CHAIN OF LAKES
PRIMARY CARE MEDICAL

New Patient Medical History

Today's Date: _____

Patient Name:_____Date of Birth: _____

Home Address:_____

How did you hear about us? _____

Phone number: _____

Emergency Contact: Name: _____Relationship to Patient:_____

Please list any other doctors you see	**Specialty**
SPECIALISTS	
	Former Primary Care

PERSONAL MEDICAL HISTORY

Please mark any conditions that you are treated for or may apply to you.

- ☐ Anxiety
- ☐ Asthma
- ☐ Blood/Clotting Disorder
- ☐ Cancer_____
- ☐ Depression
- ☐ Diabetes
- ☐ COPD
- ☐ Heart Attack:
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Thyroid Disease

Other (Please list):

_____

_____

_____

_____

_____

_____

_____

_____

CHAIN OF LAKES
PRIMARY CARE MEDICAL

SURGICAL HISTORY	
Please list any surgeries you have had	**Date:**

FAMILY MEDICAL HISTORY					
Please mark any conditions in your family.					
	Mother	Father	Brother	Sister	Other
Blockage of Arteries					
Arthritis					
Asthma					
Heart Disease					
Cancer					
Cataract					
Depression					
Diabetes Mellitus					
Eczema					
Epilepsy					
Gastrointestinal disorder					
Glaucoma					
Heart Attack					
High Blood Pressure					
High Cholesterol					
Macular Degeneration					
Mental Illness					
Migraine Headaches					
Osteoporosis					
Kidney Disease					
Stroke					
Thyroid Disease					
Other:					

8976 Conroy Windermere Rd. Orlando, FL 32835-3128
Tel: +1 (407) 217-2410 | Fax: +1 (407) 723-7555
info@chainoflakesprimarycare.com
www.chainoflakesprimarycare.com

CHAIN OF LAKES
PRIMARY CARE MEDICAL

HEALTH MAINTENANCE		
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		

MEDICATIONS			
□ I am not taking any medications.			
List all medications including over the counter, alternative, herbal, and prescriptions.			
Medication Name	**Strength**	**How many times a day?**	**Comments:**

Local Pharmacy: _____ Phone Number:_____
Mail Order Pharmacy: _____Phone Number:_____
Preferred in-office Lab company (circle): Quest Labcorp
Preferred Imaging Location:_____

8976 Conroy Windermere Rd. Orlando, FL 32835-3128
Tel: +1 (407) 217-2410 | Fax: +1 (407) 723-7555
info@chainoflakesprimarycare.com
www.chainoflakesprimarycare.com

CHAIN OF LAKES
PRIMARY CARE MEDICAL

ALLERGIES	
Allergies: Medication/Food/Environmental	Reaction

SOCIAL HISTORY

Occupation:_____
Current Home Status: □ Lives Alone □Lives w/ Spouse □Lives w/ Relatives □Domestic Violence
Do you have a living will? □Yes □ No
Do you have an advanced directive? □Yes □ No
Religion:_____
Marital Status: □ Single □Married □Separated □Divorced □Widowed

Tobacco:
□ Current every day □Current somedays □Former, quit date?_____□Never
Type (if applicable): _____

Alcohol: □ Never □Rarely □Moderate □Daily □Drinks per week_____Type?_____

Caffeine: □ Never □Rarely □Moderate □Daily Type?_____

Use of illicit drugs: □ Never □Rarely □Former, quit date?_____Type?_____

Do you exercise? □Yes, Type?_____□ No

Are you sexually active? □Yes □ No

Smoke detector in the house? □Yes □ No

Do you have any pets? □Yes, Type?_____□ No

Do you travel outside of the USA? □Yes, Where?_____ □ No

Occupational Exposures: □ Noise □Dust □Chemical Solvents □Airborne particles

8976 Conroy Windermere Rd. Orlando, FL 32835-3128
Tel: +1 (407) 217-2410 | Fax: +1 (407) 723-7555
info@chainoflakesprimarycare.com
www.chainoflakesprimarycare.com

CHAIN OF LAKES
PRIMARY CARE MEDICAL

Thank you for giving us the opportunity to care for you today!

HIPPA FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

RECORD OF DISCLOLSURES OF PROTECTED HEALTH INFORMATION

Please list the name or names of the following people and their relationship to you, that we may release information with your consent.

Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone

Patient signature Date

PRIVACY POLICY

The following is our office's privacy policy, provided to you as required by law. We do not sell or share any personal patient information with any outside companies to enable them to market their own products and services. We maintain our own personal and financial records, here within our office. It is our mission to protect our patient's privacy and secure all information with which you have entrusted us. We appreciate the trust you have placed in us. By signing this I acknowledge that I have read and understand this statement.

Signature of Patient or Guardian Date

Contact Information
I wish to be contacted in the following manner (please fill in all numbers that apply)

8976 Conroy Windermere Rd. Orlando, FL 32835-3128
Tel: +1 (407) 217-2410 | Fax: +1 (407) 723-7555
info@chainoflakesprimarycare.com
www.chainoflakesprimarycare.com

CHAIN OF LAKES
PRIMARY CARE MEDICAL

Medical Records Release Form

By signing this form, I (Patient Print) _____ __
DOB: _____authorize_____to release the following confidential health information for continuation of care: (Facility/Doctors office)

Attn: MEDICAL RECORDS
Pb#
Fax#

To: Chain of Lakes Primary Care
Fax # 407-723-7555

☐ Complete Medical Record Date of Service: _____ __
☐ H&P (within the last year)
☐ Pathology/Lab Reports
☐ Radiology/Imaging Reports
☐ Operative Reports
D Other (Specify): COMPLETE MEDICAL RECORDS, LABS, OFFICE NOTES, MRI/CT

Kindly fax all records attention# **Chain of Lakes Primary Care Dr Judith Moss or Dr Danielle Solomon Alhemovich: Fax number (407) 723-7555**

Expiration Date: __/__/_____(If left blank authorization will expire 1 year from date on signature line)

☐ I understand that declining to sign this form does not mean denial of care from the facility of provider, it may limit the coverage from insurance company for repeated testing or other rendered services out of the insurance policies governed timeframe.

☐ I have fully read, understood, and given a copy of the Patient Privacy Policy. This notice is in
compliance with HIPAA and government within such.

☐ I understand the patient has a right to revoke authorization for disclosure of protected health
information. Submission of revocation must occur in the form of a written request to the practices' compliance officer.

☐ I understand that Florida Statute 456.057 (12), Makes it clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without expressed written consent of the patient or legal representative.

Print: .....

Relationship to patient: _____ __

Signature: _____ __

8976 Conroy Windermere Rd. Orlando, FL 32835-3128
Tel: +1 (407) 217-2410 | Fax: +I (407) 723-7555

Info@chainoflakesprimarycare.com
www.chainoflakesprimarycare.com

CHAIN OF LAKES
PRIMARY CARE MEDICAL

Insurance Information:

PRIMARY INSURANCE:

Primary Insurance Co. Name: _____

Policy Holder Name: _____

Policy Holder's Date of Birth_____

Patient Relationship to Policy Holder: _____

Phone number: _____

Group #: _____

ID #: _____

Rx BIN #_____

Insurance Address: _____

Insurance Phone number: _____

SECONDARY INSURANCE:

Secondary Insurance Co. Name: _____

Policy Holder Name: _____

Policy Holder's Date of Birth_____

Policy Holder's Social Security #: _____

Patient Relationship to Policy Holder: _____

Group #: _____

ID #: _____

Rx BIN# _____

Insurance Address: _____

Insurance Phone number: _____

8976 Conroy Windermere Rd. Orlando, FL 32835-3128
Tel: +1 (407) 217-2410 | Fax: +1 (407) 723-7555
info@chainoflakesprimarycare.com
www.chainoflakesprimarycare.com

CHAIN OF LAKES
PRIMARY CARE MEDICAL

Financial Responsibility:

I understand it is the responsibility of each patient to arrange for payment for the medical services received in this office. I hereby authorize any insurance benefits to be paid directly to Chain of Lakes Primary Care LLC and recognize my responsibility to pay for all non-covered services. We will bill your insurance plan as a courtesy to you. It is not feasible for our staff be to fully aware of each health insurance plan's specific requirements or coverages. We will do everything we can to help you; however, it is your responsibility to verify that Chain of Lakes Primary Care LLC is part of your insurance plan's covered providers, and to know what your plan does and doesn't cover. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment. I hereby authorize Chain of Lakes Primary Care LLC or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received at Chain of Lakes Primary Care LLC or payment for the services I received at Chain of Lakes Primary Care LLC including but not limited to, debt collection purposes. We do offer Uninsured (self-pay). If you do not have health insurance, we will be happy to provide care for you for a discount of $75.00 per office visit but payment in full is necessary prior to your visit.

I understand that while this consent is voluntary, if I refuse to sign this consent the provider at Chain of Lakes Primary Care, LLC can refuse to treat me. I understand that this authorization can only be revoked in writing, if I revoke my consent, such revocation will not affect any actions that Chain of Lakes Primary Care, LLC physicians took before receiving my revocation.

Signature of Patient or Patient Representative: _____

Date: _____

Printed Name of Patient: _____

Relationship of Representative to Patient:_____

8976 Conroy Windermere Rd. Orlando, FL 32835-3128
Tel: +1 (407) 217-2410 | Fax: +1 (407) 723-7555
info@chainoflakesprimarycare.com
www.chainoflakesprimarycare.com

CHAIN OF LAKES
PRIMARY CARE MEDICAL
Going Beyond Concierge Medicine

Patients who desire "In-Office" Labs at Chain of Lakes Primary Care, LLC (COLPC) to draw blood understand that they will be charged a prior specified convenience fee from our approved Phlebotomy Contractor (s).

It is understood that this convenience fee is not for the drawing and handling of your blood and that it is not a "Covered Service" by your insurance company. Therefore, this fee is not reimbursable by your insurance company. If your lab work is not processed correctly by the contractor(s) or lab itself, it is not Chain of Lakes Primary Care LLC's responsibility and you will reach out to that contractor or lab directly to rectify your issue, as these services are not our responsibility to perform.

At COLPC we strive for the best and will provide contact information for these entities if asked. If you agree with this policy and would like to have your lab(s) drawn at our office, please indicate your acceptance of this policy by signing below.

You are always welcome to go in person to any lab of your choosing if more convenient to you. At any time, you may contact our office to have these ordered changed over to your specified lab. **You must physically bring a copy of your lab requisition to your specified in-person lab to avoid faxing error/issues/outages and possible delay in your care.**

I have read, understand, and agree to the office policies stated above.

X _____Date:_____
Patient Name: Print

X_____
Patient Name: Sign