PATIENT PERSONAL HISTORY

Date:_____

Confidential Record: Information contained here will not be released unless you authorize us to do so.

Last Name	First	Middle	Birth Date	Age	Birth Place
Address	City	State	Zip	Home Phone	Business Phone
Occupation	SS Number		Cell Phone	E-Mail Address	
Sex	Race		Marital Status		

Person to Notify in case of Emergency:_____ Relationship:_____

Address:_____ Phone:_____

Date of your last Physical Examination:_____ Doctor:_____

FAMILY HISTORY

Father's Age: _____Living: _____ Deceased: _____Cause of Death/Age:_____

Mother's Age _____Living: _____ Deceased: _____Cause of Death/Age:_____

Do you or your direct family (blood relative) have/had any of the following? If so who? If deceased please provide age at death

Cancer:_____
High Blood Pressure: _____
Stroke: _____
Asthma: _____
Kidney Disease: _____
Mental Illness: _____
Seizures: _____
Diverticulitis: _____
Hernia: _____
Other Disease: _____

Heart Disease: _____
Diabetes: _____
Migraine: _____
Anemia: _____
Thyroid Disease: _____
Alcoholism: _____
Hepatitis: _____
Gout: _____
Kidney stones: _____
Leukemia: _____

PERSONAL HABITS (Circle Y or N)

Smoke: Y / N _____per day for_____years Year quit:_____

Alcohol: Y / N How many per week?_____

Exercise: Y /N How many days per week?_____

CONTINUE TO NEXT PAGE

List All Medications (including supplements – name, dosage, and regiment):

_____

_____

_____

_____

Allergies (drug or food) or N/A

_____

_____

_____

_____

Surgeries/Major Medical Illnesses:

_____

_____

_____

_____

Review of Systems (circle if you currently have any of the following symptoms or diseases):

Neck Stiffness	Heartburn	Anxiety
Shortness of breath	Nausea	Back pain
Breast pain / lump	Chest pain	Loss of appetite
Nosebleed	Rapid heart rate	Joint swelling
Numbness	Diarrhea	Urinary problem
Weakness	Cold intolerance	Hot intolerance
Cough	Easily bruising	Rash
Headache	Vomiting	Depression

Describe briefly your present medical symptoms:

_____

_____

_____

_____

_____

_____

I, the patient signed below, certify that the above information is correct. I understand and agree that: **1**. I am responsible to provide correct information on this form, and that I may become financially responsible for services if insurance information provided is incorrect or incomplete; **2.** I am responsible to pay all co-payments at the time of service; **3.** TMG will file my insurance as required by contract, where applicable, and that I am responsible for full payment to TMG for services provided when TMG is a non-participating provider; 5. TMG will hold me responsible to pay costs of collection through outside collection agencies or other legal means, should that become necessary; 6. TMG will release pertinent medical records to insurance companies for documentation of today's service in order to process medical insurance claims.

Patient Name (Please Print):_____

Patient Signature:_____

Patient Authorization for Release of Protected Health Information and Medical Records

Patient's Name_____ Date of Birth_____
(Last, First, Middle/Maiden)
Patient's Address_____City_____State_____Zip_____

Phone Numbers_____

I authorize my physician and/or administrative and clinical staff at **Tallahassee Medical Group** or other healthcare provider as indicated below to release the medical information specified below to the following person or entity:

Person or Entity to Receive Information:	**Person or Entity to Disclose Information:**
Name/Organization: Cody VanLandingham, MD	Name/Organization:_____
Address: 1511 Surgeons Drive Suite C	Address:_____
City, State, Zip: Tallahassee, FL 32308	City, State, Zip_____
Phone: 850-701-0695 Fax: 850-701-0696	Phone:_____Fax_____

SPECIFIC INFORMATION TO BE DISCLOSED (check all that apply):

____Complete Medical Record ____Billing Records ____Office Notes ____Ultrasound Reports
____Lab Reports ____Surgery Records ____Mammogram Reports
____Obstetrical (OB) Records ____Paper Smear/Biopsy Reports ____Other (specify):_____

DATES OF SERVICE:_____

PURPOSE:____Changing Physicians____Personal Copy to Patient____Attorney____Insurance____Workers' Compensation

Other_____

This authorization will expire on:_____(If no date is specified, it will expire 60 days after date signed).

CHECK AND INITIAL BELOW:

____I DO____I DO NOT authorize the release of information pertaining to specific laboratory tests of **HIV** infection (Human Immunodeficiency Virus, the causative agents of AIDS), the results of such tests, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions**, and all medical records and clinical information relating thereto.
Initials of individual giving authorization:_____

____I DO____I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **mental health or psychiatric conditions.**
Initials of individual giving authorization:_____

____I DO____I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related** and/ or **alcohol-related treatment**.
Initials of individual giving authorization:_____

I have read and understand the nature of this authorization and I have been provided a copy of TMG's Notice of Privacy Policy and the opportunity to review the same. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Office at ***Tallahassee Medical Group, Administrative Offices 1511 Surgeons Drive, Tallahassee, Florida 32308 Attn: Compliance Office***. I understand that the revocation is not effective to the extent that my physician of Tallahassee Medical Group has taken action in reliance upon this authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I also understand that such revocation does not affect TMG's right to use or disclose any information as otherwise provided for the Notice of Privacy Policy. My physician will not condition my treatment, payment, enrollment in a health plan eligibility for the benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. When my health 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 and/or other applicable federal and state laws. Releaser and its agents and employees are hereby authorized to obtain inspect and reproduce such records and/or information hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and or information

_____ _____
Signature of Patient or Patient's Representative Witness

_____ _____
Relationship to Patient Date
(If applicable, attach documentation of guardianship or Power of Attorney)