



# PREMIER

FAMILY MEDICINE - URGENT CARE - WELLNESS

### Update of Patient Information

First Name		Middle Name	Last Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		City, State, Zip		E-mail Address <i>(Required)</i>
Date of Birth / /	SSN - -	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed		
Preferred Phone		Secondary Phone	May we activate your Patient Portal so you may access your records <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is your <i>preferred</i> method of contact? <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> E-Mail <input type="checkbox"/> Mail				
Employer	<input type="checkbox"/> Check here if Retired	Occupation	Referred By	
Emergency Contact	Contact Phone	Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Parent <input type="checkbox"/> Friend		
Race <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> Other Race: _____ <input type="checkbox"/> Unreported/Refused to Report				
Preferred Language		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unreported/Refused to Report		
Do you have an Advanced Directive or Living Will? <input type="checkbox"/> Yes (Please provide a copy for office records.) <input type="checkbox"/> No				
Name Financially Responsible Party		SSN of Insured - -	Date of Birth / /	
Relationship of Financial Party to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian				

<b>Reason for Visit:</b>	<b>What are your Overall Top Health &amp; Wellness Concerns:</b>		
	1. _____		
	2. _____		
	3. _____		
<b>MEDICATIONS/SUPPLEMENTS/VITAMINS:</b> <input type="checkbox"/> Check here if not on Medications		<b>ALLERGIES: MEDICATION &amp; NON MEDICATION ALLERGIES:</b>	
1. _____	4. _____	7. _____	1. _____
2. _____	5. _____	8. _____	2. _____
3. _____	6. _____	9. _____	3. _____
<b>SURGERIES:</b> <input type="checkbox"/> Check here if no Surgery History		<b>HOSPITALIZATIONS:</b> <input type="checkbox"/> Check here if no Hospital History	

### Patient-Centered Healthcare

\_\_\_\_\_*(initials)* Our goal is to be your partner in healthcare and offer you quality and evidence-based care. We value continuity of care and want you to be able to identify one of our providers as your personal healthcare provider. It is our goal to coordinate your healthcare across all of the settings in which you may receive care. In order for us to create a patient-centered-medical home we need you to take an active role in your healthcare. It is your responsibility to provide a complete medical history as well as any information about care you receive outside of our practice. Please keep your provider informed of new medicines, allergies, hospitalizations, specialty visits, test results, and vaccines.

(Please list your healthcare provider of choice)



**Consent to Leave Phone Messages**

I understand that as part of my health care, PFH may need to reach me by phone.

( ) I **DO** authorize PFH to leave a message on my  home telephone,  cell phone, and/or  work phone regarding laboratory/test results and imaging studies. *However, I understand that sensitive information and/or results that will require medication follow-up or discussion will require that I make an appointment with the physician.*

( ) I **DO NOT** authorize PFH to leave message on my telephone (home, cell, or work) regarding any type of testing results. *I will accept the responsibility of making an appointment with the physician to obtain the results.*

**HIPPA** ( ) I hereby give consent to my health care provider to discuss or release my private health care information to  
 =====>> (i.e. Spouse, parent, care-taker): Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Patient's Signature or Authorized Party:** \_\_\_\_\_

**Patient Portal**

\_\_\_\_ (initials) PFH offers you access to your own personal web portal where you can obtain your records and contact the office. The portal can be used to message your provider, request appointments or referrals, and to manage your prescriptions. The portal is not for urgent issues, messages sent through the portal will not be checked until the next business day. Please provide your email address for this function: \_\_\_\_\_ (email)

**Other**

\_\_\_\_ (initials) I hereby consent that I will not use any recording device of voice or image on the premise of Premier Family Health this includes items such as cameras, voice recorders, phones and google glasses.

\_\_\_\_ (initials) I hereby consent that I would like to receive information on services offered by Premier either by email, mail or other. Premier does not provide your information of third parties and will not provide this information to unrelated parties for their own marketing and will not use this information for telephone solicitation.

**I have read and fully understand and accept the terms of the Premier Family Health, PA**

\_\_\_\_\_  
 Patient Name or Authorized Party (printed)

\_\_\_\_\_  
 Patient Signature or Authorized Party

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Witness Name (printed)

\_\_\_\_\_  
 Witness Signature

\_\_\_\_\_  
 Date



By my signature, I am giving PFH authorization to obtain medical records or any past records pertinent to my health care from any consulting physician or other health care facility treating me during the course my care at this facility.

I hereby request that any specific records needed for my care be released to:

**Premier Family Health, PA  
 1037 State Road 7, Suite 211  
 Wellington, Florida 33414  
 Office: (561) 798-3030 Fax: (561) 798-8242**

\_\_\_\_\_  
 Patient's Full Name (Print)

\_\_\_\_\_  
 Date of Birth

\_\_\_\_\_  
 Social Security Number

\_\_\_\_\_  
 Patient's Signature or Authorized Party

\_\_\_\_\_  
 Date

**Premier Urgent Care**

**Premier Family Health & Wellness**

**Premier Center for Healthy Aging**