ACVHealth
An Outreach of Advent Christian Village

Copeland Clinic
Welcome to Our Practice

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City/State/Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____ Social Security No.: _____

Date of Birth: _____ Age: _____ ☐Male ☐Female

Ethnic group: ☐White ☐Asian ☐Black/African American
☐Hispanic ☐Multi-racial ☐Native American

Primary Language Spoken: _____ Preferred Pharmacy

Marital Status: Single Married Separated Divorce Widowed

Occupation: _____

Next of Kin/Emergency Contact: Name: _____

Phone: _____ Relationship: _____

List any hospitalizations for major illnesses or surgical operations (use additional sheets if needed):

Type of Illness/Operation	Year	Physician	Hospital

10820 Marvin Jones Blvd.
Dowling Park, FL 32064

PO Box 4310
Dowling Park, FL 32064

Tel: (386) 658-5300
TDD 1-800-955-8771

Fax: (386) 658-5130
www.acvillage.net

Please list all medications (prescription and over-the-counter):

Name of Drug	Dosage	Directions

Past Medical History:

HAVE YOU EVER HAD ANY OF THE FOLLWING HEATH CONDITIONS IN THE PAST 6 MONTHS:

Alcoholism or Drug Habit	no	yes	Heart Murmur	no	yes
Anemia	no	yes	High Blood Pressure	no	yes
Angina	no	yes	Kidney or Bladder Problems	no	yes
Arthritis, Gout or Rheumatism	no	yes	Liver Disease	no	yes
Asthma or Emphysema	no	yes	Osteoporosis	no	yes
Cancer	no	yes	Pancreas Disease	no	yes
Cataracts	no	yes	Parkinson's Disease	no	yes
Circulation Problems	no	yes	Prostate Disease (Men Only)	no	yes
Chronic Lung Disease	no	yes	Rheumatic Fever	no	yes
Congestive Heart Failure, or Other Heart Conditions	no	yes	Seizures or Epilepsy	no	yes
Depression/Emotional Illness	no	yes	Stroke	no	yes
Diabetes	no	yes	Tuberculosis (Active Requiring Hospitalization)	no	yes
Fractures - Wrist, Hip or Spine	no	yes	Ulcers (Peptic or Duodenal)	no	yes
Gallbladder Disease	no	yes	Other _____		
Glaucoma	no	yes	_____		
Heart Attack	no	yes	_____		

Allergic to any Medications? No Yes List: _____

Family History:

Please list the current status of your immediate family:

Grandparents	Alive or Deceased	Age (Now or at Death)	Comments/Cause of Death
Parents			
Siblings		**Age/Sex**	
Children			

Immunizations:

Flu vaccine	☐ No	☐ Yes	Date if known: _____
Pneumonia vaccine	☐ No	☐ Yes	Date if known: _____
Tetanus	☐ No	☐ Yes	Date if known: _____
Zostavax	☐ No	☐ Yes	Date if known: _____

Social History:

Do you smoke? ☐No ☐Yes

If yes: How many cigarettes do you smoke each day? _____

Do you smoke every day? ☐No ☐Yes
How soon after you wake up do you smoke your first cigarette? _____

Are you interested in quitting? ☐ No ☐ Yes If a

former smoker, how long since you last smoked?

☐Less than 1 Month ☐3–6 Months ☐1–5 Years ☐More than 10 Years

☐1–3 Months ☐6–12 Months ☐5–10 Years

Have you had a drink containing alcohol during the past year? ☐No ☐Yes

If yes: How often did you have a drink in during the past year?

☐Monthly or Less ☐2–3 Times per Week
☐2–4 Times a Month ☐4 or More Times per Week ☐If yes:
How many drinks did you have on a typical day?

☐1 or 2 ☐5 or 6 ☐10 or more
☐3 or 4 ☐7 to 9

If yes: How often did you have more than six drinks on one occasion?

☐ Never ☐Less than Monthly ☐Daily or Almost Daily
☐Monthly ☐Weekly

Have you had sex in during the past 12 months? ☐No ☐Yes

Have you ever had a sexually transmitted disease? ☐No ☐Yes

If yes: ☐Chlamydia. ☐Gonorrhea ☐Syphilis ☐Herpes

Do you have little interest or pleasure in doing things? ☐No. ☐Yes

Do you have feelings of being down, depressed or hopeless? ☐ No ☐ Yes Do you have any advanced directives? ☐ No ☐ Yes

If no: Would you like to discuss today? ☐No ☐Yes

Please note: If you arrive more than 15 minutes late for an appointment, the appointment will need to be rescheduled.

Patient Signature _____ Date _____

Provider Signature _____ Date _____

HIPAA Compliant

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of services to Copeland Clinic/ACV Community Services, LLC for services rendered. I understand my insurance will be billed for me as a courtesy and accept that I am financially responsible for my services and treatments received.

RELEASE OF INFORMATION

I hereby consent for the release of my records and any information needed for payment of claims and processing. I hereby consent for the release of my medical records to specialists for continued care and treatment.

MEDICARE/MEDICAID

I certify that the information given by me Is correct. I request that payment of authorized benefits be made on my behalf.

HIPPA ACKNOWLEDGMENT STATEMENT / NOTICE OF PRIVACY POLICY

I acknowledge that I may be given a photocopy of the Notice of Privacy should I request one.

CONSENT FOR TREATMENT — ACV / COPELAND CLINIC

I hereby give written consent for treatment for services rendered by ACV/Copeland Clinic and voluntarily agree to diagnostic procedures and health care services, medical services, surgical treatments, x-ray treatments, Injections which may be administered or performed under the general Instructions of a physician, the physician's assistants or the physician's designees. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations in the clinic.

ACKNOWLEDGMENT: By signing below, I certify that I have read, understand and consent to this form's content.

A photocopy of these assignments shall be as valid as the original.

_____ _____

Patient/Guardian Signature Date

E-Prescribing Consent Form

E-Prescribing is defined as a physician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribing program. These include:

- **Formulary and benefit transactions:** Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions:** Provides the prescriber with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification:** Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing the consent form, you are agreeing that the Copeland Medical Center can request and use your prescription medication history from other health care providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent for the Copeland Medical Center to enroll me in the E-Prescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ Print _____

Patient Name Date of Birth

_____ Patient _____

Signature Date

_____

Relationship to Patient

Medical Insurance Information Form

Health Insurance

Name of Insured Party (Subscriber Name): _____

Relationship to Patient: _____ DOB: _____

Insured Party's Social Security Number: _____

Primary Insurance Company's Name: _____

Policy ID #: _____

Group # for Plan: _____

Secondary Insurance Company's Name: _____

Policy ID #: _____

Group # for Plan: _____

_____

Patient/Guardian Signature