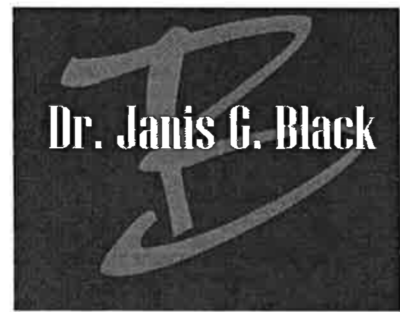
Family Health Center at Port St John
Dr. Janis G. Black
Taniqua Andrews, APRN
Sarah Crandall, APRN
3740 Curtis Blvd Suite 108
Port St John, FL 32937



Patient Information Form

Please fill out form completely (check no or does not apply), please do not leave questions blank, unless indicated. The more information you provide enables the physician to provide better care.

Name: ______________________________ Today's Date:___________ Age:____ Marital Status:_____

Email Address: ___________________________ May we email you with Appt reminders? ________

Occupation: ____Retired? _______________

Birth date: __________ Birthplace: ____________________ Lived outside of US?:________________

Ethnicity: _______________________________ Preferred Language: ______________________________

Who referred you to see the doctor today? ____

What is the reason for today's visit? ____

____

Past Medical History

Allergies Do you have any food or drug allergies? If so, please list below and describe.

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

Have you had any reactions to IVP dye used for X-ray studies? ___yes ___no

Medications For any additional medications please continue on back of form.

Name of Medication Dose Instructions Prescribing Physician

____

____

____

____

____

____

____

____

Herbs,supplements,vitamins:

____

____

Patient Name:_________________________________ **Date:**__________________

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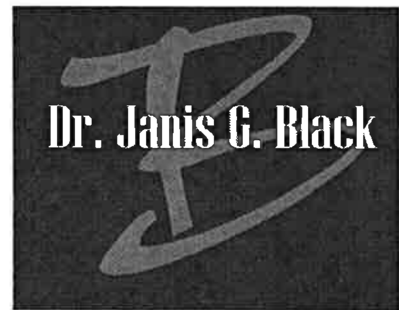

Surgeries:

Year	Surgery	Hospital	Doctor

Have you ever been advised to have a surgical operation that was not done? ___Yes ___No
If yes, explain. ____

Have you ever had radiation or chemotherapy? ___Yes ___ No If yes, please explain.

Start Date		End Date				
Month	Year	Month	Year	Area Treated	Hospital	Doctor

Blood Transfusions ___Yes ____No When______________________________________
Illnesses (rheumatic fever, polio, TB, hepatitis, meningitis, malaria) ________________
____

Do you see a Specialist (Cardiologist, OBGYN, Pulmonologist, Urologist, etc.)

Specialty	Doctor's name	Phone/fax	City, State	Last visit

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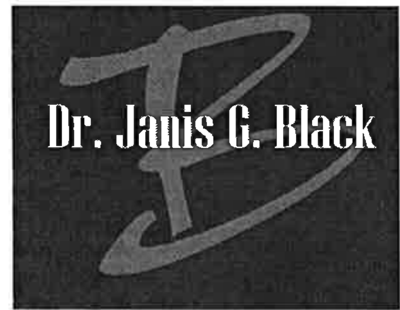

Family History

Relation	Age	High Blood Pressure High Cholesterol Heart Disease/Stroke Heart Attack	Diabetes	Cancer (What kind and age at Diagnosis)	Lung Disease COPD Emphysema	Seizures Neurological Disorders	Mental Illness Suicide Depression Alcoholism	Rheum. Arthritis Lupus	Other Medical Concern	Age at Death
M Grandfather										
M Grandmother										
P Grandfather										
P Grandmother										
Father										
Mother										
Brothers										
Sisters										
Children										
Other relatives										

Personal History

Do you use any medical devices? Check all that apply. ____glasses ____ hearing aids
____walker ____wheelchair ____oxygen ___Cpap ___Other________________________________
What medical equipment company do you use? ________________________________

Smoking:

Do you currently smoke cigarettes? ___Yes ___No
If yes, are you interested in quitting? ___Yes ___No. If not, did you previously? ___Yes ___No
If you stopped, when was it? ______ How many years have you smoked? __________

Patient Name:________________________________ **Date:**______________________

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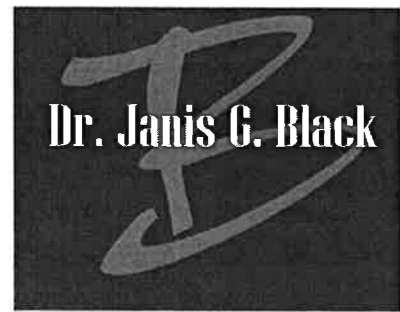

During the entire time, what is the average number of packs per day smoked? ________

Do you smoke a pipe or cigars? ___Yes ___No. If yes, how long?____________________

Do you or did you use snuff/chewing tobacco? ___Never ___Past ___Current-How Long_____

Alcohol:

Do you drink any alcoholic beverages? ____Current ____Former What kind? ____________

How much? ___1-2 ___2-3 ___4+ How often? ____________Daily, Weekly, Weekends, Rarely.

Has it ever interfered with your personal or professional life? _____Yes_____No If yes,explain

____

Have you ever been treated for this? ____

Drug Use:

Have you ever used illegal/recreational drugs? ____Current ____Past ____Never

If yes, what kind? ____________________ how often?______________________

Have you ever had formal treatment for this?_________________________________

Have you ever been addicted to or abused prescription medication?__________________

Women only:

Last Menstrual Period : ______________ Might you be pregnant? Yes____ No____ Unsure____

Contraceptive Method None___ Pills ___ Condoms ___ Surgical ___ Menopause ___ Other ___

Number of times pregnant: ______ # of Deliveries: _______ # of Children ________

Last Pap Smear: __________ Performed By Dr: ____________________ Results: ______________

Prior abnormal Pap? _________________ When? ______________ Last Mammo? :______________

Action taken for abnormal pap? Repeat exam _____ Cryotherapy _____ Cone _____ LEEP _____ Other _____

Testing:

Colonoscopy or Other Bowel or Digestive Studies? (Why, When, Results, When to Repeat?)_____________

____

Stress Test/Cardiac Cath/EKG/Heart Studies? (Why, When, Results, Actions Taken/Advised?) __________

____

Have you ever had a DEXA scan (Bone Density Scan) done?______________________

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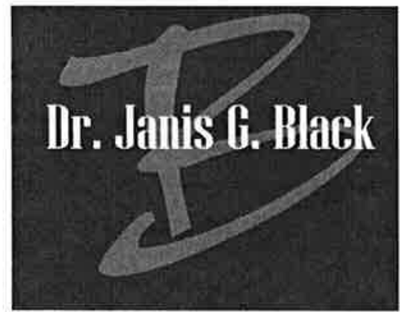

Vaccines:

Flu Vaccine?____________________________ Pneumonia Vaccine?______________________

Shingles Vaccine? _______________________ Tetanus Vaccine? ________________________

Have you completed your Hepatitis B series? ____

Patient Portal

Have you been given information about our patient portal? _____Yes _____No

Would you like more information about our Patient Portal where you can login and access your lab results, appointment times, and visit summaries? _____Yes _____No

Our office would be happy to provide you with more information about our new Patient Portal and provide you will your login information, please ask our staff.

What Three things would you like to discuss with your care provider today?

1.____

2.____

3.____

Thank you for completing this information it will enable us to give you the best possible care.

Patient Name:_______________________________________ **Date:**____________________

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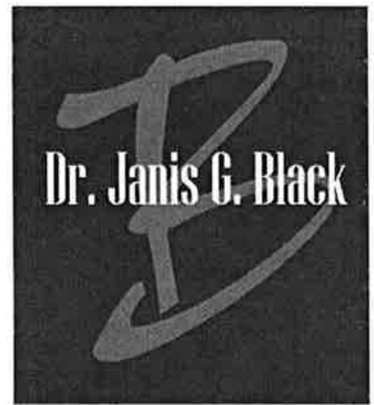
(321)633-5500 Fax (321)633-5566



Acknowledgement of receipt of HIPAA notice of privacy practices.

I have received a copy of Dr. Janis Black's HIPAA Notice of Privacy Practices. The notice describes how medical/protected health information may be used and disclosed. I understand that I should read it carefully, I am aware that the notice may be changed at any time. I may obtain a revised copy of the notice by requesting one from Dr. Black or her staff.

Initial below:

____________ I am accepting a copy at this time.

____________ I am refusing a copy, but am aware that I can request a copy at any time.

If you have any questions regarding our HIPAA Policy please feel free to ask our staff.

Patient Signature:____ Date:__________

Witness Signature:____ Date:__________

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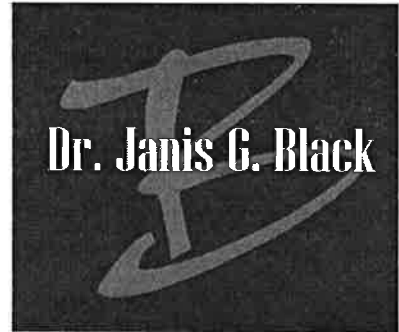

Authorization to disclose health information

Patient Name: ______________________________ DOB: ______________

Address: ____________________________________ Date: ___________

I authorize the Family Health Center at Port St John to share my personal health information, such as test results, medications, appointment times, and other details in relation to my care with the following person(s):

Name: ___________________________ Relationship: __________________

Name: ___________________________ Relationship: __________________

Name: ___________________________ Relationship: __________________

I understand that certain information relating to my health such as HIV/AID status, behavioral health services and psychiatric care, and drug and alcohol treatments will not be disclosed without my written permission.

I also understand that I have the right to revoke this authorization at any time. Unless revoked, this authorization will not expire. If I have any questions about the disclosure of my health information, I can contact Dr Black's office at (321) 633-5500.

Patient signature: ________________________ Date: ________________

Witness Signature: ________________________ Date: ________________

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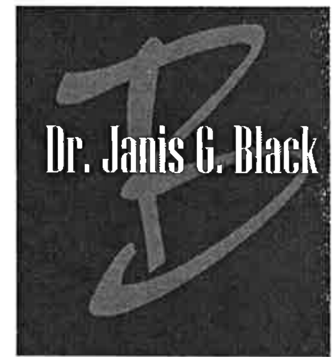

No Show, Late Cancellation, and Unconfirmed Appointment Notice

Due to the high demand for appointments and the number of no shows and late cancellations, The Family Health Center at Port St. John has had to institute a policy regarding these broken appointments.

No shows and Late Cancellations waste the doctors' limited appointment availability. They adversely affect the care provided to our patients by wasting appointment times that would otherwise be used by sick patients or patients who are requesting to be seen sooner.

If you are unable to make your appointment, you will need to cancel by calling the office at least 24 hours in advance of your scheduled appointment time so that the time-slot can be used for another patient. Failing to do so may results in a fee being billed to your account in the amount of **$50.00**. **This fee is subject to change. This fee is not covered by insurance and the patient is responsible for paying this before their next appointment.** You may cancel your appointments by calling our office at 321-633-5500. If it is after business hours you must leave a detailed message about your cancellation.

Our office makes two attempts to confirm your appointment by calling 48 hours prior and again 24 hours prior. You are responsible for verbally confirming your appointment with our office. If you are unable to call until after hours, please leave a detailed message confirming your appointment. Failing to do so may require us to reschedule your appointment to a later date.

Consecutive no shows or late cancellations will result in discharge from the practice, as we are unable to properly provide the quality of care that is necessary when appointments are not kept.

Your signature below indicates that you understand the policy, and agree to be responsible for no show appointments, late cancellations, and unconfirmed appointments.

Patient Name_______________________________________ Date ________________

Patient Signature____

Witness Signature ____

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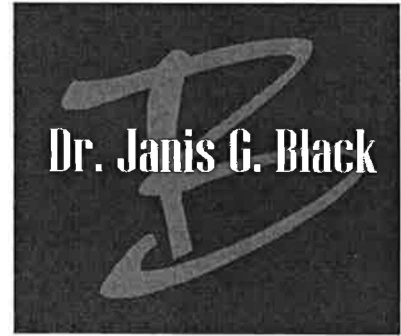

Advance Directives

(For compliance with the patient self determination)

Patient Name: ______________________________

Date of Birth: ______________ Social Security Number: ________________

Have you executed an Advance Directive? __________ Yes __________ No

If yes, is this directive in the form of:
(Circle your answer)

- Living Will
- Durable Power of Attorney
- Healthcare Surrogate

If you executed Advance Directives in any of these forms, have you provided this office with a copy for your medical records? ____________ Yes ____________ No

If you would like more information regarding Advance Directives, please speak to our staff.

Patient Name: __________________________ Date: ________________

Patient Signature: ______________________________

Witness Signature: ________________________ Date: ________________

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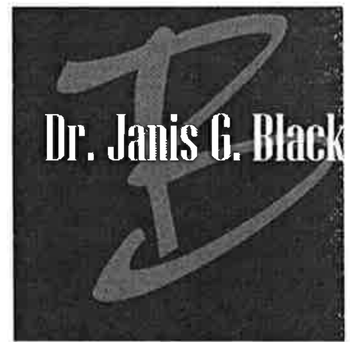

Authorization to release health information

Patient name:______________________________ Date of Birth:__________

Address:______________________________ Phone:__________

I Authorize:______________________________

Address:______________________________ Phone:__________

To release the following health records:

_____Complete health record ______Consultation reports _____EKG/Cardiac Testing
______History and Physical _______Progress Notes ______Labs/X-ray Reports
______Medication list _______Immunizations ______Other

In compliance with Florida Statues which require special permission to release otherwise privileged information, please release records pertaining to: **(PATIENT MUST INITIAL)**

______HIV/AIDS results _____Substance abuse/treatments ______Developmental disabilities

Purpose of need for disclosure:

____Further Medical Care _____Payment of Claim ______Legal ______School
____Application for Insurance _____Disability Claim ______Personal ______Other

Please release this information to:

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Port St. John, Florida 32927
Phone: (321) 633-5500 Fax: (321) 633-5566

I am aware that the release of information carries the potential for an authorized re-disclosure and the information may not be protected under federal confidentiality laws. I may contact the number above with any questions or concerns regarding my health information.

I understand that this authorization expires in 90 days and that I may revoke it at any time.

Patient Name______________________________ Date__________________
Witness Name______________________________ Date__________________