GRACE MEDICAL HOME

# Eligibility Adult Intake Patient Questionnaire

Patient Name: ________________________________________ DOB: ____________________

1. Please list all current medical conditions/problems:

   ______________________________________________________________________________

   ______________________________________________________________________________

2. Is your medical condition the result of an accident? ○ Yes ○ No
   If yes, then when and where?______________________________________________________

3. Is this a work related injury? ○ Yes ○ No
   If yes, please explain:____________________________________________________________

4. Are you retaining an attorney in relation to this condition/injury? ○ Yes ○ No
   If yes, please explain:____________________________________________________________

5. Are you currently under the care/supervision of any other physician for any aspect of your medical care?
   ○ Yes ○ No If yes, what are you being treated for? ______________________________

6. Are you involved in a clinical trial? ○ Yes ○ No
   If yes, please explain:____________________________________________________________

7. Are you taking any chronic pain medications which are considered to be narcotic? ○ Yes ○ No

8. Have you been recently discharged from the hospital? ○ Yes ○ No
   If yes, please explain:____________________________________________________________

9. Did you report your income for last year by filing a federal tax return with the IRS? ○ Yes ○ No ○Filed Extension

10. Are you currently being treated for or have you ever been hospitalized or diagnosed for a psychiatric, mental health or emotional disorder? ○ Yes ○ No
    If yes, what is the condition and where were you treated? _____________________________

11. What medications are you presently taking for this disorder?_____________________________

12. Are you currently in individual, family, group or couples counseling? ○ Yes ○ No
    If yes, who and where?_________________________________________________________

13. Is treatment for this disorder your primary reason for seeking services at Grace Medical Home? ○ Yes ○ No

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I verify that the information provided above is correct. I further understand that failure to provide accurate information may result in discharge from Grace Medical Home.

Patient Signature: ________________________________________ Date:______________________

Witness Signature:________________________________________

 **"See to it that no one misses the grace of God." - Hebrews 12:15**

# Intake and Eligibility Form

## Section 1: Please complete the following information.

| **Full Legal Name:** | **Today's Date:** |
|---|---|
| **Home address:** | |
| **Email:** (for appointment reminders and health related topics related to your care): | |

**Phone Numbers**

Check ONE that you want us to call first

Home phone: ________________________ ○ Prefer we call this first?

Cell phone: ________________________ ○ Prefer we call this first?

Work phone: ________________________ ○ Prefer we call this first?

## Section 2: Patient Profile

| **Gender:**<br>○ Female<br>○ Male | **Social Security Number (required):** | **Do you consider yourself**:<br>○ Not Hispanic/Latino<br>○ Hispanic/Latino |
|---|---|---|
| **Marital Status:**<br>○ Single<br>○ Married<br>○ Separated<br>○ Divorced<br>○ Widowed | **Date of Birth (required):**<br><br>**How were you referred to Grace?** | **Race:**<br>○ White<br>○ Black/African American<br>○ Asian<br>○ Native Hawaiian<br>○ Other Pacific Islander<br>○ American Indian/Alaskan Native<br>○ Other |
| **Preferred Language:**<br>○ English<br>○ Spanish<br>○ Haitian Creole<br>○ Other, I speak…<br>________________ | **What is the highest level of education you completed?**<br>○ Not yet completed high school or GED<br>○ Completed High School or GED<br>○ Associates degree or higher (from college/university) completed | **Where do you currently live?**<br>○ Own or rent an apartment/house<br>○ Staying with friends/relatives<br>○ Shelter<br>○ Transitional housing<br>○ Staying on the street, in car, in woods, etc. |

**FOR OFFICE USE ONLY .**

| | |
|---|---|
| Grace Doctor/Primary Provider: | Financial Group and Insurance Group<br>○ Above 125%<br>○ Below 125%<br>○ Medicaid SOC<br>○ United Way Diabetes Program |
| Proof of legal residency type: | |
| Employment status verification type: | Account Number: |
| Name of Person Completing Intake: | |



**"See to it that no one misses the grace of God." - Hebrews 12:15**

# Intake and Eligibility Form


**Section 2b: Patient Profile(continued)**

| **Are you a veteran?** | **Are you a member of a religious organization** (e.g. church, temple, etc)? |
|---|---|
| ○ No<br>○ Yes | ○ No<br>○ Yes, I attend ____________________ |

**Section 3: Parent or Guardian Information**

If this form is for a child under the age of 18, please complete the information about the child's parent or legal guardian.

| Parent or Guardian's Name | Relationship | Home Phone Number | Patient at Grace? |
|---|---|---|---|
| | | | ○ Yes<br>○ No |
| | | | ○ Yes<br>○ No |

**Section 4: Emergency Contact Information**

| Emergency Contact Name | Relationship | Address | Phone |
|---|---|---|---|
| | | | |

**Section 5: Patient's Employment & Student Status**

| **Are you currently working?**<br>○ Yes, full-time<br>○ Yes, part-time<br>○ No, last date of work was<br>____________ | **Who is your current employer? If you are not currently working, who was your most recent employer?** |
|---|---|
| **Are you currently a student?**<br>○ Yes, part-time<br>○ Yes, full-time<br>○ No | **What school do you attend?** |
| Are you a migrant agricultural worker? (an individual whose principal employment is in agriculture on a seasonal basis and who establishes a temporary home for the purposes of such employment)<br>○ Yes ○ No | Are you a seasonal agricultural worker? (an individual whose principal employment is in agriculture on a seasonal basis and who does not establish a temporary home for purposes of employment.)<br>○ Yes ○ No |

Signature: I certify by my signature that, to the best of my knowledge, the information in the sections above is true and complete.

Signed: ________________________________ Date ____________

# Intake and Eligibility Form


## Section 6: Health Care History

Is there a particular doctor's office, health center, or other place that you usually go if you are sick or need advice about your health? ○ Yes ○ No

If no, have you ever been a regular patient at a health center or doctor's office? ○ Yes ○ No

When (what year) were you last seen as a patient there? _________

Where would you typically go to get care for a sudden medical problem such as a sinus infection or a badly twisted ankle? Check ONLY ONE.

○ Health Clinic ○ My regular doctor ○ Emergency Room
○ Urgent care office (like Centra Care or Minute Clinic) ○ Would not get care
○ Other (please describe)

Where would you typically go to get checked for chronic issues such as diabetes, high blood pressure, heart disease, asthma or other chronic illness? Check ONLY ONE.
○ I do not have a chronic illness
○ Health Clinic ○ My regular doctor ○ Emergency Room
○ Urgent care office (like Centra Care or Minute Clinic) ○ Would not get care
○ Other (please describe)

Where would you typically go to get checkups, physicals, shots/immunizations, or other preventive care? Check ONLY ONE.
○ Health Clinic ○ My regular doctor ○ Emergency Room
○ Urgent care office (like Centra Care or Minute Clinic) ○ Would not get care
○ Other (please describe)

**FOR OFFICE USE ONLY:**

**NOTES:**

___

___

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# Intake and Eligibility Form


**Section 7: Emergency Room (ER) and Hospital History**
**Please list ONLY those visits within the past year.**

NOTE: If you have been to the ER or hospital in the last year, and you can find your discharge papers from that visit, **please bring them to your first appointment**. That will help your nurse and doctor understand better what happened and give you better care.

**ER History within the past year**

In the last year, have you been to a hospital's Emergency Room (ER)? ○ Yes ○ No

If yes, please fill out the information below on when, where, and why:

| Approx date of visit | Hospital | Reason for visit/chief complaint |
|---|---|---|
| | | |
| | | |
| | | |

**Hospital History within the past year**

In the last year, have you been admitted to a hospital? ○ Yes ○ No

If yes, please fill out the information below on when, where, and why:

| Approx date of visit | Hospital | Reason for hospitalization |
|---|---|---|
| | | |
| | | |
| | | |

I, hereby, consent to the release of my demographic information only (name, address, social security number, and date of birth) to Florida Hospital, Orlando Health, and the members of the Primary Care Access Network for the sole purpose of tracking whether cost savings have been achieved through primary care services offered at Grace Medical Home.

____________________ Patient Name　　____________________ Patient Signature　　________ Date

 **"See to it that no one misses the grace of God." - Hebrews 12:15**

51 Pennsylvania Street
Orlando, FL 32806

Tel: (407) 936-2785
Fax: (407) 936-2792

## Consent for Release of Confidential Medical Records

Patient Name:________________________________________ Date of Birth:__________________

Purpose / Need for Information:

- o Continuing Medical Care (Referred to Specialist)
- o Insurance
- o Moving
- o Changing Physcians
- o Legal Review/Action
- o Personal Use
- o Dissatisfied with care
- o Over 18
- o Other (Please Specify)

Specific Documentation Requested:

- o Medical Records
- o Mental Health Records
- o Laboratory Reports
- o Radiology Reports
- o Other (Please Specify) ________________________________________________________

This information, including diagnosis and records of any evaluation, examination and/or treatment rendered to the above named during the period:__________________________________

Information Requested From:________________________________________________________

(Facility or Practice Name)________________________________________________________

________________________________________________________

______________________ (Phone) __________________________ (Fax)

___________________________________ ________________________

Signature of Patient / Legal Representative Date

___________________________________ ________________________

Printed Name Relationship

This request is authorized to include any Federal and/or State protected information under Florida Statutes 394.459(9) Psychiatric Information. 397.053/396.112 Drug and/or Alcohol Abuse Information. 381.609 HIV and Aids Related conditions and/or 397.501(3) Records of a Minor Client.

I understand that this authorization will expire 90 days from the date of the signature or when acted upon, whichever event occurs first. I hereby release to the following addressee, its employees and appointed representatives from any and all liability that may arise from the release of information as I have directed.

This authorization for the release of the above indicated documents may be revoked at any time, upon notification of the patient or representative as signed above. Revocation has no effect on prior action taken under direction of the signed dated consent for release.

PATIENT CONSENT AND AUTHORIZATIONS

## Your Signature Will Serve for All of the Following:

**Consent:** I hereby give consent for Grace Medical Home to provide necessary treatments discussed. I have received a copy of the Privacy Policy of Grace Medical Home and authorize use/disclosure of information to coordinate and/or manage my care or the care of my child(ren) and any related services, receive payment for services, and perform general healthcare operations.

Grace Medical Home may call my home 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 treatment, payment, and healthcare operations (TPO), such as appointment reminders, and any calls pertaining clinical care, including laboratory and radiology results among others.

Grace Medical Home may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, school immunization, and/or physical forms; all correspondence will be marked “Personal and Confidential”.

Grace Medical Home may e-mail to my home or other alternative location any items that assist the practice in carrying out PTO.

I permit the copy of this authorization to be use in place of the original.

**Financial Responsibility:** I understand that there is an annual enrollment fee to become a patient of Grace and that I am responsible for a small facility fee for office visits. I acknowledge that I am responsible for these charges.

**Missed Appointment Policy:** I understand that if I am not able to keep an appointment, I must call to reschedule. If I do not show up for 3 scheduled appointments without calling, I may be dismissed from being a patient with our practice.

____________________________________ _______________________

Signature Date

____________________________________

Print Name/Relationship

____________________________________

Child’s Name (Please Print)

GRACE MEDICAL HOME

51 Pennsylvania Street ● Orlando, FL 32806 ● (407)936-2785

## Patient Authorization for Use or Disclosure of Protected Health Information

I, ________________________, hereby authorize use or disclosure of protected health information about me as described below:

1. Grace Medical Home is authorized to use or disclose information about me:
2. The following person (or class of persons) may receive disclosure of protected health information about me:
   Name and Address: ___________________________________
   ___________________________________________________
   ___________________________________________________

This Protected Health Information would be disclosed as described in our privacy policies for the maintenance and delivery of care.

Unless you sign here, no information about alcohol/substance abuse, HIV/AIDS, or Mental Health will be disclosed:

YES, disclose this information: ___________________________________________________________

NO, DO NOT disclose this information: ____________________________________________________

I understand that I do not need to consent to the release of this information. I will not be denied treatment if I do not authorize the requested use and disclosure of this protected health information. By signing this release, I give my consent willingly for the specified above.

This Authorization shall be in force and effect until ________________________________ at which time this Authorization to use or disclose this Protected Health Information shall expire.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to Privacy Office at Grace Medical Home, 51 Pennsylvania Street, Orlando, FL 32806. I understand that a revocation is not effective to the extent that Grace Medical Home has relied on the use or disclosure of the Protected Health Information.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy the Protected Health Information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this Authorization

I have reviewed the information above, and any questions I may have had about this form have been answered to my satisfaction. I have been offered and/or given a copy of this form.

__________________________________________ __________________________
Signature (patient over 18 years of age) Date

__________________________________________ __________________________
Signature of parent/guardian Relationship to Patient

__________________________________________ __________________________
Witness to signature Date

Copy of this form was offered to client. Copy was _____ accepted _____ refused

# UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT & QUALITY OF CARE

***PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW***

**Patient (name and information of person whose health information is being disclosed):**

Name (First Middle Last):_________________________________________

Date of Birth (mm/dd/yyyy):______________________

Address: _____________________________ City:__________________ State:________ Zip: _______

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***You may use this form to allow your healthcare provider to see and obtain access to your health information. Your choice on whether to sign this form will not affect your ability to get medical care or health insurance coverage and cannot be used as the basis for denial of health care services.***

**By signing this form, I voluntarily authorize and give my permission and allow disclosure:**

**OF WHAT:** **ALL MY HEALTH INFORMATION including any information about sensitive conditions** (if any) {See page 2 for details]
**FROM WHOM:** ALL information sources [See page 2 for details]

**TO WHOM:** Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: __________________________________ Phone:_(___)___________

Address:_________________________________________________ Fax:_(___)_____________

**PURPOSE:** To provide me with medical treatment and related services, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

**EFFECTIVE PERIOD:** This authorization/permission form will remain in effect until the day I withdraw my permission.

**WITHDRAWING MY PERMISSION:** I can withdraw my permission at any time by giving written notice to the person or organization named above in “To Whom.”

**In addition:**

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information me be redisclosed to other persons [See page 2 for details.]
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

X_______________________________________________ ________________________________
Signature of Patient or Patient’s Legal representative Date Signed (mm/dd/yyyy)

_______________________________________________
Print Name of Legal Representative (if applicable)
Check one to describe the relationship of Legal Representation to Patient (if applicable):
□ Parent of minor
□ Guardian
□ Other personal representative (explain: ______________________________________________)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

## Explanation of Form Florida AHCA FCA4200-004
## "Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including by not limited to:**
   a. Drug, alcohol, or substance abuse
   b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
   c. Sickle cell anemia
   d. Birth control and family planning
   e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
   f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form**

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Withdrawl": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

***Note to recipient(s) of the information disclosed under this permission:*** *This information may have been disclosed to you from records protected by state and/or federal confidentiality rules (42 CFR Part 2 or 38 CFR Part 1). If so, the state and/or federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by state law and/or 42 CFR Part 2 (e.g., certain medical emergencies) or 38 CFR Part 1. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patient with sickle cell anemia or HIV infection.*

*This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under 45 CFR Parts 160 and 164 ("HIPPA"); Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) § 13405 ("HITECH Act"); 42 U.S. Code §290dd-2; 42 CFR Part 2; 38 U.S. Code section 7332; 38 CFR 1.475 (Veterans Affairs); 20 U.S. Code § 1232g ("FERPA"); 34 CFR parts 99 and 300; Florida Statue 408.051(4) ("Universal Patient Authorization Form"); and all other Florida Statues, the Florida Constitution, Florida regulations or administrative rules requiring patient authorization, consent or permission to release such records (including but not limited to Florida Statues §456.057(7)(a), §395.3025(4), §394.4615(2)(a),§381.004, §397.501(7), §760.40(2), §392.65(1), §384.29(1), and §385.202(3)).*

Form **4506-T**
(Rev. January 2012)
Department of the Treasury
Internal Revenue Service

# Request for Transcript of Tax Return

▶ **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-1872

**Tip.** Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

| | |
|---|---|
| **1a** Name shown on tax return. If a joint return, enter the name shown first. | **1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)** |
| **2a** If a joint return, enter spouse's name shown on tax return. | **2b Second social security number or individual taxpayer identification number if joint tax return** |

**3** Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

**4** Previous address shown on the last return filed if different from line 3 (see instructions)

**5** If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

GRACE MEDICAL HOME, 51 PENNSYLVANIA STREET, ORLANDO, FL 32806 Phone: (407) 936-2785

**Caution.** *If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your IRS transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.*

**6** **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ ____________

**a** **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . . ☐

**b** **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 30 calendar days . ☐

**c** **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 30 calendar days . . . . . . . ☐

**7** **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

**8** **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2010, filed in 2011, will not be available from the IRS until 2012. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 45 days . . . ☐

**Caution.** *If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.*

**9** **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately. ____________ ____________ ____________ ____________

Check this box if you have notified the IRS or the IRS has notified you that one of the years for which you are requesting a transcript involved **identity theft** on your federal tax return . . . . . . . . . . . . . . . . . . . . . . . . . . ☐

**Caution.** Do not sign this form unless all applicable lines have been completed.

**Signature of taxpayer(s).** I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of the signature date.*

Phone number of taxpayer on line 1a or 2a

**Sign Here**

▶ **Signature** (see instructions) — Date

▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** — Date

ORLANDO HEALTH
1414 Kuhl Avenue • Orlando, Florida 32806-2093

LINE UP PATIENT I.D. LABEL HERE

## AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name:______________________________ Social Security #:______________

Address:______________________________

Date of Birth: ____/____/____ Date of Service:______________ Phone #:______________

Identification Shown:______________________ Mail ❑ Pick Up ❑

I hereby authorize Orlando Health to use and **disclose to**: ❑ **or obtain from:** ☐ **or allow review:** ❑

______________________________ ______________
Name of Facility or Person Phone

______________________________
Street Address City State Zip Code

**SEND RECORDS TO:** (Name of Facility or Person) GRACE MEDICAL HOME

51 PENNSYLVANIA STREET ORLANDO FL 32806
Street Address City State Zip Code

the following information contained in my medical record regarding my hospitalization, care and treatment (please initial):

____ Complete Record
____ Abstract of Record
____ Therapy Records
____ Progress Note(s)
____ All Diagnostic Test Results
____ Consultation
____ Radiology Only
____ Operative Report
____ Pathology Report(s)
____ Lab Only
____ Other (please specify)
______________________

The purpose for the release of information at the request of the individual is:
❑ Insurance ❑ Legal Action ☑ Continued Treatment ❑ Personal Use ❑ Patient Communication (Behavioral Health)
❑ Other (Please Specify) ______________________

This authorization will expire on the following date, event or condition: 1 Year

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.

May **NOT** include information related to (please initial):

____ HIV/AIDS ____ Mental Health ____ Drug and/or Alcohol Abuse ____ Genetic Counseling/Testing Information

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Orlando Health may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form.

______________________________ ______________
Patient/Legal Representative or Parent/Legal Guardian Signature Date

Translator or Interpreter's Name: ______________________________

**Official Use Only:** ______________________________ Date:______________

☐ Name of Person Releasing Information ☐ Name of Person Assisting with Review Number of pages copied ________

☐ **I wish to revoke this authorization.** Signature: ______________________ Date: ______________

GRACE MEDICAL HOME

**For Office Use Only:**
- ○ Entered into chart
- ○ Scanned in e-MDs
- ○ Appointment Date: ______________
- ○ Provider: ______________

**Date:**______________________

# Adult Health Summary Form

**NAME:**________________________________________ **DOB:** _______________________

**CURRENT PROBLEMS:**

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**ALLERGIES TO MEDS/FOODS/OTHER AGENTS:** ○ **NONE**

| Medication | Reaction or Side Effects |
|---|---|
| | |
| | |
| | |
| | |

**CURRENT MEDICATIONS/ VITAMINS/ OTC:** ○ **NONE**

| Medication | Dose | Freq. | Medication | Dose | Freq. |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Patient Name:________________________

**PAST MEDICAL HISTORY:** ________________________________

***Cardiovascular***

- Heart Rhythm Disturbance (Arrhythmia)
- Congenital Heart Disease (specify type) ________________________________
- Congestive Heart Failure
- Coronary Artery Disease
- Deep Venous Thrombosis (DVT)
- High Cholesterol (Hyperlipidemia)
- High Blood Pressure (Hypertension)
- Myocardial Infarction – Date ______________
- Other: ______________________________

***Pulmonary***

- Asthma
- COPD
- Sleep apnea
- Other: ______________________________

***Gastrointestinal***

- Gall stones (Cholethiasis)
- Liver Cirrhosis
- Colon Polyps
- Crohn's Disease
- Reflux (GERD)
- Hepatitis
- Ulcerative Colitis
- Other: ______________________________

***Kidney (Genitourinary)***

- Kidney (Renal) Stones
- Other:

***Musculoskeletal***

Arthritis: ○ Osteoarthritis ○ Rheumatoid ○ Unknown

- Lupus (Systemic Lupus Erythematosis)
- Other: ______________________________

***Endocrine***

- Diabetes: Circle - Type I Type II
- Thyroid–
- Hyperthyroidism
- Hypothyroidism
- Other: ______________________________

***Neurologic***

- Stroke (Cerebrovascular Accident)
- Seizure disorder
- Other: ______________________________

***Hematologic***

- Clotting (Coagulation) disorder
- Sickle Cell Anemia
- Other: ______________________________

***Allergy***

- Allergic rhinitis
- Other: ______________________________

***Cancers***

- Type: ______________________________

***Other Medical Problems/Diseases***:

- ______________________________
- ______________________________

---

**For Women: Gynecologic History:**

# Pregnancies (gravid): _______ # Abortions:_________

# Deliveries (parity): ________ # Miscarriages:________

Sexually active: ○ Yes ○ No

Current Birth Control: Method: ______________________

**Mammogram:** ○ Yes ○ Never

Date of Last Mammogram: ______________

Results: ○ Normal ○ Abnormal

**Pap Smear:** ○ Yes ○ Never

Date of Last Pap: ______________

Results: ○ Normal ○ Abnormal

Patient Name:________________________

## EMERGENCY ROOM HISTORY

| REASON | DATE |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## HOSPITALIZATIONS (Other than surgeries):

| REASON | DATE |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**PREVENTATIVE HEALTH: The following information helps greatly with your medical care. Please check all that apply if known.**

Colonoscopy: Date of Last:__________

Results: ○ Normal ○ Abnormal ○ Results unknown ○ Refused ○ Never

Mammogram: Date of Last:_________ Next Mammogram Due:___________

Results: ○ Normal ○ Abnormal ○ Results unknown ○ Refused ○ Never ○ BiRads

Pap Test: Date of Last: _________ Results: ○ Negative ○ Refused ○ Abnormal

Prostate Exam: Date of Last:________ Results: ○ Normal ○ Abnormal ○ PSA level: _______

PPD (Tuberculosis skin test): ○ Negative ○ Positive

TSH level: ________

Vaccines:

- ○ Influenza Date: _________
- ○ Gardisil (HPV) Date: _________
- ○ Pneumococcal Date: _________
- ○ Tetanus Date: _________
- ○ Varicella Zoster (Shingles) Vaccine Date: _________

## PREVIOUS MEDICAL PROVIDERS:

Primary Care Provider: ________________________________________________

Specialists: ________________________________________________

## SURGICAL HISTORY:

| OPERATION | DATE |
|---|---|
| | |
| | |
| | |
| | |

Patient Name:________________________

**FAMILY HISTORY:**

| Relative | Living? | Age (or age at death) | List serious illnesses |
|---|---|---|---|
| **Father** | (Y) (N) | | |
| **Mother** | (Y) (N) | | |
| **Brothers** | (Y) (N) | | |
| | (Y) (N) | | |
| **Sisters** | (Y) (N) | | |
| | (Y) (N) | | |
| **Sons** | (Y) (N) | | |
| | (Y) (N) | | |
| **Daughters** | (Y) (N) | | |
| | (Y) (N) | | |
| **Paternal Grandfather** | (Y) (N) | | |
| **Paternal Grandmother** | (Y) (N) | | |
| **Maternal Grandfather** | (Y) (N) | | |
| **Maternal Grandmother** | (Y) (N) | | |

**SOCIAL HISTORY:**

Occupation: ________________________________

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Number of Children: ________

Do you exercise regularly? (Y) (N) Frequency: ○ Rarely ○ Daily _______ days/week

**TOBACCO USE:**

- Never Smoked
- Current smoker
  - Every Day ○ Intermittent
- Past smoker
- Smokeless Tobacco

**ALCOHOL USE:**

Do you drink alcohol? ○ Never ○Past ○ Yes

Number of drinks per week? ___________

Is alcohol use a concern for you or others? ○ Yes ○ No

**SUBSTANCE USE:**

Do you use recreational/street drugs? ○ Yes ○ No

List/Type:

**MENTAL HEALTH:**

- Anxiety
- Depression ( Mood Disorder)
- Bipolar (Mood Disorder)
- Suicide Attempt
- Schizophrenia
- Other:________________________________

**COMMUNICABLE DISEASES:**

Sexually Transmitted Diseases? ○ Yes ○ No

- List:______________________________

Reportable Diseases?

- o Hepatitis
- o Tuberculosis
- o Other? ___________