Harbor Physicians
PRIMARY CARE & INTERNAL MEDICINE

Patient's Name: _____ | DOB: _____

Comprehensive Patient Questionnaire Date: _____

Personal Information

Full Name: _____

Date of Birth: _____ / _____ / _____ Age: _____ Gender: _____

Phone Number: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Language: _____ Communication preference: _____

Ethnicity: _____Race: _____

Religion: _____ Marital Status: _____

Spouse's name: _____ Spouse's Phone Number: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Primary Insurance Information

Primary insured's name: _____ DOB: _____

Primary Relationship to insured: _____

Primary insured SSN: _____ Insured's Phone #: _____

Driver's license #_____

Primary Insurance Name: _____ Primary Plan name: _____

Primary Subscriber ID: _____ Primary group #: _____

Harbor Physicians
PRIMARY CARE & INTERNAL MEDICINE

Patient's Name: _____ | DOB: _____

Secondary Insurance Information

Secondary insured's name: _____ DOB: _____

Secondary Relationship to insured: _____

Secondary insured SSN: _____ Insured's Phone #: _____

Driver's license #_____

Secondary Insurance Name: _____ Secondary Plan name: _____

Secondary Subscriber ID: _____ Secondary group #: _____

Employment Information

Employment Status: _____ Professional Title: _____

Employer Name: _____ Work phone: _____

Work Fax: _____

Employer address: _____

Prior Care and Specialists

Previous Primary Care Physician: _____

Phone: _____

Specialist(s) you see regularly and their phone #: _____

_____

_____

Referred by: _____

Harbor Physicians
PRIMARY CARE & INTERNAL MEDICINE

Patient's Name: _____ | DOB: _____

HEALTH HISTORY

Current Medical Conditions

Please check any conditions you have been diagnosed with:

☐ Diabetes	☐ High blood pressure	☐ Heart disease
☐ Thyroid disorder	☐ Kidney disease	☐ Liver disease
☐ Seizures	☐ Migraines	☐ Cancer (type: _____)
☐ Stroke	☐ Asthma / COPD	☐ Depression / Anxiety
☐ Other: _____		

Past surgeries or hospitalizations (with year if possible):

_____

_____

_____

Family Medical History

Please check if anyone in your family has had:

☐ Diabetes	☐ High blood pressure	☐ Heart disease
☐ Stroke	☐ Cancer	☐ Other: _____

Medications

Please list all medications you currently take (including vitamins, supplements, or over-the-counter):

_____

_____

_____

_____

_____

Allergies

Do you have any allergies to medications, foods, or the environment?

☐ No

☐ Yes → Please list: _____

Reaction(s): _____

Harbor Physicians
PRIMARY CARE & INTERNAL MEDICINE

Patient's Name: _____ | DOB: _____

Lifestyle

Do you currently smoke?
☐ No ☐ Yes → How much? _____
Do you drink alcohol?
☐ No ☐ Yes → How often? _____
Do you use recreational drugs?
☐ No ☐ Yes → Please list: _____
Do you exercise regularly?
☐ No ☐ Yes → Type/intensity/frequency? _____

_____

Review of Systems

Please check if you currently have or recently experienced:

☐ Fever / Chills	☐ Unexplained weight loss	☐ Joint pain
☐ Chest pain	☐ Shortness of breath	☐ Skin rash
☐ Abdominal pain	☐ Frequent urination	☐ Headaches
☐ Other: _____		

Additional Information

Is there anything else you would like your care team to know?

_____

_____

Family History

List medical illness and/or cause of death:

Mother: _____

Father: _____

Siblings: _____

Spouse: _____

Son/Daughter: _____

Additional Comments: _____

Signature of responsible party _____
Date _____

Harbor Physicians
PRIMARY CARE & INTERNAL MEDICINE

Patient's Name: _____ | DOB: _____

REVIEW OF SYSTEMS

System 1: General (Overall Health & Constitutional Symptoms)

Symptom	Check Box	Symptom	Check Box
Arthritis/Rheumatism	☐	Memory Loss	☐
Back Pain (recurrent)	☐	Muscle Weakness	☐
Bone Fracture	☐	Numbness/Tingling	☐
Cancer	☐	Obesity	☐
Diabetes	☐	Osteoporosis	☐
Foot Pain	☐	Rheumatic Fever	☐
Gout	☐	Weight Loss/Loss	☐
Headaches/Migraines	☐	Fever / Chills (from short form)	☐
Joint Pain	☐	Unexplained weight loss (from short form)	☐
None	☐		

System 2: Skin, Hair, & Nails

Symptom	Check Box	Symptom	Check Box
Abnormal Pigmentation	☐	Itching	☐
Boils	☐	Jaundice	☐
Brittle Nails	☐	Psoriasis	☐
Dry Skin	☐	Rash (Skin rash)	☐
Eczema	☐	Skin Disease	☐
Frequent infections	☐	Hair/Nail changes	☐
Hives	☐	None	☐

Harbor Physicians
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Patient's Name: _____ | DOB: _____

System 3: Respiratory (Lungs & Breathing)

Symptom	Check Box	Symptom	Check Box
Any Lung Troubles	☐	Difficulty Breathing	☐
Asthma or Wheezing	☐	Pleurisy or Pneumonitis	☐
Bronchitis	☐	Spitting up blood	☐
Chronic or Frequent Cough	☐	Trouble Breathing	☐
Shortness of Breath	☐	URI (Cold) Now	☐
None	☐		

System 4: Cardiovascular (Heart & Circulation)

Symptom	Check Box	Symptom	Check Box
Awakening in the night smothering	☐	Heart Murmur	☐
Chest Pain or Angina (Chest pain)	☐	Heart Trouble	☐
Congestive Heart Failure	☐	High Blood Pressure	☐
Cyanosis (blue skin)	☐	Irregular Heartbeat	☐
Difficulty walking two blocks	☐	Pain in legs	☐
Edema/Swelling of Hands, Feet or Ankles	☐	Palpitations	☐
Heart Attacks	☐	Poor Circulation	☐
Varicose Veins/Phlebitis	☐	None	☐

Harbor Physicians
PRIMARY CARE & INTERNAL MEDICINE

Patient's Name: _____ | DOB: _____

System 5: Gastrointestinal (Digestive System)

Symptom	Check Box	Symptom	Check Box
Abdominal Pain	☐	Gallbladder Disease	☐
Appetite Changes	☐	Gas/bloating	☐
Black Stools	☐	Heartburn or Indigestion	☐
Bleeding with Bowel Movements	☐	Hemorrhoids or Piles	☐
Blood in Vomit	☐	Hepatitis	☐
Crohn's Disease/Colitis	☐	Hernia	☐
Constipation	☐	Liver Trouble	☐
Cramping or pain in the Abdomen	☐	Nausea/Vomiting	☐
Difficulty Swallowing	☐	Painful Bowel Movements	☐
Diverticulosis	☐	Peptic Ulcer (Stomach or Duodenal)	☐
Frequent Diarrhea	☐	Recent change in bowel habits	☐
None	☐		

System 6: Genitourinary (Urinary & Reproductive)

Symptom	Check Box	Symptom	Check Box
Blood in Urine	☐	Incontinence	☐
Bright's Disease	☐	Kidney Stones	☐
Burning or painful Urination	☐	Kidney Trouble	☐
Decrease in force/flow	☐	Night time Urinating	☐
Frequent Urination (Frequent urination)	☐	Prostate Problems	☐
None	☐		

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Patient's Name: _____ | DOB: _____

System 7: Eyes, Ears, Nose, Throat, & Mouth (EENT)

Symptom	Check Box	Symptom	Check Box
Blurring	☐	Hearing problems	☐
Double Vision	☐	Impaired Hearing	☐
Eye Disease or Injury	☐	Chronic Sinus Trouble	☐
Eye Pain/Discharge	☐	Itchy Nose	☐
Glasses	☐	Nosebleeds	☐
Glaucoma	☐	Postnasal drip	☐
Itchy Eyes	☐	Sinusitis	☐
Vision changes	☐	Sneezing or Runny Nose	☐
Ear Disease	☐	Gum Bleeding	☐
Ear Infections	☐	Hoarseness	☐
Ears ringing	☐	Loss of Taste	☐
Mononucleosis	☐	Sore Throat	☐
Sores	☐	None	☐

System 8: Neurological (Nerves, Brain, & Head)

Symptom	Check Box	Symptom	Check Box
Convulsions/Seizures	☐	Headaches/Migraines (Headaches)	☐
Dizziness	☐	Paralysis	☐
Fainting Spells	☐	Psychiatric Care	☐
Gait/Coordination	☐	Stroke	☐
Trauma	☐	Tremor/Hand Shaking	☐
None	☐		

Harbor Physicians
PRIMARY CARE & INTERNAL MEDICINE

Patient's Name: _____ | DOB: _____

System 9: Hematologic & Endocrine (Blood, Glands, Hormones)

System/Symptom	Check Box	System/Symptom	Check Box
Become colder than before	☐	Abnormal Bruising or Bleeding	☐
Changes in Hair Growth	☐	Anemia	☐
Changes in hat or glove size	☐	Blood Disease	☐
Fatigue Sweating/Night Sweats	☐	Excessive Bleeding after tooth extraction	☐
Fever/Chills	☐	Phlebitis	☐
Frequent infections	☐	Slow to heal	☐
Goiter	☐	Hematologic: None	☐
Heat/cold intolerance	☐	Thyroid Disease	☐
Hormone Therapy	☐	Weakness/Paralysis	☐
Lymph node Enlargement	☐	Weight Change	☐
Sleep Problems	☐	Endocrine: None	☐

System 10: Mental Health (Please answer all that apply)

Question	Yes	No
Have you ever been diagnosed or treated for **Depression and/or Anxiety**?	☐	☐
Have you ever been diagnosed or treated for an **eating disorder** (e.g., anorexia/bulimia)?	☐	☐
Do you **panic when stressed**?	☐	☐
Do you have a problem with your **appetite when under stress**?	☐	☐
Do you **cry frequently**?	☐	☐
Have you ever **attempted suicide**?	☐	☐
Have you ever **seriously thought about hurting yourself**?	☐	☐
Do you have **trouble sleeping**?	☐	☐
Have you ever been to a **counselor**?	☐	☐
Have you been diagnosed or treated for **Bi-Polar disorder**?	☐	☐

Harbor Physicians
PRIMARY CARE & INTERNAL MEDICINE

Patient's Name: _____ | DOB: _____

System 11: Men Only (If applicable)

Question	Yes	No
Do you usually get up to **urinate during the night**?	☐	☐
Any **loss of libido or sex drive**?	☐	☐
Any **blood in your urine**?	☐	☐
Have you had any **kidney, bladder, or prostate infections** within the last 12 months?	☐	☐
Any difficulty with **erection or ejaculation**?	☐	☐

System 12: Women Only (If applicable)

Question	Yes	No
Heavy periods, irregularity, spotting, pain, or discharge?	☐	☐
Are you **pregnant or breastfeeding**?	☐	☐
Any **hot flashes or sweating at night**?	☐	☐
Do you have **menstrual tension, bloating, irritability, or other symptoms** at or around the time of your period?	☐	☐
Recurrent vaginal infections?	☐	☐
Pain/bleeding with sex?	☐	☐

Harbor Physicians
PRIMARY CARE & INTERNAL MEDICINE

Patient's Name: _____ | DOB: _____

Gynecological History (Women Only - Please Fill In)

Field	Response	Field	Response
Age at onset of menstruation:	_____	Date of last menstruation:	_____
Number of pregnancies:	_____	Length of cycle:	_____
Number of live births:	_____	Days of flow:	_____
Number of miscarriages:	_____	Birth control method:	_____
Number of abortions:	_____	Date of last PAP:	_____
		Date of last Mammogram:	_____

All Patients (Additional Comments)

Is there anything else that hasn't been covered above that you would like to add or explain?

_____

_____

My signature indicates the above information is correct.

Signature of Patient (or Guardian/Authorized Representative) Full Name (if not patient) Date

_____

Harbor Physicians
PRIMARY CARE & INTERNAL MEDICINE

2140 Kingsley Ave, Suite 1, Orange Park, FL 32073
Ph: 904-368-6809 | Fax: 904-368-6819

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____
Date of Birth: ____ / ____ / _____

Authorized Person(s)

I authorize Harbor Physicians to communicate with and release my protected health information (PHI) to the individual(s) listed below.

Name: _____
Relationship: _____
Phone Number: _____

Information Authorized for Release

This authorization includes, but is not limited to: appointments, billing/insurance information, medical records, lab/test results, and other related healthcare information.

Expiration

This authorization expires one (1) year from the date signed, unless otherwise specified below.

Other expiration date (if applicable): ____ / ____ / _____

Signature

Patient or Legal Representative Signature: _____
Printed Name (if Legal Representative): _____
Relationship to Patient (if Legal Representative): _____
Date: ____ / ____ / _____

Harbor Physicians
PRIMARY CARE & INTERNAL MEDICINE

Medical Records Release Form

Please complete this form to authorize the release of your medical records.

Patient Information

Name: _____ DOB: _____ Phone: _____

Address: _____

Records Release

IMPORTANT – OFFICE USE ONLY

Please do **NOT** complete the "Provider/Facility" section below. This section will be completed by our office to allow this authorization to be used for multiple providers and to ensure accurate processing of your request.

I authorize the release of my records FROM:

Provider/Facility: _____

Address: _____

Phone: _____ Fax: _____

TO BE RELEASED TO:

Provider/Facility: **Harbor Physicians**

Address: 2140 Kingsley Ave Suite 1, Orange Park, FL 32073

Phone: 904-368-6809 Fax: 904-368-6819

Information to be Released

☐ All records ☐ Specific: _____ ☐ Dates: _____ to _____

Purpose

☐ Continuation of care ☐ Personal ☐ Legal ☐ Insurance ☐ Other: _____

Expiration

This authorization expires 12 months from the date of signing unless otherwise specified:

_____

Authorization

I understand this authorization may be revoked in writing at any time, except to the extent that action has already been taken. Information disclosed may be subject to redisclosure.

Signature: _____ Date: _____

Representative (if applicable): _____ Relationship: _____

Harbor Physicians
PRIMARY CARE & INTERNAL MEDICINE
2140 Kingsley Ave STE 1, Orange Park, FL 32073
Phone: 904-368-6809 | Fax: 904-368-6819 | harborphysicians@gmail.com

Patient's Name: _____ | DOB: _____

HIPAA Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. Your Protected Health Information (PHI) includes your name, address, phone number, medical history, treatment information, and billing details.

Your Health Information Rights:

• Inspect and Copy: You have the right to inspect and copy your medical and billing records within 30 days of a written request.

• Request Amendment: You may request corrections to your records if you believe information is incomplete or inaccurate. We will respond in writing within 60 days, including reasons for denial if applicable.

• Request Confidential Communication: You may request we contact you by alternative means or at an alternative location.

• Request a Restriction: You may ask us not to use or disclose PHI for treatment, payment, or operations. We are not required to agree, but if we do, we will comply (except in emergencies).

• Accounting of Disclosures: You may request a list of disclosures made of your PHI. The first request within a 12-month period is free.

• Paper Copy: You have the right to obtain a paper copy of this notice at any time.

• File a Complaint: You may file a complaint with us or with the Secretary of Health and Human Services if you believe your privacy rights were violated.

• Authorize Other Use: Any use or disclosure not described in this notice requires your written authorization. You may revoke authorization in writing.

Use and Disclosure of Health Information:

• Treatment: To coordinate or manage your medical care with other providers.

• Payment: To obtain payment from your insurance company or third-party payer.

• Healthcare Operations: To support daily business operations such as quality improvement, audits, or staff training.

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Patient's Name: _____ | DOB: _____

• Public Health & Safety: To prevent disease, report abuse or neglect, and reduce serious threats to health or safety.

• Research: To conduct approved research studies under appropriate oversight.

• As Required by Law: When required by federal, state, or local law.

• Other Permitted Uses: Including FDA requirements, legal proceedings, coroners, national security, or worker's compensation matters.

We are required by law to maintain the privacy and security of your health information. We will notify you promptly if a breach occurs that may compromise your privacy or security. We reserve the right to change our privacy practices and will make the new notice available upon request.

By signing below, you acknowledge that you were advised of Harbor Physicians' HIPAA Notice of Privacy Practices.

Signature of Patient
or Responsible Party: _____ Date: _____

Harbor Physicians
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Phone: 904-368-6809 | Fax: 904-368-6819 | harborphysicians@gmail.com

Financial Policy and Assignment of Benefits

Patient Name: _____ DOB: _____

Please read each policy carefully, then **INITIAL** each statement to acknowledge understanding and agreement.

[ ] If I do not have my insurance card, referral, and/or co-payments, my appointment may be rescheduled until required documents or payments are provided.

[ ] I must pay all co-payments at the time of my visit and any procedure deductibles and coinsurance up to payment in full for the planned procedure.

[ ] Any overpayment will be refunded upon request after the insurance payment/remittance is received.

[ ] A $25 service fee will be added for any returned checks. The fee and check amount must be paid using certified funds (cashier's check, money order, or cash).

[ ] If I cannot keep a scheduled appointment, I must contact Harbor Physicians at least 24 hours in advance. A $25 fee applies to missed appointments and a $50 fee applies to missed procedures not canceled with 24-hour notice.

[ ] Accounts not paid in full within 90 days of the statement date will be charged a 35% collection agency processing fee and turned over to collections.

Harbor Physicians allows 60 days from the date of filing for insurance companies to process or pay a claim. I acknowledge that I am responsible for providing my insurance company with necessary information and am ultimately responsible for knowing my insurance benefits.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for services performed by the attending physician.

Signature of Responsible Party: _____ Date: _____

ASSIGNMENT OF BENEFITS

I authorize insurance payment of medical benefits directly to Harbor Physicians for services rendered. This assignment remains in effect until revoked by me in writing. A photocopy of this authorization is considered as valid as the original. I understand that I am financially responsible for all charges not paid by insurance and authorize the release of all medical information necessary to secure payment.

Signature of Responsible Party: _____ Date: _____

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Eligibility Waiver

Subscriber Information:

Full Name: _____

Social Security Number: _____

Date of Birth: _____

Effective Date (For Benefits Eligibility): _____

Patient Information (if different):

First Name: _____ Middle/MI: ____ Last Name: _____

I (The Above Named Person) hereby certify that I am eligible for benefits effective on the date stated above.

I have chosen Harbor Physicians to be my medical provider.

I understand if the above is not true, I am responsible for all charges related to services provided to me. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from Harbor Physicians.

Signature of Patient
or Responsible Party: _____ Date: _____

Harbor Physicians
PRIMARY CARE & INTERNAL MEDICINE

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Ph: 904-368-6809 | Fax: 904-368-6819

Patient Conduct & Discharge Acknowledgment

Patient Name: _____
Date of Birth: _____

Acknowledgment of Care Expectations

I understand that my healthcare provider and their staff are committed to providing safe, respectful, and effective care. In return, I agree to conduct myself in a respectful manner, follow the treatment plan recommended by my provider, and comply with office policies and instructions.

I understand that the following behaviors may result in my discharge from this practice:

- Repeatedly refusing or not following medical advice or treatment plans (non-compliance).
- Disruptive, abusive, or threatening behavior toward staff, other patients, or providers.
- Any action that interferes with the safe and effective delivery of care.

I acknowledge that if I engage in any of the above behaviors, my provider may decide to terminate the patient-provider relationship. If discharged, I will be provided with appropriate notice and resources to find alternative care.

By signing below, I acknowledge that I have read and understand this policy and agree to follow the expectations outlined above.

Patient Signature: _____ **Date:** _____

Provider/Staff Witness: _____ **Date:** _____