PREMIER
FAMILY MEDICINE - URGENT CARE - WELLNESS

Update of Patient Information

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

Reason for Visit:

What are your Overall Top Health & Wellness Concerns:

1. _____
2. _____
3. _____

MEDICATIONS/SUPPLEMENTS/VITAMINS: ☐ Check here if not on Medications			ALLERGIES: MEDICATION & NON MEDICATION ALLERGIES:
1._____	4._____	7._____	1._____
2._____	5._____	8._____	2._____
3._____	6._____	9.	3._____

SURGERIES: ☐ Check here if no Surgery History	HOSPITALIZATIONS: ☐ 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)

Premier Urgent Care **Premier Family Health & Wellness** **Premier Center for Healthy Aging**

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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.***

( ) 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 parities 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

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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	

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