Dr Cheri McCue Family Practice
Dr Cheri McCue MD

5 Ryant Blvd.
Sebring, Fla 33870
863-991-2819 fax: 863-446-0639

NEW PATIENT INTAKE FORM

Patient's Last Name:_____ First Name: _____Middle Initial:_____
Local Address:_____City:_____State:_____Zip:_____
Home Phone: _____Work Phone: _____Cell Phone:_____
Date of Birth:_____
Social Security Number:_____
Northern Address:_____
City:_____ State:_____ Zip:_____
Northern Phone#:_____
How long are you here in Florida: From _____ to _____
Which address do you want correspondences to go to? [ ] Local Address [ ] Northern Address

Email Address:_____

Employer Name:_____ Phone:_____
Employer Address:_____City:_____State:_____
May we contact you at work: Yes No

Referred to this office by:_____
This is used to thank patients and doctors for their referrals to our office

Primary Care Physician:
Who is your Primary Care Physician? _____

Pharmacy Information:
What is your local pharmacy? _____
What is your mail order pharmacy if used)? _____

Name of Emergency Contact:_____ Relationship:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____

*** I authorize payment of medical benefits billed to my insurance company to be paid to Dr Cheri McCue MD and Dr Cheri McCue Family Practice. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for any fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.
*** It is my responsibility to understand my insurance for coverage, co-payment/deductible etc.
*** I agree to pay all copayments, co-insurances and deductibles at the time services are rendered.
*** I will pay by (check one) [ ] cash [ ] check

_____ _____
Signature of patient or guardian Date

Patient Name:_____ Today's Date:_____
Referring Physician:_____ Patient's Date of Birth:_____
Reason for Visit:_____
_____

Personal Medical History: Please check any of the conditions that represent a SIGNIFICANT problem for **you.**

GENERAL: __abnormal activity level __fatigue __fevers & chills __loss of appetite __night sweats __pale skin __unexpected weight gain __unexpected weight loss __weight gain due to diet __weight loss due to diet

EYES: __blindness __discharge __double vision __dryness of eyes __eye pain __loss or blurring of vision __itchy eyes __redness __swelling __watery eyes __wearing glasses

EARS, NOSE, MOUTH, & THROAT __allergies __dizziness __ear drainage __ear pain __wearing hearing aids __hearing loss __hoarseness __mouth sores __nasal discharge __nose bleeds __nose pain __post nasal drip __runny nose __sinus drainage __sore throat __trouble swallowing __teeth problems __ringing in ears

CARDIOVASCULAR: __chest pain/pressure __blue/purple skin color __excessive sweating __edema __murmurs __palpitations __ radiation of pain

RESPIRATORY: __coughing __sputum production __coughing up blood __O2 dependent __shortness of breath ___shortness of breath with activity ___snoring __rapid heart beat __tobacco use __wheezing

GASTROINTESTINAL: __abdominal pain __anorexia __blood in stool __constipation __diarrhea __diverticulosis/diverticulitis __food intolerance __gallbladder disease __blood in stool __hemorrhoids __hepatitis __hiatal hernia __IBS __increased belching __increased flatus __indigestion __yellow skin color __black stool __nausea/vomiting __polyps __use of antacids ___vomiting blood

GENITOURINARY: ___abnormal menses __chlamydia __decreased libido __dribbling __painful urination __frequency of urination _blood in urine __herpes __hormone replacement therapy __hot flashes __inter-menstrual bleeding __waking up to urinate at night __pelvic pain __frequency in urination __pregnancy __sexually transmitted disease __stress incontinence __urge incontinence __recurrent UTIs __vaginal discharge __vaginal itching

MUSCULOSKELETAL: __back pain __cramps __disc disease __gout __joint erythema __joint pain __joint replacement __joint swelling __decreased range of motion __muscle pain __neck pain __nighttime muscle cramps __stiffness __weakness

INTEGUMENTARY: __acne __dryness __eczema __itching __hair loss __lumps __psoriasis __rosacea __scalp flaking and itching __skin cancer __skin rashes __skin ulcers

NEUROLOGICAL: __gait disturbance __head trauma __headache __local weakness __memory loss __mental illness __numbness __paralysis __tingling/burning __seizure activity __speech difficulty __tremors

PSYCHIATRIC: __changes in sleep pattern __compulsions __depression __disturbing thoughts or feelings __hyperactivity __moodiness __obsessive thoughts __panic attacks __suicidal thoughts or attempts

ENDOCRINE: __excessive sweating __excessive thirst __goiter __heat or cold intolerant __hormone replacement __excessive eating

HEMATOLOGIC/ __abnormal bleeding __bruising __cancer __nose bleeds __past transfusions

LYMPHATIC: __swelling of lymph gland

ALLERGIC/ IMMUNOLOGIC __anaphylactic reactions __skin welts __environmental allergies __rashes __seasonal allergies __sneezing __hives

APNEA ___Daytime Sleepiness __Un-refreshed sleep __snoring ___take naps during the day ___Difficulty concentrating __anyone witnessed you stop breathing when you sleep ___overweight ___memory loss ___loss of libido ___smoker ___former smoker ___wake up chocking or gasping for air ___wake up at night for any reason ___currently on a bipap/cpap

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Current Medications:

Please list all of your medications, including over the counter medications.

Medication Name	Strength	# times a day

Medication Name	Strength	# times a day

Please list all allergies including medications, food and environmental:

_____

_____

_____

Family History: Please answer the following about your immediate family.

Father	Living or deceased	If deceased: age and reason
	Please list father's medical conditions ->	
Mother	Living or deceased	If deceased: age and reason
	Please list mother's medical conditions ->	
Brother	# living____ # deceased_____	Medical conditions:
Sisters	# living____ # deceased_____	Medical conditions:
Children	# living____ # deceased_____	Medical conditions:
	Unknown	Reason: adopted other:_____

Personal History:

Do you drink alcohol?_____ Type of Alcohol: Beer / Liquor / Wine
If yes, what is your daily consumption?_____ How many years?_____

Do you smoke cigarettes, pipe, cigars, chewing tobacco or snuff?_____
If yes, what is/was your daily consumption?_____ How many years?_____
When did you quit (month/year)?_____

Do/Did you use recreational drugs?_____ Type:_____ Patient Initials_____

What is or was your profession:_____

Patient's Personal Medical History

Please check if you have any of the following Medical Conditions:

	Alzheimer's		Gallstones		Migraines
	Anemia		GERD / Reflux		Narcolepsy
	Anxiety		Glaucoma		Neck Pain
	Arthritis		Gout		Neuropathy
	Asbestos Lung Disease		Headaches		Obesity
	ASHD		Hearing Loss		Osteopenia
	Asthma		Heart Attack		Osteoporosis
	Atrial Fibrillation		Heart Disease		Pacemaker
	Back Pain		Heart Murmur		Palpitations
	Barrett Esophagus		Heartburn/Indigestion		Pancreatic Disease
	Bipolar Disorder		Hemorrhoids		Pancreatitis
	Blood Clots		Hepatitis		Parkinson's Disease
	Blood Transfusions		High Blood Pressure		Pleural Effusion
	Bradycardia		High Cholesterol/Triglycerides		Pneumothorax
	Brain Tumor		HIV		Prostate problems
	Bronchiectasis		IBS		Pulmonary Embolism
	Cancer, Type _____		Insomnia		Recurrent UTI
	Cardiac Catherizations R / L		Irregular Heart Rhythm		Recurrent Pneumonia
	Carotid Stenosis		Jaundice		Recurrent Bronchitis
	Chest Pain		Kidney Disease		Restless Leg Syndrome
	Cirrhosis of Liver		Kidney Failure		Sarcoidosis of lung
	Colitis		Kidney Stones		Seizure
	Congestive Heart Failure		Leukemia		Sleep Apnea
	COPD		Liver Disease		Stroke
	Crohn's Disease		Lung Collapse		Syncope
	Depression		Lung Cancer		Thyroid Disease
	Diabetes		Lung Disease		TIA
	Diverticulosis		Lung Nodule		Transplants
	DVT - Deep Vein Thrombosis		Lupus		Other:
	Eczema		Lymphedema		Other:
	Emphysema		Lymphoma		Other:
	Fibromyalgia		Melanoma		Other:
	Frequent Falls		Memory Loss		Other:

Surgeries and Hospitalizations

Please list any **surgeries** and **hospitalizations**:

Date or approx date	Reason for surgery

Immunization Record:

When was your last:

Flu Vaccine:_____ Shingles Vaccine:_____ Prevnar 13:_____ Pneumovax 23 _____
Bone Density:_____ CXR:_____

Females Only:
Mammogram:_____ Pap Smear:_____

Males Only:
PSA:_____

Other:

Do you have any other problems you want to discuss? [ ] Yes [ ] No

_____
_____
_____

I agree that the information I have provided is current and accurate to the best of my knowledge.

Patient's Signature:_____ Date:_____

Physician's Signature:_____ Date:_____

REQUEST FOR RELEASE OF MEDICAL RECORDS

Dr Cheri McCue Family Practice

5 Ryant Blvd

Sebring, Fla 33870

863-991-2819 fax: 863-446-0639

Dr Cheri McCue MD

I hereby request that my medical records be released
to ***Dr Cheri McCue MD*** for the purpose of continuity of medical care:

Requesting From:

Physician Name/Other: _____

Address:_____

City:_____ State: _____Zip:_____

_____ _____

Patient's Signature Date

Patient Information: *Please print*

Name:_____

Address:_____

City:_____ State :_____Zip:_____

Date of Birth:_____ SS#:_____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____

I hear by authorize the Staff of Dr Cheri McCue Family Practice to disclose my health information to:

Dr Cheri McCue, MD 5 Ryant Blvd. Sebring, FL 33870

By fax to 863-446-0639

I authorize any medical personnel to provide pertinent date to Dr Cheri McCue Family Practice, concerning my medical history and consent to review the medical records by government agencies as required by law.

This authorization is limited to one year following the signature date on this form.

Information to be disclosed, send all that are marked:

[ ] history and physical exam	[ ] x-rays/MRI/CT scans	[ ] diagnosis
[ ] admission/discharge summary	[ ] consultation	[ ] treatment
[ ] progress notes	[ ] billing information	[ ] list of medications
[ ] emergency room records	[ ] prescription for therapy	[ ] any/all of the above

[ ] other: _____

I understand that the information to be disclosed includes my identity, diagnosis and treatment including alcohol, drugs, genetic testing, behavioral or mental health services, reproductive rights, sexually transmitted disease, AIDS, HIV information, as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above, and that the recipient is prohibited from disclosing this information to any other party and disclosure is not necessary or required for the purpose stated.

I understand that I have the right to revoke this authorization at any time. I understand I revoke this authorization, I must do so in writing and present my written verification to the health information management department. I understand that this revocation will not apply to the stand that Dr Cheri McCue Family Practice has already taken action in reliance on this authorization. This authorization will automatically expire. One year from the date of my signature, and less unspecified that this authorization will terminate on the following day, or concurrently with the following event or condition: _____

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to procure, treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure in the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the health information department at 863-991-2819.

Patients Signature: _____ Date: _____

(If legal representative, signed below and state relationship to authority to do so and attaches the document of authority.)

Legal Representative: _____ Date : _____

Relationship: _____

Witness: _____ Date: _____

Dr Cheri McCue Family Practice

HIPPA Practices and Communication Form

Receipt of HIPPA Privacy Policy

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices for Dr Cheri McCue Family Practice which describes the practices policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the practice.

_____

Printed Name

_____ _____

Signature Date

Disclosure and Release of Health Information

Pertaining to the health insurance portability and accountability act of 1996 (HIPPA) below or our attempts to protect our patients right to privacy. Your check [x] indicates the degree to which your information is to be released.

I _____, authorize the following people to obtain information regarding my medical history protected by Dr Cheri McCue Family Practice:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

They can have access to the following:

[ ] appointment [ ] diagnosis
[ ] test results [ ] treatment plan
[ ] financial/ patient balances [ ] insurance information
[ ] status to account [ ] any/all of the above
[ ] Do not give out any information to anyone other than myself.

_____ Date: _____

Patient/Responsible Party Signature

_____ Date: _____

Witness

This assignment of information will stay in effect until revoked or changed by me in writing.