PATIENT INFORMATION

Last Name:	**First Name:**	**Middle Name:**
Mailing Address:	**City:**	**State/Zip:**
Home Phone:	**Cell Phone:**	**Email:**
Date of Birth:	**Age:**	**Social Security Number:**
Sex: **□MALE □FEMALE**	**Marital Status:** **□Single □Married □Divorced □Widowed**	

IN CASE OF EMERGENCY

Name of emergency contact person:	**Relationship to patient:**	**Home Phone:**	**Cell Phone:**
Mailing Address:	**City:**	**State**	**Zip Code:**

RESPONSIBLE PARTY (GUARANTOR)

The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip the next section. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Guarantor's Last Name:	**Guarantor's First Name:**	**Relationship to Patient:**
Guarantor's Mailing Address:	**City:**	**State/Zip Code:**
Guarantor's Phone Number:	**Guarantor's Date of Birth:**	**Guarantor's Social Security No.:**

OTHER INFORMATION

Pharmacy Name:	**Pharmacy Location:**	**Pharmacy Phone No:**

Carden Dodson Medical Associates, LLC
1411 N. Flagler Drive, Suite 7900
West Palm Beach, FL 33401
Phone (561) 655-8448

PATIENT HISTORY FORM

NAME:_____ **DATE OF BIRTH:**_____

PAST MEDICAL HISTORY: Please list any medical conditions from which you have suffered in the past or currently:

PAST HOSPITALIZATIONS-SURGERIES: Please list any surgeries, or hospitalizations, reason & date:

ALLERGIES: List any allergic reactions or adverse side effects you've had to any drugs or other

Drug/Food/Item	**Type of Reaction**	
Prescription Medications	**Dose**	**How often taken**
Over-the-counter medications	**Dose**	**How often taken**

FOR WOMEN ONLY:

Age onset of menses?	
When was your last menstrual period?	
Number of Pregnancies?	
Number of Births?	

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SOCIAL HABITS

NAME:_____ **DATE OF BIRTH:**_____

Do you smoke or chew tobacco? If YES, how much?	**YES**	**NO**
Are you a former smoker? If YES, when did you quit?	**YES**	**NO**
Do you use alcohol? If YES, how much?	**YES**	**NO**
Do you exercise regularly? If YES, how often?	**YES**	**NO**
Do you have or have you used illicit drugs?	**YES**	**NO**

IMMUNIZATIONS	**YES**	**NO**	**DATE**
Pneumoccal			
H. Influenza			
Shingles Vax			
Hepatitis B			
Tetanus			
Other			

FAMILY HISTORY	Mother	Father	Maternal Grandparent	Paternal Grandparent	Brother	Sister	Son	Daughter
Colon/Rectal Cancer								
Breast or Female Cancer								
Stroke/Heart Attack								
Diabetes								
High Blood Pressure								
High Cholesterol								
Alzheimer's Disease								
Alcohol/Drug Abuse								

Age of Parents: _____**Mother** ☐Alive ☐Deceased _____**Father** ☐Alive ☐Deceased

Number & Age of Children:_____ **Healthy:** ☐YES ☐NO

☐Are you experiencing an unusually stressful situation? ☐YES ☐NO EXPLAIN:_____

☐Are there any specific personal issues you would like to bring up at the time of your visit? ☐YES ☐NO

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MEDICAL RECORDS REQUEST FORM

Patient Name:_____ Date of Birth:_____

I request and authorize my previous doctor or specialists to release healthcare information of the patient named above to:

Name: CARDEN & DODSON, M.D.
Address: 1411 N. FLAGLER DRIVE, SUITE 7900
WEST PALM BEACH, FL 33401

Specific description of the information that may be used or disclosed (including dates):

_____

_____

_____

Specific description of how the information will be used:

_____

_____

1. I understand that this authorization will expire on _____;
2. I understand that I am responsible for any charges associated with obtaining my medical records (some practices may charge for copying, etc);
3. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Signature Medicine in writing;
4. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits if applicable;
5. I may inspect or copy any information used or disclosed under this agreement; and
6. I understand that if person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient or Patient's Representative Relationship to Patient

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AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Your health information is personal and private. Please complete this form as there are times when you may want us to be able to share your health information with someone such as your child, your spouse/partner, your parent or caregiver/guardian.

I request and authorize Signature Medicine to be able to discuss my personal health information to the following list of authorized people:

Name/Relationship_____ Phone No.:_____

Name/Relationship_____ Phone No.:_____

Name/Relationship_____ Phone No.:_____

Name/Relationship_____ Phone No.:_____

Name/Relationship_____ Phone No.:_____

All medical records/health information may be discussed except:

Please specify _____

_____

******IF THEY ARE NOT ON THIS LIST, WE WILL NOT BE ABLE TO SPEAK TO THEM ABOUT YOUR PERSONAL HEALTH INFORMATION UNLESS THEY ARE YOUR MEDICAL POWER OF ATTORNEY.**

******IF YOU WISH TO ADD OR SUBTRACT PEOPLE FROM THIS LIST, YOU MUST NOTIFY US EITHER IN WRITING OR IN PERSON.**

_____ _____

PATIENT SIGNATURE **DATE**

_____

PATIENT PRINTED NAME

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IMPORTANT INFORMATION ABOUT PROVIDER/PATIENT EMAIL
PLEASE READ THIS INFORMATION CAREFULLY

Email communications are two-way communications. However, responses and replies to emails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition.

If you have an urgent or an emergency situation, you should not rely on provider/patient email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though provider/patient e-mail is not available to you - and seek assistance by means consistent with your needs.

Email messages on your computer, your laptop, and/or your PDA have inherent privacy risks-especially when your email access is provided through your employer or when access to your email messages is not password protected.

Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the post office.

Email messages may be inadvertently missed. To minimize this risk, the practice requires you respond appropriately to a test email message before we will allow health information about you to be communicated with you via email. You can also help minimize this risk by using only the email address that you are provided at the successful conclusion of the testing period to communicate with our office.

You agree to hold harmless the practice for information sent through email that may be lost due to technical failures.

Email is sent at the touch of a button. Once sent, an email message cannot be recalled or cancelled. Errors in transmission, regardless of the sender's caution, can occur.

In order to forward or to process and respond to your email, individuals at our practice other than your health care provider may read your email message. Your email message is not a private communication between you and your treating provider.

Neither you nor the person reading your email can see the facial expressions or gestures or hear the voice of the sender. Emails can be misinterpreted.

At your health care provider's discretion, your email messages and any and all responses to them may become part of your medical record.

_____ _____

PATIENT SIGNATURE DATE

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