North Florida Surgeons

Account # _____

ALL questions must be answered completely

I. YOUR APPOINTMENT TODAY IS WITH DR. _____

Patient Name: **LAST** _____ **FIRST** _____ **MI** ____

Sex ____ DOB ___/___/___ Age: _____ SS#_____

Person Responsible For Bill (If other than patient) _____

Patient Address: _____

City _____ ST _____ ZIP _____ Home Phone: _____

Cell Phone _____ Email Address _____

Referring Physician: _____

(PLEASE INCLUDE THE PHYSICIAN'S FIRST NAME)

Primary Care Physician: _____

(PLEASE INCLUDE THE PHYSICIAN'S FIRST NAME)

Race: White, Black, Asian/Pacific Islander, Hispanic, American Indian, Other (Please circle one)

Marital Status: Married Divorced Single Widow Separated (Please circle one)

If retired, date and place retired from: _____

Employer's Name: _____ Phone #:_____

Employer's Address:_____

City _____ ST _____ Zip _____

II. **PRIMARY INSURANCE COVERAGE:** _____

Policy holders (subscriber's) name: _____ DOB _____

Policy holder's SS#: _____ Sex: M F

Your relationship to policy holder: _____

Policy #: _____ GRP#_____

Policy holder's employer:_____

Employer's address: _____ Phone #:_____

SECONDARY INSURANCE COVERAGE: _____

Policy holders (subscriber's) name: _____ DOB _____

Policy holder's SS#: _____ Sex: M F

Your relationship to policy holder: _____

Policy #: _____ GRP# _____

Policy holder's employer:_____

Employer's address: _____ Phone #: _____

III. **KNOWN DRUG ALLERGIES:** _____

Spouse's Name: _____

Patient Driver's License #: _____

DO YOU HAVE A LIVING WILL: ____ Yes ____ No

Name of Emergency contact (other than spouse) _____

Relationship of emergency contact person: _____

Phone #: _____

IV. **Pharmacy Name & Address:** _____

I certify that, to the best of my knowledge, the above information is complete and accurate.

SIGNATURE: _____ Date:_____

Witness _____

ST. VINCENT'S
BARIATRIC SERVICES
St. Vincent's HealthCare

4203 Belfort Road
Roger Main Building – Suite 250
Jacksonville, FL 32216
Phone: 904-450-6090
Fax: 904-450-6099

MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Authorization to Disclose Protected Health Information to a Third Party

Patient Name: _____ DOB: _____

I hereby authorize _____

To disclose the following Protected Health Information:

☐ Entire Medical Record ☐ Discharge Summary ☐ History and Physical Exam
☐ Operative Report ☐ Lab Tests ☐ X-ray and/or Imaging Reports
☐ Immunization Record ☐ Office Medical Records
☐ Other _____

AS PART OF THE PROTECTED HEALTH INFORMATION (Medical Record), THE FOLLOWING INFORMATION WILL BE DISCLOSED UNLESS STRICKEN:

Sexual Abuse Information Drug and Alcohol Abuse Information AIDS/HIV
Child Abuse and Neglect Information Psychiatric Information

Such records shall be disclosed to: **St. Vincent's Medical Center Riverside, Southside or Clay**

This authorization will permit the Physician or Company requesting information to receive the designated Protected Health Information included in the medical record for a period of 1 year unless otherwise indicated:

_____

I don't have to sign this authorization in order to receive treatment from my primary care provider. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Signed: _____ *Date:* _____
Patient or Legal Representative

Print: _____ _____
Legal Representative Name *Relationship to Patient*

For Office Use Only
Fax completed request to (904)450-6099 or Mail completed form to: Address Located Above

Requester: _____ *Date:* _____
Office Representative