Welcome to
Cooper Family Medical

Please keep this letter so you have access to this information at any time you need it.

- The doctor is available 24 hours a day for your urgent healthcare needs and will return your call. Avoid expensive emergency room co-pays and long waits.

►Please call our office at (941)744-5510◄

- If you have an urgent healthcare need during business hours, 8:00am-5:00pm, we will make the necessary arrangements to see you.

- **Preferred Hospital**: Your doctor has selected this hospital because of their confidence and professional rapport they have with the hospital and the specialists.

▪ MANATEE MEMORIAL HOSPITAL ▪

- **Preferred Laboratory:**

▪ LAB CORP. ▪

- After a hospital stay or emergency room visit, please contact our office immediately after discharge. Your doctor will need to see you in the office to assure your continued recovery.

- If you are a Medicare patient: your doctor encourages you to be seen at least every six (6) months. This will help both you and your doctor maximize preventative care.

- Scheduling appointments: Call our office to schedule your appointment and be sure to always bring your medication with you to each appointment. If you are unable to keep your appointment please call us at least 24 hours in advance so we can offer that appointment to someone else with a healthcare need.

- To avoid receiving a bill: Call the office before seeing a specialist or undergoing a procedure as Humana requires a referral. DO NOT GO FOR LAB TESTS, XRAYS, PHYSICAL THERAPY, ETC. UNTIL OUR OFFICE IS NOTIFIED.

Cooper Family Medical

General Information:

Patient Last Name | First Name | MI | Date Of Birth

Home Phone Number | Cell Phone Number | E-Mail Address

Home Address | City | State | Zip

– – | Male Female | Single Married Divorced Widowed

Social Security # | (Please Circle) | (Please Circle)

Employer

Pharmacy

Primary Insurance Carrier | Policy ID

HMO PPO POS OTHER | ( )

(Type Of Plan) | Insurance Carrier Phone #

Primary Card Holder's Name/Relation: | DOB:

Second Insurance Carrier | Policy ID

HMO PPO POS OTHER | ( )

(Type Of Plan) | Insurance Carrier Phone #

IMPORTANT: In case of an emergency, who would we contact?

Name | Relationship

Address (Street/City/Zip) | Home Phone

( ) | ( )

Cell Phone | Work #

"I understand that I am financially responsible for all charges, whether or not paid by insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give Cooper Family Medical consent to perform medical treatment."

(Patient/Guardian Signature) | Date

Cooper Family Medical

Patient Medical History

Patient Last Name: _____ **Patient First Name:** _____ **DOB:** _____

Date of last physical exam: _____ **Previous Physician's Name:** _____

Physician's Address: _____

Past History (Personal & Allergies)

Have you had any of the following illnesses? :

	YES	NO		YES	NO		YES	NO
Amputation	☐	☐	CVA/TIA	☐	☐	Migraine Headache	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Nervous Breakdown	☐	☐
Alcohol Overuse	☐	☐	Emphysema/COPD	☐	☐	Ostomies_____	☐	☐
Allergies (Other than medications)	☐	☐	Falls	☐	☐	Paralysis	☐	☐
			Gallbladder Disease	☐	☐	Rheumatic Fever	☐	☐
Arthritis	☐	☐	Gout	☐	☐	Seizures	☐	☐
Asthma	☐	☐	HIV / AIDS	☐	☐	Sexually Transmitted	☐	☐
Bleeding Disorder	☐	☐	Heart Attack / MI	☐	☐	Diseases		
Cancer	☐	☐	Other Heart Disease	☐	☐	Sickle Cell Anemia	☐	☐
Location: _____			(CHF / CAD)			Sleep Disorder	☐	☐
Cardiac Arrhythmias	☐	☐	Hepatitis	☐	☐	Stomach Ulcers	☐	☐
Pacemaker:	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Chicken Pox	☐	☐	Jaundice	☐	☐	Vascular Disease	☐	☐
Colitis	☐	☐	Kidney Disease	☐	☐		☐	☐
Depression	☐	☐	Measles / Mumps	☐	☐		☐	☐

Personal Habits:

Have you ever smoked? ☐ YES ☐ NO If yes, are you a regular smoker now? ☐ YES ☐ NO

Have you used chewing tobacco? ☐ YES ☐ NO If yes, number of yrs. ____ If no, when did you quit? _____

Do you regularly drink alcohol? ☐ YES ☐ NO If yes, how often: _____

Have you used any of the following: Marijuana LSD Heroin Cocaine Speed Other

(Please Circle)

Operations: List and indicate approximate year

_____

_____

_____

Serious Injuries: List and indicate approximate year

_____

_____

_____

Hospitalizations: (Other than operations)

List and indicate approximate year

_____

_____

_____

Diagnostic Tests/Exams:

Last Test/Exam & Date	Location/Provider
Eye Exam:	
Foot Exam:	

Immunizations: (Please give date) **Hepatitis B** _____ **Flu**_____ **Polio**_____

Typhoid_____ **Smallpox**_____ **Tetanus**_____ **Pneumococcal**_____ **Chicken Pox**_____

Cooper Family Medical

Patient Last Name: **Patient First Name:** **DOB:**

Family History	Circle Sex		If Living		If Deceased	
			Age	Health	Age at Death	Cause
Father						
Mother						
Brothers/Sisters	M	F				
	M	F				
	M	F				
Husband/Wife						
Sons/Daughters	M	F				
	M	F				

Check if any blood relative has or had any of the following and indicate their relationship to you:

	Please Circle		Relationship		Please Circle		Relationship
Arthritis	Yes	No		High Blood Pressure	Yes	No	
Asthma	Yes	No		Intestinal Polyps	Yes	No	
Bleeding Tendency	Yes	No		Kidney Disease	Yes	No	
Cancer	Yes	No		Leukemia	Yes	No	
Colitis	Yes	No		Migraine	Yes	No	
Congenital	Yes	No		Nervous Breakdown	Yes	No	
Heart Disease	Yes	No		Rheumatic Fever	Yes	No	
Diabetes	Yes	No		Sickle Cell Anemia	Yes	No	
Emphysema	Yes	No		Stomach Ulcers	Yes	No	
Epilepsy	Yes	No		Stroke	Yes	No	
Goiter	Yes	No		Suicide	Yes	No	
Gout	Yes	No		Tuberculosis	Yes	No	
Hay Fever	Yes	No		Other	Yes	No	
Heart Attack	Yes	No					

Medications:

- ☐ Asthma Wheezing Medicine
- ☐ Aspirin, Bufferin, Anacin, Tylenol, or Similar Products
- ☐ Blood Pressure Pills
- ☐ Cortisone, Prednisone
- ☐ Cough Medicine
- ☐ Digitalis or Heart Medicine
- ☐ Hormones
- ☐ Insulin or Diabetic Pills
- ☐ Anemia Medication
- ☐ Laxatives
- ☐ Sleeping Pills / Tranquilizers
- ☐ Thyroid Medicine
- ☐ Stomach / Digestive Medicine
- ☐ Weight-Reducing Pills
- ☐ Blood Thinners or Coumadin
- ☐ Dilantin or Seizure Medications
- ☐ Water Pills or Diuretics
- ☐ Antibiotics
- ☐ Phenobarbital / Barbiturates
- ☐ Vitamins
- ☐ Other Prescription / Over the Counter Drugs

Cooper Family Medical

Patient Last Name: **Patient First Name:** **DOB:**

List each medication; its dosage and how often you take it, including vitamins and herbal supplements.

Medications	Dosage	How Often?	When did you start?

Are you allergic to any medications: ☐ YES ☐ NO **If yes, Please list medications & the reactions.**

Medication	Reaction

Cooper Family Medical

Patient Last Name: _____ **Patient First Name:** _____ **DOB:** _____

Social and Lifestyle History: **Primary Language:** _____

(Please Circle)

Is there someone that lives in your residence?	**Yes** **No**	If yes, please list name and relationship:
Type of Residence		Apartment Mobile Home House: One Story Two Story Assisted Living Facility: Facility Name:_____ Other: _____
Durable Medical Equipment	**Yes** **No**	Wheel Chair_____ Oxygen_____ Walker_____ Nebulizer _____ Cane_____ CPAP/BIPAP_____ Other_____
Can you afford medicines?	**Yes** **No**	Potential Referral to Patient Assistance Program
Transportation provided by?		

Nutritional History:

(Current Weight)	(Current Height)	
_____ Lbs.	_____ Ft _____ In	**Weight Changes in the past 6 months?** **Yes** **No**

Current Diet Plan:

Exercise / Activity:

Current Activity	How Often
Physical Limitations:	

Activities of Daily Living:

Do you require assistance to bathe or groom?	**Yes** **No**	**If yes, Explain:**
Do you require assistance for your toilet needs?	**Yes** **No**	**If yes, Explain:**
Do you require assistance to eat?	**Yes** **No**	**If yes, Explain:**
Do you have hearing loss?	**Yes** **No**	**Do you wear hearing aids?** **Yes** **No** Last hearing exam date: _____

Additional Comments and Notes:

Cooper Family Medical

Patient Last Name: _____ **Patient First Name:** _____ **DOB:** _____

Preventative Service History		
Preventative Services	**Date Received**	**Findings and Recommendations**
Bone Mass Measurement (Density)		
Cardiovascular Disease Screening		Hypercholesterolemia ☐
Cholesterol ▶	_____	Hyperlipidemia ☐
LDL ▶	_____	Other ☐ _____
EKG ▶	_____	EKG Results: _____
Colorectal Cancer Screening		
Flexible Sigmoidoscopy ▶	_____	
Barium Enema ▶	_____	
Colonoscopy ▶	_____	
Fecal Occult Blood Test ▶	_____	
Diabetic Screening		
Hg A1C ▶	_____	Cataracts ☐ Other _____
Foot Exam ▶	_____	
Eye Exam ▶	_____	
Glaucoma Screening		Glaucoma ☐
PAP and Pelvic Examination		
Prostate Cancer Screening		
Digital Rectal Exam (DRE)	_____	
Prostate Specific Antigen Test (PSA)	_____	
Mammogram Screening		
Breast Self Exam ▶	_____	
Mammogram Screening ▶	_____	

_____ _____

Date Reviewed **Physician Signature**

Cooper Family Medical

HIPAA Consent Form

Patient's Name(Printed) : _____ **Date of Birth:** _____

Do We Have Permission to:

Mail medical information to your home? Yes_____ No_____

Leave a detailed message on your home/cell answering machine for:

Appointment Information? Yes_____ No_____
Billing Information? Yes_____ No_____
Other Medical Information? Yes_____ No_____

Leave a detailed message on your work answering machine for:

Appointment Information? Yes_____ No_____
Billing Information? Yes_____ No_____
Other Medical Information? Yes_____ No_____

I give permission to share information with the following person(s):

Appointment Information : _____ Relation/ Phone #: _____
Billing Information: _____ Relation/ Phone #: _____
Medical Info (Including biopsy & Lab result _____ Relation/ Phone #: _____

With my consent, Cooper Family Medical may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Cooper Family Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. By signing this form, I am consenting to Cooper Family Medical use and disclosure of information according to the Notice of Privacy Practices, and acknowledge receiving a copy of Notice of Privacy Practices.

I authorize release of any medical information necessary to all my insurance companies to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment direct to Cooper Family Medical. I understand that I am responsible for all co-pays, deductibles, and uncovered services. I authorize use of this form for all my insurance submissions. I authorize Cooper Family Medical to release information concerning my treatment to any of my other physicians. I authorize my signature to be placed "on file" for purposes of Medicare and insurance claim for submission. Under penalty of perjury, I declare that I have read the forgoing and the facts alleged are true, to the best of my knowledge and belief.

Patient Signature:_____ **Date:**_____

Witness Signature(CFM Employee):_____ **Date:**_____

Cooper Family Medical

Request for Protected Health Information / Patient Authorization for Release of Records

Patient Name: _____ S.S.# _____

Date of Birth _____ Patient Phone Number(s): _____

Treatment Dates to Be Released: _____

Type of Visit: Inpatient ☐ Outpatient Surgery ☐ ER ☐ Outpatient Test ☐ Therapy ☐ Other ☐

PERSON(S) / ORGANIZATION(S) AUTHORIZED TO MAKE DISCLOSURE:

_____

_____

RELEASE INFORMATION TO: (*recipient of disclosure*)

Name: Cooper Family Medical
Address: 5123 Fourth Avenue Circle East
Apt, Suite or PO #: _____
City, State, and Zip: Bradenton, Florida 34208
Phone: 941-744-5510
Fax: 941-744-5166

PURPOSE OF THE DISCLOSURE: ☐ Insurance ☐ Legal ☐ Continuing Care ☐ Personal ☐ Other (specify) _____

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:

☐ Face Sheet	☐ ER Record	☐ Physician Progress Notes	☐ Other (specify)_____
☐ Consent Form	☐ Therapy Records	☐ Physician's Orders	_____
☐ Discharge Summary	☐ Radiology Report	☐ Lab Results	_____
☐ History & Physical	☐ Mammogram	☐ Abstract of all records	
☐ Operative Reports	☐ EKG	☐ Copy of Itemized Bill	
☐ Pathology Reports	☐ Consultations	☐ Radiology disc/films	

SPECIFIC INFORMATION TO <u>NOT</u> BE DISCLOSED: _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the HIM Department.. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature.

I hereby authorize this medical facility and/or ScanSTAT Technologies to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.

I hereby release this medical facility and/or ScanSTAT Technologies from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 90 days from the date signed.

This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information. I authorize that this information may be faxed when applicable.

_____ _____
PATIENT'S SIGNATURE **DATE**

_____ _____
PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN **DATE**

_____ _____
WITNESS **DATE**