Unknown
Unknown

DATE: ______________

MEDICAL HISTORY

Name: ______________________________ DOB: ______________

Occupation: ____________________ Disabled: Yes No reason: ______________

ALLERGIES to medications: ____

CURRENT MEDICATIONS: ____

____

SURGERIES: ____

____

1. On blood thinners? Yes No
2. Bleeding disorders? Yes No
3. Rheumatoid arthritis? Yes No
4. Acid Reflux/GERD? Yes No
5. Psychiatric disorder? Yes No
6. Chest pain? Yes No
7. Irregular heartbeat? Yes No
8. Pacemaker? Yes No
9. Seizures? Yes No
10. High Cholesterol? Yes No
11. Thyroid Disorder? Yes No
12. Anxiety? Yes No
13. Hepatitis? Yes No
    If yes, what type of hepatitis: ______________
14. History of blood clots? Yes No
15. Osteoarthritis? Yes No
16. Gout? Yes No
17. HIV/AIDS? Yes No
18. Asthma/Emphysema? Yes No
19. Heart Disease? Yes No
20. Heart Attack? Yes No
21. Stroke? Yes No
22. High Blood Pressure? Yes No
23. Diabetes? Yes No
24. Depression? Yes No
25. Sleep Apnea? Yes No
26. Cancer? Yes No
    If yes, what type of cancer: ______________

Any condition not listed above: ____

Jehovah's Witness: Yes No

Do you drink alcohol? Yes No If yes, how much per week? __________

Do you use tobacco? Yes No If yes, what kind and how much? ______________

Have you ever used tobacco? Yes No If yes, how many years since quitting? ______________

HOGAN G. YI, M.D., P.A.

The Sports Medicine & Orthopedic Clinic

Name:____
First Middle Last

Address:____
Street City ST Zip

Home Phone:__________________ Cell:__________________ Social Security #:__________________

Consent to text: ______ yes ______ no

Male / Female: ______ Marital Status:________ Date of Birth:__________________ Race: ____________

Language: ______________ Ethnicity: ______Hispanic ______Non Hispanic

Employer:______________________________ Work Phone:__(______)______________

Emergency Contact: ______________________ Phone: ______________ Relationship: ____________

If minor child, parent/guardian name:______________________________ SSN:______________

Email Address: ______________________________@ ______________________

Referred by: ____

Primary Care Physician:______________________________ Phone:__________________

Nature of Problem:____

Work Related? ______ YES ______ NO If yes, Date of Injury: ______________________

Auto Accident? ______ YES ______ NO If yes, Date of Accident: ______________________

Preferred Pharmacy: ______________________ Location/Phone: ______________________

INSURANCE INFORMATION: Provide copy of insurance card(s) and photo ID for your file

The undersigned authorizes the release of any medical information to Dr. Hogan G. Yi, M.D., P.A.:

Patient Signature: ______________________________ Date:__________________

Hogan G. Yi, M.D.

PRIVACY POLICY ACKNOWLEDGMENT

With my consent, Hogan G Yi, MD, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations, as well as to comply with a subpoena or worker's compensation matter. I further authorize Dr. Hogan G Yi's office to access my medication history through our electronic prescription service.
I have the right to review *Notice of Privacy Practices*, prior to signing this consent. I may revoke my consent in writing except to the extent that the practice has already made disclosures upon my prior consent.
In addition, I authorize Dr. Hogan Yi's office to leave a message regarding appointment reminders with whomever answers my home phone or on my answering machine.

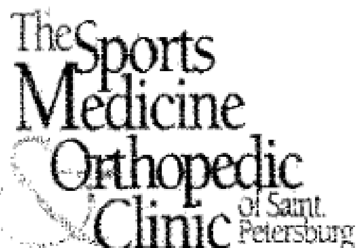
PLEASE PROVIDE YOUR INSURANCE CARD AND DRIVERS LICENSE SO WE CAN MAKE A COPY FOR YOUR FILE.

ASSIGNMENT and RELEASE: I certify that I, and/or my dependent(s) have insurance coverage with the disclosed insurance company(ies) and assign directly to Hogan G. Yi, MD, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature of all insurance submissions.

The above named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize the office of Hogan G. Yi, M.D. to download my medication history and Rx benefits into my account from a Rx clearinghouse.

Patient Signature: ____

Date:____________________



Hogan G. Yi, M.D.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

In order to have your PHI shared in circumstances OTHER than those listed in the Notice of Privacy Practices, please list below any individuals who are authorized to obtain your PHI from the office of Hogan Yi, M.D., P.A.

____

____

____

____

____

_____________________________ ____________________
Signature of Patient/Guardian Date

Ten Pasadena Avenue North ■ Post Office Box 40658 ■ St. Petersburg, Florida 33743-0658
Telephone (727) 381-2500 ■ Fax (727) 343-8746

Hogan G. Yi, M.D., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ______________________________, have received a copy of this office's "Notice of Privacy Practices".

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

_____Individual refused to sign

_____Communication barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining the acknowledgement

_____Other (Please specify)

____

____