



BRIGHT CARE MEDICAL GROUP

PATIENT INFORMATION

Patient's Name _____ Phone # _____

Address _____
Street City State Zip Code

Social Security # _____ Date of Birth ____/____/____ Age _____ Sex: ___M ___F

Employer _____ Occupation _____

Emergency Contact _____ Phone # _____

Email _____

Marital Status: ___Single ___Married ___Widowed Preferred Language: English ___Spanish ___
Race: ___American Indian/Alaskan ___Asian ___African American ___Caucasian ___Hawaiian ___Other: _____

Pharmacy _____
Name Address Phone #

PRIMARY INSURED

___ Self (if self, you do not need to complete the rest of this section) ___ Spouse ___ Parent Other: _____

Name _____ Phone # _____

Address _____
Street City State Zip Code

Social Security # _____ Date of Birth: ____/____/____ Age: _____ Sex: ___M ___F

INSURANCE

Primary Insurance Company Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

ID#: _____ Group #: _____

Secondary Insurance Company Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

ID#: _____ Group #: _____

If not self:

Insured Name: _____ Insured Date of Birth: ____/____/____ Insured Social Security #: _____

Patient/ Guardian Signature Date

Bright Care Medical Group LLC

Name: _____ Sex: M F DOB: _____

What brings you to see me today?

Do YOU have any drug allergies: Penicillin Sulfa Tetracycline Other

Family Health History

This pertains to YOUR BLOOD (genetic) relatives ONLY

Relative Type	Living (L) or Deceased (D)	Current age/age @ death	Cause of death	Health condition you wish me to know about
Father				
Mother				
Brother (s)				
Sister (s)				
Mother's Father				
Mother's Mother				
Father's Father				
Father's Mother				
Child(ren)				
<input type="checkbox"/> I was adopted				

Your Chronic Medical Condition(s)

Chronic Condition	Year Diagnosed	Chronic Condition	Year Diagnosed
Diabetes		Hypertension	
COPD, Bronchitis, Asthma		High cholesterol	
CAD/ Heart attack		Hypothyroidism	
CHF (heart failure)		Depression (anytime throughout life)	
Pacemaker/ Defibrillator		Acid Reflux (GERD)	
Atrial Fib/ Heart Arrhythmia		Cirrhosis/ Hepatitis A B C	
Peripheral Vascular Disease		Gout/ Osteoarthritis	
DVT (blood clot)		Erectile Dysfunction	
Stable Chest Pain (angina)		Sleep Apnea	
Seizures/ Epilepsy		Cataracts/ Glaucoma	
Stroke/ TIA		Parkinson's	
Dementia/ Alzheimer Disease		Mechanical Valve	
Rheumatoid Arthritis		Cancer:	
HIV/ AIDS		Chemo Tx/ Radiation	
Neuropathy		Dependency (drug/ alcohol)	
Migraines		Amputation: where?	

Bright Care Medical Group LLC

Name: _____ Sex: M F DOB: _____

Review of Systems

Please circle all that you have experienced within the **past 6 months**

Fever / Chills	Dizziness/ spinning	Fainting	Forgetfulness	Headache
Sweating	Weakness	Weight loss/ gain	Numbness	Nervousness
Loud snoring	↑ Daytime sleepiness	Trouble sleeping	Imbalance	Hives/ rash
Diarrhea	Indigestion/ heartburn	Constipation	Nausea	Vomiting
Rectal bleeding	Dark colored stools	Abdominal pain	↑ Urination	Blood in urine
Painful urination	Incontinence (leakage)	Trouble swallowing	Bruising	Itching
Change in skin	Non- healing sores	Vision changes	Earaches	Loss of hearing
Discharge of ear	Hoarseness	Ringing in ears	Nosebleeds	Sore throat
Sinus issues	Teeth / gum concerns	Congestion	Cough	Shortness of breath
Palpitations	Chest pain/ discomfort	Leg swelling	Varicose veins	Pain in legs with walking
↑ Thirst	↑ Hunger	Cold/ burning feet	Joint pain	Breast / nipple discharge
Vaginal discharge	Breast lump	Penial discharge	Testicle lump	Painful intercourse

Smoking History: I was NEVER a smoker CURRENT smoker FORMER smoker

I currently smoke: ____ (number of packs daily) for ____ (number of years)

I did smoke: ____ (number of packs daily) for ____ (number of years) & quit in ____ (enter year)

Alcohol History: I have never drank I am a current drinker I drank but now do not

I currently drink ____ (number of alcoholic beverages) Daily Weekly Monthly (please circle)

Previously I drank ____ (number of alcoholic beverages) Daily Weekly Monthly (please circle)

I quit in ____ (enter year). I have attended AA in past ____ NO ____ YES

Illicit Drug History: I have used illicit drugs: NEVER CURRENTLY IN PAST

Type of drug: Marijuana Cocaine Methamphetamine Heroin Other: _____

Bright Care Medical Group LLC

Name: _____ Sex: M F DOB: _____

Prevention & Maintenance of your Health

Type	MM/DD/YYYY	Type	MM/DD/YYYY	Type	MM/DD/YYYY
Flu Vaccine		Mammogram		Heart Cath	
Pneumonia Vaccine		Pap Smear Last Menses: Hysterectomy: Y N		ECHO (ultrasound of heart)	
Shingles		Bone Density		Stress test	
Hep B series		Colonoscopy Polyps: Y N		Chest Xray	
Eye Exam		Endoscopy (EGD) Barrett's Y N		Prostate Exam/ PSA	

Blood Transfusion (s)

Please list dates & reason for transfusion (s)

Date (s)	Reason

Hospitalizations in the past 1 year

Reason for hospitalization	Date

Surgical History (All major surgeries)

Procedure Type	Date

Fractures

Type/ Bone	Date

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Name: _____ Sex: M F DOB: _____

Please list all medications in the following tables. Please pay attention to table headings.

OVER THE COUNTER MEDICATION (S)

Name of medication	Dose	How many times a day
		1 2 3 4 <input type="checkbox"/> as needed
		1 2 3 4 <input type="checkbox"/> as needed
		1 2 3 4 <input type="checkbox"/> as needed
		1 2 3 4 <input type="checkbox"/> as needed
		1 2 3 4 <input type="checkbox"/> as needed

PHYSICIAN PRESCRIBED MEDICATION(S)

Name of medication	Dose	How many times a day
		1 2 3 4 <input type="checkbox"/> as needed
		1 2 3 4 <input type="checkbox"/> as needed
		1 2 3 4 <input type="checkbox"/> as needed
		1 2 3 4 <input type="checkbox"/> as needed
		1 2 3 4 <input type="checkbox"/> as needed
		1 2 3 4 <input type="checkbox"/> as needed
		1 2 3 4 <input type="checkbox"/> as needed
		1 2 3 4 <input type="checkbox"/> as needed
		1 2 3 4 <input type="checkbox"/> as needed
		1 2 3 4 <input type="checkbox"/> as needed
		1 2 3 4 <input type="checkbox"/> as needed

Bright Care Medical Group LLC

Name: _____ Sex: M F DOB: _____

Other Providers Participating In My Healthcare

Type	Name of Doctor	Phone number
Cardiologist		
Dermatologist		
ENT ear/nose/throat)		
Gastroenterologist		
GYN		
Nephrologist		
Oncologist		
Ophthalmologist		
Orthopedist		
Psych (counselor)		
Pulmonologist		
Rheumatologist		
Urologist		

My last Primary Care Doctor was:

Name: _____

Phone Number: _____

Advance Directive/ Living Will/ Power of Attorney/ 5 Wishes/ DNR

I understand that I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. An Advance Directive refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply: We would like a copy for our records.

I have executed an Advanced Directive I have NOT executed an Advance Directive

Check the one(s) you have and can provide copies of to our office:

Living Will Durable Medical Power of Attorney 5 Wishes Do Not Resuscitate (DNR)

_____/_____/20____
Signature Printed Name Date

Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent for Bright Care Medical Group to use and disclose protected health information about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Bright Care Medical Group describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Bright Care Medical Group reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Bright Care Medical Group.

With this consent, Bright Care Medical Group may call my place of residence or other alternative location and leave a message on voice-mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Bright Care Medical Group may mail to my home or other alternative locations, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Bright Care Medical Group restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement.

By signing this form, I am consenting to allow Bright Care Medical Group to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or if I later decide to revoke it, Bright Care Medical Group may decline to provide treatment to me.

TPO Definition: Treatment, Payment, Operation

Signature

Printed Name

Date

/20

HIPAA Privacy Authorization Form
Authorization for Use or Disclosure of Protected Health Information

I authorize Bright Care Medical Group to use and disclose my protected health information as described below:

1. Extent of information to be released
 - a. I authorize the release of my COMPLETE health record (including records relating to my mental health as well as treatment of alcohol and/ or drug abuse initials: _____)
 - b. I authorize the release of my COMPLETE health record with the **EXCEPTION** of the following information: (please initial next to the records to exclude)
 1. _____ Mental Health records
 2. _____ Alcohol/ drug abuse treatment
 3. _____ Other: (please specify): _____
2. This medical information may be used by the entity I authorize to receive this information for medical treatment, consultation, billing/ claims, payments, or other purposes as I may direct.
3. This authorization shall be in force and effective until
 - a. _____ (list date)
 - b. Twelve months from date this form is signed **initials:** _____
4. I understand that I have the right to revoke this authorization at any time. I further understand that in order to revoke I must submit in writing. I understand that the revocation is not effective to the extent that any person/ entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim.
5. I understand that my treatment, payment, enrollment, and/ or eligibility for benefits will not be conditioned on whether I sign this authorization.
6. I understand the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state laws.
7. I authorize the release of information to include diagnosis, records, exams rendered to me, and claims data to the following individuals:
 - a. Spouse: Name: _____
 - b. Child(ren): Name(s) _____
 - c. Other (please indicate relationship) _____
8. Messages regarding my healthcare may:
 - a. _____ (initial) be left on any one of my messaging systems using the numbers I have provided
 - b. _____ (initial) NOT be left on any messaging system. I would like a message to return the provider's call instead.
9. Fax Number of Bright Care Medical Group LLC 352-708-6153 Telephone Number 352-708-3021

Signature

Printed Name

_____/_____/20_____
Date

Prescription Pick- up Authorization

Last Name: _____ First Name: _____

Date of Birth: ____/____/____

I hereby authorize the individual(s) listed below to pick up my prescribed prescription(s) from any of the Bright Care Medical Group locations. Bright Care Medical Group staff reserves the right to request proof of identity to pick up any prescriptions. My representative must be able to provide a valid photo identification. I further understand that any individual who is not listed will NOT be able to pick up my prescriptions. I am able to change this authorization at any time but understand that the changes MUST be submitted in writing to Bright Care Medical Group.

Name of authorized person (please print legibly)

Relationship to patient named above

Signature

Printed Name

_____/_____/20____
Date

Consent to Release Confidential Information

Last Name: _____ First Name: _____

Last 4 of SS#: _____ Date of Birth: _____ / _____ / _____

I hereby authorize that a copy of my medical records be released to the following: Records

to be released to:

Records to be released from:

Phone: _____

Fax: _____

Please initial next to option of your choice:

_____ This release is to cover **ALL** records contained in my medical chart to include psych, drug, & any alcohol treatments.

_____ This release is to cover ALL records contained in my medical chart EXCEPT:

_____ Any psychiatric records/ treatment

_____ Any drug related records/ treatment

_____ Any alcohol related records/ treatment

I understand that the purpose of the record release is for continuity of my medical care. The information contained in my medical records (s) may include diagnosis, evaluation and/ or treatment of any mental or emotional condition (s). This may also include alcohol and/ or drug related addictions. Information regarding HIV infection with any probable causative agent of AIDS are also considered a part of my medical record. The expiration of this release is one year from the date of signature. I may revoke this authorization at any time by notifying and providing Bright Care Medical Group in writing. The written revocation will be effective on the date of notification except to any actions already taken. Any information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Federal privacy regulations. By authorizing the use or disclosure of information, there will be no conditions placed on my health care or payment of my health care. I have the right to receive a copy of this form after I have signed it. In compliance with Florida State Law, I may be required to pay a fee for any retrieval and photocopying of records and/ or supervising inspections of medical records.

Signature

Printed Name

Date

____ / ____ / 20____

Patient Responsibility Form

1. The patient is responsible for providing Bright Care Medical Group with the most correct, active and up to date information about their insurance prior to each visit.
2. Bright Care Medical Group will bill to the insurance most recently provided by the patient. If information given by the patient is inaccurate and the insurance denies the claim, the patient will be responsible for the balance of the visit. Please be aware that with some insurance companies there are timely filing deadlines by providing correct information at the time of service is critical. Timely filing means the patient's insurance plan may not pay the claim after a certain amount of time after the service.
3. Patients are responsible for the payment of co-pays at the time of service.
4. Patients are responsible for paying any applicable co-insurance, deductibles and all other procedures or treatment not covered by their insurance plan.
5. Bright Care Medical Group is not responsible for knowing what each individual insurance plan does or does not cover. If the patient has questions about their plan and what services are covered, they should contact their insurance.
6. In the event a patient's health plan determines a service to be "not payable", the patient will be responsible for the complete charge and agree to pay the costs of all services provided.
7. Patients have the right to check with their insurance about coverage before receiving any service provided at Bright Care Medical Group.
8. The patient's health insurance policy is a contract between the patient and their Health Insurance Company or employer. It is the patient's responsibility to know if their insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether our physicians participate.
9. The patient is responsible for knowing if our doctor is in-network with their insurance plan and if the services are covered. Any balances applied to an out of network rate will be the responsibility of the patient to pay.
10. If the patient is uninsured, the patient agrees to pay for the medical services rendered to them at the time of service.
11. Medicare may not cover some of the services that the patient's doctor recommends. The patient will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help the patient decide whether they want to receive services, knowing they may be responsible for payment. Patients should read the ABN carefully.
12. The patient agrees that in return for the services provided to them by Aegis Medical Group, they will pay their account at the time service is rendered or upon insurance claim processing- If a payment plan is necessary, the patient understands that the agreement is for past due balances only, and that all future co-payments, co-insurances and/or deductibles, are due at the time of service. If
13. co-payments, co-insurances and/or deductibles are assigned by the patient's insurance company or health plan, they agree to pay them to Bright Care Medical Group.

Worker's Compensation and Automobile Claims

Bright Care Medical does **not** accept and/or file workers comp or auto claims.

I have read the above and understand the contents of this form. I have been given the opportunity to ask any questions and I am satisfied with my current knowledge regarding Bright Care Medical Group policies regarding patient responsibilities.

Signature

Printed Name

____/____/20____
Date