Reason for Today's Visit ____ Todays Date ____________________

Name ____ DOB____/____/____ SS#:________________________

Physical Address______________________________ City___________________ State______ Zip___________

Mailing Address (if different) ______________________City _________________ State ______ Zip __________

Cell Phone # _________________________ Email Address (optional) ___________________________________

Primary Care Physician Name, Address & Phone #:____

Allergies and adverse reactions: ____

Have you used tobacco products? Yes/ No/ Never- Circle one. If yes, current or former? ____________________

List any prescribed medications that you are taking:

____

____

We are required to ask the following based on governmental regulations: (Please circle)
Race: Asian / Native Hawaiian-Pacific / Black –African American/ White / Hispanic/ Other race/unreported
Ethnicity: Hispanic – Latino/Not Hispanic / Decline to report

EMERGENCY CONTACT:
Name: ______________________________________ Mobile Phone: ___________________________________
I do ☐ / do not ☐ authorize the disclosure or personal health information (HIPAA) to designated individuals listed:
Name: ______________________________ Relationship: _____________________Phone: _________________

Would you like us to file a claim with your insurance? Yes No If yes, please complete the following.

INSURANCE INFORMATION:

Primary Carrier:
Name: ______________________________________
Member #: __________________________________
Group #: ____________________________________
Policy Holder: _______________________________
DOB: _____________ Relationship: ______________
Address: ____________________________________

Secondary Carrier:
Name: __________________________________
Member #: _______________________________
Group #: _________________________________
Policy Holder: _____________________________
DOB: _____________ Relationship: ___________
Address: _________________________________

I have been advised of and provided access to Nation's Best Family Health Care's Notice of Privacy Practices and the Florida Patient Bill of Rights and I agree to the authorization to treat and financial policies. ______________ initial here.

The above information is true to the best of my knowledge: I hereby authorize my insurance benefits to be paid directly to the practice. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Nation's Best Family Health Care to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

Patient's Printed Name___________________________________ Signature _____________________________

COVID-19 SCREENING QUESTIONNAIRE

NAME ______________________________ PHONE NUMBER: ______________________

CAR COLOR/MODEL ____

1) I NEED THE FOLLOWING TESTING COMPLETED:
   - ☐ COVID TEST TO LOOK FOR ***ACTIVE INFECTION***
   - ☐ COVID TEST TO LOOK FOR ***PREVIOUS INFECTION (Antibody testing on hold for now)***
   - ☐ COVID TESTING TO BE CLEARED FOR WORK/SURGERY OR OTHER CONCERNS
   - ☐ **NOT SURE**, I WOULD LIKE TO DISCUSS WITH PROVIDER FIRST

2) IF **PREVIOUSLY** ILL, WHEN WAS YOUR ILLNESS?______________________________

3) IF **CURRENTLY** ILL, HOW LONG HAVE YOU HAD SYMPTOMS?____________________

4) CHECK ANY SYMPTOMS YOU HAVE OR HAD RELATED TO TODAY'S VISIT :

☐ FEVER	☐ SHORTNESS OF BREATH	☐ NAUSEA	☐ LOSS OF TASTE
☐ COUGH	☐ DIFFICULTY BREATHING	☐ VOMITTING	☐ LOSS OF SMELL
☐ CHEST PAIN	☐ WHEEZING	☐ DIARRHEA	☐ FATIGUE
☐ HEADACHE	☐ SORE THROAT	☐ BODY ACHES	☐ NO SYMPTOMS

5) CHECK ANY POSSIBLE EXPOSURES YOU MAY HAVE HAD:

☐ RETURN FROM CRUISE SHIP	☐ SUSPECTED EXPOSURE AT WORK
☐ TRAVEL TO AFFECTED AREA	☐ NO SUSPECTED EXPOSURES
☐ POSITIVE COVID PERSON	

6) PLEASE CHECK ANY RISK FACTORS:

☐ OVER AGE 65	☐ GI DISEASE	☐ ACTIVE CANCER
☐ HYPERTENSION	☐ DIABETES	☐ HISTORY OF CANCER
☐ CARDIAC DISEASE	☐ AUTOIMMUNE DISEASE	☐ HISTORY OF STROKE
☐ LUNG DISEASE (COPD)		☐ OTHER CONDITION

7) IF EXPOSED, WHERE WAS YOUR EXPOSURE? ______________________________

8) WHAT INDUSTRY/WHERE DO YOU WORK?__________________________________

OFFICE USE ONLY ☐ Insured ☐ Self Pay

☐Male ☐Female Vitals: BP ________ Pulse ________ 02Sat ________ Temp ________

☐ COVID Swab ☐ Antibody lab drawn ☐ Rapid Test ☐ Other__________

Patient's name ______________________________________ Date of birth ________/________/_______

Social Security Number ________-_____-________ Telephone number (________) _______-______

Please release my medical records **from**:

☐ Nation's Best Family Health Care 1514 West 23rd Street, Panama City Florida, 32444 FAX: 850-640-3949	☐ Name of provider: ________________________________ Provider's address: ________________________________ ____ Provider's Fax Number: ____________________________

TO:

☐ Nation's Best Family Health Care 1514 West 23rd Street, Panama City Florida, 32444 FAX: 850-640-3949	☐ Name of provider: ________________________________ Provider's address: ________________________________ ____ Provider's Fax Number: ____________________________

Please release:
□ All records/labs from past two years
□ Records from the past (time period) ___________________
□ Labs/diagnostic testing (time period) __________________
□ ____

I request that health information regarding my care and treatment be released as set forth on this form. In accordance with The Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. I understand that signing this authorization is voluntary.
2. This authorization may include disclosure of information relating to Alcohol and drug abuse, mental health treatment, and CONFIDENTIAL HIV related information.
3. This authorization will expire 90 days after the date signed.

____ Date: ______________________________
Patient's Signature

____Date:______________________________
Witness Signature