



Demographics

First Name:	Middle Name:
Last Name:	Sex:
Date of Birth:	Email:
Primary Phone Type:	Phone Number:
Social Security Number:	Address:
City:	State, Zip Code:
Race:	Language:

Emergency Contact

Relationship to Contact:	
First Name:	Last Name:
Phone Number:	Zip Code:

Financial Information

Who is responsible for you?	
What is your method of payment?	
Insurance Type:	Member ID:
Group Number:	Policy Holder:



Preferred Pharmacy

Allergies

Name	Reaction

Medications

Name	Dosage/Instructions



Past Medical History

Please mark if you have a history of any of the following conditions (check all that apply):

- Cancer** (Please specify type and any treatments): _____
 - Stroke** (Ischemic/Hemorrhagic)
 - Diabetes** (Type 1/Type 2)
 - Heart disease** (Myocardial Infarction, CHF, arrhythmias, CABG, stents)
 - Hypertension** (and any complications): _____
 - Chronic Kidney Disease** (History of dialysis or transplants)
 - Respiratory Conditions** (COPD, Asthma)
 - Autoimmune Diseases** (Lupus, Rheumatoid Arthritis, Multiple Sclerosis, etc.)
 - Seizure Disorders / Epilepsy**
 - Liver Disease** (Cirrhosis, Hepatitis B/C, fatty liver, NAFLD, Alcohol Use)
 - Thyroid Disorders** (Hypothyroidism, Hyperthyroidism)
 - Psychiatric History** (Depression, Bipolar Disorder, Anxiety)
 - Blood Disorders** (Anemia, Clotting Disorders)
 - Neurologic Conditions** (Parkinson's, Dementia, Migraines)
 - Arrhythmias** (Atrial Fibrillation, supraventricular tachycardia, aflutter, etc.)
-

Specialist Care

Please list any specialists you currently see or have seen in the past:

- Specialist Name: _____ | Reason for Visit: _____
- Specialist Name: _____ | Reason for Visit: _____
- Specialist Name: _____ | Reason for Visit: _____
- Specialist Name: _____ | Reason for Visit: _____

Past Medical History

Please check all that apply:

Head

- Trauma

Eyes

- Wears glasses/contacts
- Glaucoma
- Blindness
- Cataracts

Ears

- Hearing aids

Nose/Sinuses

- Sinus infections
- Allergic Rhinitis

Mouth/Throat/Teeth

- Dentures

Cardiovascular

- HTN
- Myocardial infarction
- Other heart disease
- Aneurysm
- Murmur
- Dysrhythmia
- Angina
- DVT

Respiratory

- Asthma
- Bronchitis
- COPD - Bronchitis/Emphysema
- Pneumonia
- Pleuritis

Gastrointestinal

- Ulcer
- Hemorrhoids
- Jaundice
- Hepatitis
- Cirrhosis
- Gallbladder disease
- Hiatal hernia
- Heartburn
- GERD

Genitourinary

- Hernia
- STDs
- Incontinence
- UTI(s)
- Nephrolithiasis
- Other kidney disease

Endocrine

- Type 1 DM
- Type 2 DM
- Hyperlipidemia
- Thyroiditis
- Hypothyroidism
- Thyroid disease
- Goiter

Heme/Onc

- Anemia
- Cancer

Infectious

- Tuberculosis (dz)
- Tuberculosis (exposure)
- HIV
- STDs

Musculoskeletal

- Arthritis
- Gout
- M/S injury

Skin

- Psoriasis
- Dermatitis
- Other skin condition(s)
- Mole(s)

Neurological

- Severe headaches, migraines
- Stroke
- TIA
- Seizures
- Epilepsy

Psychiatric

- Depression
- Bipolar disorder
- Hallucinations, delusions
- Suicidal ideation
- Suicide

Other

- _____

Surgical History

Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Laminectomy | <input type="checkbox"/> Aneurysm repair |
| <input type="checkbox"/> Spinal fusion | <input type="checkbox"/> Breast resection/mastectomy |
| <input type="checkbox"/> Hip arthroplasty | <input type="checkbox"/> Cholecystectomy/bile duct surgery |
| <input type="checkbox"/> Hip replacement | <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Carpal tunnel release surgery | <input type="checkbox"/> Inguinal hernia repair |
| <input type="checkbox"/> Rotator cuff surgery | <input type="checkbox"/> Bariatric surgery/gastric bypass |
| <input type="checkbox"/> Skin cancer excision | <input type="checkbox"/> Hemorrhoid surgery |
| <input type="checkbox"/> Cataract/lens surgery | <input type="checkbox"/> Cesarean section |
| <input type="checkbox"/> LASIK | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Sinus surgery | <input type="checkbox"/> TAH-BSO |
| <input type="checkbox"/> Nasal surgery | <input type="checkbox"/> Dilation and curettage |
| <input type="checkbox"/> Tonsillectomy/Adenoidectomy | <input type="checkbox"/> Bilateral tubal ligation |
| <input type="checkbox"/> CABG | <input type="checkbox"/> TURP |
| <input type="checkbox"/> PTCA/PCI | <input type="checkbox"/> Prostatectomy |
| <input type="checkbox"/> Pacemaker/defibrillator | <input type="checkbox"/> Prostate surgery |
| <input type="checkbox"/> Carotid endarterectomy/stent | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Other | <input type="checkbox"/> Knee arthroplasty |
| | <input type="checkbox"/> Back surgery |

Family History

Family Member	Disease
Mother	
Father	
Brother(s)	
Sister(s)	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	



Social History

Please check all that apply:

Tobacco

- Current everyday smoker
- Current some day smoker
- Former smoker
- Smoker, current status unknown
- Never smoker
- Unknown if ever smoked
- Heavy tobacco smoker
- Light tobacco smoker

Alcohol

- Do not drink
- Occasional drink
- Frequently drink
- Drink daily
- History of Alcoholism

Drug Abuse

- IVDU
- Illicit drug use
- No illicit drug use

Cardiovascular

- Eat healthy meals
- Regular exercise
- Take daily aspirin

Safety

- Wear seatbelts
- Household Smoke detector
- Keep Firearms in home

Sexual Activity

- Sexually active
- Safe sex practices
- Exposure to STI
- Not sexually active

Birth Gender

- Male
- Female
- Undifferentiated

Please check here if you have traveled domestically or internationally within the past 6 months

Additional History

Last Mammogram:	Where:
Last Colonoscopy:	Where:
Hospitalizations:	
Procedures:	
Implantable Devices:	
OBGYN History:	



Release Of Patient Records Authorization

Date: _____

THE PATIENT.

I hereby release all medical information, including diagnosis, medical, surgical, laboratory, or radiologic records of any treatments, examinations, or tests rendered to CareLink Primary Care. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

Patients Name: _____

Date of Birth: _____

AUTHORIZATION.

I authorize the company below:

Company Name: _____

Phone Number: _____

Fax Number: _____

To disclose the following:

DISCLOSURE.

The Authorized Party has my permission to disclose medical records to:

Name: **CareLink Primary Care**

Address: **907 Mar Walt Dr St 2023 Fort Walton Beach, FL 32547**

Phone: **850-613-4024** Fax: **850-374-3352**

Email: carelinkprimarycare@gmail.com

IV. **PURPOSE.** The reason for this authorization is for continuation of medical care.

Signature: _____ Date: _____



HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

1. Name/ Relationship to Patient/ Phone Number:

2. Name/ Relationship to Patient/ Phone Number:

I do not wish for my healthcare information to be released to anyone.

The release of this information will remain in effect until terminated by me in writing.

Signature: _____

Date: _____



Photography Consent

I, _____, consent to medical images and/or video being made of me.

I agree that the images may be:

- Placed in my medical record for future reference and/or treatment.
- Electronically be emailed to my treating health professional.
- Duplicated for the referring doctor
- Used by health professionals for medical education and training.
- Used in paper or electronic health records.

This consent may be revoked at any time with a written request by the patient.

By signing below, I confirm that I understand this consent form.

Signature: _____ Date: _____



Consent for Treatment

Thank you for choosing CareLink Primary Care for your primary care needs. We are committed to providing you with quality and affordable health care.

Please read carefully and let us know if you have any questions.

1. Nature of Treatment

The treatment I receive may include evaluations, tests, diagnostic procedures, preventive services, and medical interventions consistent with my condition and current standards of care.

2. Risks and Benefits

I have been informed of the general risks, side effects, and benefits of proposed treatments. I understand that no guarantees have been made regarding the results of any treatment.

3. Privacy and Confidentiality

My health information will be protected in compliance with HIPAA. My medical records will only be shared with authorized personnel involved in my care or as required by law.

4. Financial Responsibility

I am financially responsible for all services provided to me, including those not covered by insurance. I understand I may receive separate bills for laboratory, radiology, or other services.

5. Right to Refuse or Withdraw Consent

I have the right to decline or withdraw consent for treatment at any time, understanding that it may affect the provider's ability to offer care.

6. Communication and Follow-Up

CareLink Primary Care may contact me via phone, text, voicemail, email, or patient portal regarding my care, results, and appointment reminders. I agree to receive such communications.

7. Medical Decision-Making Authorization

If I am unable to make decisions for myself, I authorize my designated representative (if applicable) to make medical decisions on my behalf in accordance with Florida law.

8. Electronic Records and Signatures

By signing electronically, I consent to the use of electronic records and signatures and acknowledge that I have received the appropriate disclosures.

Print Name of Patient / Responsible Party:

Signature: _____ Date: _____



Non Covered Services Disclosure

Thank you for choosing CareLink Primary Care for your healthcare needs. We are committed to providing high-quality care and ensuring transparency in all aspects of our financial process.

Please take a moment to review our payment policy:

1. **Insurance Participation**

Please be aware that CareLink Primary Care may *not be* a participating provider with your insurance company. This means that we do not have an agreement with your insurer to accept their payment rates for services rendered. As such, you will be responsible for paying any balances not covered by your insurance.

2. **Insurance Billing**

We will submit claims to your insurance provider on your behalf. However, it is your responsibility to verify your insurance benefits and coverage prior to receiving services. It is important to understand that your insurance policy may not cover all services, or may cover them at a reduced rate, leaving you with a balance.

3. **Responsibility for Payment**

You are financially responsible for all charges related to your care, including any amounts not covered by your insurance. This includes co-payments, deductibles, coinsurance, and charges deemed as non-covered services by your insurance.

4. **Balance Due**

If your insurance provider does not cover a portion of the bill, or if you are responsible for any balance after insurance payment, you will be billed directly for the remaining amount. Payment for any outstanding balance is due upon receipt of the bill.

5. **Non-Payment**

If payment is not received within a reasonable time frame, we may charge late fees or take additional action to collect the outstanding balance, including referring your account to collections.

By receiving services at CareLink Primary Care, you acknowledge that you understand and agree to this payment policy. If you have any questions or concerns about your insurance coverage or billing, please do not hesitate to contact our office.

Thank you for your cooperation and understanding.

Signature: _____

Date: _____



Cancellation and No Show Policy

Patients must call and cancel or reschedule their appointments within 48 hour notice unless approved by the staff to avoid a cancellation/no show charge.

You will be charged as listed below:

For appointments 15 minutes- 30 minutes: \$50.00

For appointments 30 minutes- 60 minutes: \$100.00

Name on Card: _____ Zip Code: _____

Card Number: _____

Expiration Date: _____ CVV: _____

I have read, understand, and agree with all of the above statements.

Patient Print Name: _____

Patient Signature: _____

Date: _____

Witness Signature: _____

Date: _____