



The Center for Health and Age Management

Primary Care | Weight Management | Anti-Aging Medicine

PRIMARY CARE PATIENT INFORMATION FORM

Date: _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

Date of Birth ____/____/____ Age _____ Sex: M / F Marital Status: M S D W

Social Security Number _____ Email Address _____

Home Address:

Street _____

City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Employer _____ Occupation _____

Work Address

Street _____

City _____ State _____ Zip _____

Spouse's Name _____

Phone _____

Occupation _____

Emergency Contact Person _____

Relation _____

Home Address _____ Phone _____

City _____ State _____ Zip _____

Name _____

REASON FOR VISIT / MAIN CONCERN _____

Primary Care Physician _____ Date of Last Physical _____

PRESCRIPTION MEDICATIONS (PLEASE INCLUDE NAME, DOSE AND NUMBER PER DAY)

1.	4.
2.	5.
3.	6.

NON PRESCRIPTION MEDICATIONS (LIST OVER THE COUNTER, HERBAL, AND VITAMINS)

1.	4.	7.
2.	5.	8.
3.	6.	9.

*****DO YOU HAVE ANY ALLERGIES OR REACTIONS TO ANY MEDICATIONS:**

NO _____ YES _____
 MED: _____ REACTION: _____
 MED: _____ REACTION: _____
 MED: _____ REACTION: _____

REVIEW OF SYSTEMS: (PLEASE CIRCLE IF YOU HAVE /HAVE HAD IN THE PAST 12 MOS*)**

GENERAL	EYES	EAR, NOSE, THROAT	SKIN
Weight Loss	Double Vision	Hearing Loss	Bruise Easily
Fever	Dry Eyes	Ringing in Ears	Rashes
Night Sweats	Redness	Sore Throat	Change in Moles
Depression	Pain	Bloody Nose	Hair loss/thinning hair

CARDIOVASCULAR	RESPIRATORY	GASTROINTESTINAL	URINARY
Heart Palpitations	Chronic Cough	Constipation	Frequent Urination
Chest Pain	Bloody Sputum	Diarrhea	Blood in Urine
Heart Racing	Shortness of Breath	Blood in Stools	Painful Urination
Ankle Swelling	Wheezing	Excessive Thirst	Lack of Control

NEUROLOGICAL	MUSCULOSKELETAL	HEMATOLOGIC	ALLERGIC
Headaches	Joint Pain	Bleeding Gums	Swelling
Dizziness	Muscle Pain	Unexplained Bleeding	Hives
Numb Arms/ Legs	Weak Arms/Legs	Transfusion	Redness/ Scaling

***IF NONE OF THESE APPLY, PLEASE INITIAL HERE: _____



HIPAA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES

You may be contacted by our office to remind you of appointments, Healthcare Treatment Options or other Health Services that may be of interest to you. In order to maintain your privacy, please answer the following:

May we contact you at home? YES NO Ok to leave Message? YES NO
May we contact you at work? YES NO Ok to Leave Message? YES NO
May we contact you VIA Cell? YES NO Ok to Leave Message? YES NO
If it is ok to leave a message, that includes.....
Practice Name and Phone Number Only YES NO
Detailed or Specific Message YES NO

Would you like to authorize someone else to schedule, confirm, or change appointments?

If so, please provide: Name _____ Phone: _____

Would you like to authorize someone else to receive medical information on your behalf?

If so, please provide: Name _____

For the purpose of marketing, advertising, special events and offers, may we contact you via email and/or newsletter? YES NO

HOW DID YOU HEAR ABOUT US?

Website

The Yellow Pages / Telephone Book

A Friend or Family Member (name) _____ May we Contact Y N

Internet Search (Google Yahoo Other _____)

Newsletter or Mailer

An Article or Advertisement in _____

Michael P. Heim, DO has posted my rights as a patient under the HIPAA (Health Insurance Portability and Accountability) ACT on his website www.tampahealthcenter.com. I have had the opportunity to read and understand my rights. I understand I can request a written copy at any time. I have been provided the opportunity to ask questions regarding my rights and received answers to my satisfaction.

I understand that The Center for Health and Age Management is a fee for service practice and that I am financially responsible for all charges upon date of service.

Patient Name

Date

Patient/Parent/Guardian Signature