

PINNACLE MEDICAL GROUP
Family Medicine

7005 Cortez Road West, Bradenton, FL 34210 • 941-792-2122

PATIENT INFORMATION

Patient Name: _____ Age: _____

Date of Birth: _____ Social Security Number: _____

Home phone: _____ Alternate Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

Sex: Male Female Marital Status: S M W D

Ethnicity: _____ Preferred Language: _____

Race: American Indian or Alaska Native Black or African American Asian
 Native Hawaiian or Other Pacific Islander Unreported/Refused to Report White

Billing address if different from above (winter residents, please put northern address):

Address: _____ City: _____ State: _____ Zip: _____

Method of payment: Cash Check Visa MasterCard Discover American Express

Reason for Visit: _____

Insurance Holder's Name: _____

Date of Birth: _____ Policy Holder's Social Security Number: _____

I, the undersigned, hereby voluntarily consent to medical care and/or diagnostic treatment by Pinnacle Medical Center and its employees and to medical and diagnostic treatments as explained to me by the attending physician and whomever he/she may designate as his/her assistant. I am aware the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

I hereby authorize my insurance benefits to be paid directly to the above signed physician, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

**I UNDERSTAND THAT PINNACLE MEDICAL GROUP IS HEREBY RELEASED OF ANY
LEGAL OR MEDICAL IMPLICATIONS THAT MAY ARISE FROM THIS RELEASE**

Signature of patient or Authorized Individual

Date

Relation to patient: _____ Copy of Medical Power of Attorney: Y N

Witness

Date

NEW PATIENT HISTORY

Date: _____

Name: _____ Pinnacle ID: _____

Primary reason for appointment:

Family History: Please check all that apply, if deceased please state cause

	Grandparents					
	Father	Mother	Siblings	Children	Mothers	Fathers
Heart Disease						
Hypertension						
Diabetes						
Stroke						
High Cholesterol						
Seizures						
Anemia						
Kidney Disease						
Liver Disease						
Glaucoma						
Thyroid Disease						
Mental Illness						
Allergies						
Easy Bleeding						
Arthritis						
Cancer (specify type)						

Primary reason for appointment:

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NEW PATIENT HISTORY

Habits:

Tobacco	
Alcohol	
Drugs (recreational)	
Exercise	
Coffee	
Tea	

Medication you are currently taking - Please include over the counter medications:

Previous Hospitalizations - Please include dates and reasons:

Allergies / Reactions to any medication:

Adult Immunizations - Please provide date of last immunization:

Influenza	
Tetanus	
Pneumonia	
Hepatitis	

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NEW PATIENT HISTORY

General Health History:

	Year	Normal or Abnormal
Chest X-Ray		
HIV		
Bone Density		
Stool Occult Blood		
Tuberculin		
Colonoscopy		

Height (without shoes): _____

Highest weight: _____

Current Weight: _____

Lowest weight: _____

Female:

	Year	Normal or Abnormal
Mammogram		
PAP test		

Last Menstrual Period: _____ Number of Pregnancies: _____

Name of Gynecologist: _____

Male:

	Year	Normal or Abnormal
PSA		
Prostrate Check		

NEW PATIENT HISTORY

Please check below any symptoms you may have had:

Weight Loss		Urinary Incontinence	
Constant Fatigue		Urinary Infections or Stones	
Insomnia Difficulty		Urinating	
Severe Headaches		Enlarged Glands	
Dizziness		Frequent Infections	
Allergies (Hay Fever)		Joint Pain/Deformity	
Asthma		Ulcer in Stomach	
Persistent Cough		Thyroid Problems	
Chest Pain		Seizures	
Heart Burn		Hepatitis	
Persistent Diarrhea		Anemia	
Persistent Constipation		Easy Bleeding	
Blood in Stool		Depression	
Albumin in Urine		Other	
Blood In Urine		Persistent Anxiety	
Swollen Legs		Sinusitis	
Hemorrhoids		Shortness of Breath	
Varicose Veins		Hernia	
Diabetes		Forgetfulness	
Pneumonia		Irritability	
Circulatory Problems		Persistent Back Pain	
Decreased Vision		Erectile Dysfunction	
Decreased Hearing		High Blood Pressure	
Pain in Legs when walking		High Cholesterol	

Additional information you would like to share with physician:

CONSENT FOR MEDICAL CARE

Date: _____

Patient ID: _____

Patient Name: _____

Provider: _____

PROCEDURE:

- | | |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> Excision |
| <input type="checkbox"/> I & D | <input type="checkbox"/> Cryotherapy |
| <input type="checkbox"/> Aspiration | <input type="checkbox"/> Injection |

Location: _____

Risks and benefits of the above procedure were discussed with me and I wish to proceed with procedure as indicated above.

I acknowledge that _____ (provider) has recommended the above treatment and I was provided an opportunity to discuss this information and have my questions answered.

Patient's Signature

Date

Witness

Date

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**Patient Consent to Receive Mail, Telephone
and/or E-mail Message**

DOB: _____

Please print (Last Name) (First Name) (M.I.)

Do we have permission to?

Send a yearly appointment card to your home? Yes No

Send test results to your home? Yes No

Send test results to your email? Yes No

Email address: _____

Leave the following information on your home answering machine/voice mail/email:

Appointment information Yes No

Billing information Yes No

Medical information Yes No

Leave the following information on your work answering machine/voice mail:

Appointment information Yes No

Billing information Yes No

Medical information Yes No

I give permission to share appointment information with the person named below:

Name: _____

I give permission to share medical information (including biopsy/lab results, prescriptions, etc.) with the person(s) listed below:

Name: _____

Name: _____

I give permission to share billing information with the person listed below:

Name: _____

Signature of Patient: _____ Date: _____

For internal purposes only - Account No: