucoma	Heart disease	Migraines	_____
Anxiety	Cancer: _____	Heart murmur	Neuropathy	_____
Anemia	Clotting Disorder	Hepatitis: _____	Seizures	
Arthritis	Diabetes	High blood pressure	Stroke	

Family Medical History: (Please circle all that apply)

ADHD	Bladder problems	Emphysema/COPD	High cholesterol	Thyroid disease
Alcoholism	Irregular heart	Epilepsy	HIV/AIDS	Ulcers
Allergies	beat	Heart attack	Kidney disease	_____
Asthma	Glaucoma	Heart disease	Migraines	_____
Anxiety	Cancer: _____	Heart murmur	Neuropathy	_____
Anemia	Clotting Disorder	Hepatitis: _____	Seizures	
Arthritis	Diabetes	High blood pressure	Stroke	

Patient Information Sheet

Allergies to Medications:

_____

_____

Other medical problems not listed above:

_____

_____

Surgical History: (Please list all prior surgeries and approximate dates performed)

_____

_____

Hospitalization History:

_____

_____

Social/Cultural History:

Smoking/Tobacco use: Current: _____Past: _____Never:_____

Alcohol use: Current:_____ Past: _____Never:_____

Current occupation:_____

Marital Status_____

Women: How many pregnancies/living children_____

Men: How many children _____