HARBOR PHYSICIANS
Primary Care & Internal Medicine

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

Patient Name: _____ DOB_____

New Patient Packet

Date: _____

Personal Information

Full Name: _____DOB: ____/ ____/ _____Age: _____

Sex: ☐ Male ☐ Female SSN: _____

Address: _____

City: _____State: _____Zip: _____

Home Phone: _____Cell: _____

Preferred Phone: ☐ Home ☐ Cell

Email: _____

Preferred Language: _____

Communication Preference: ☐ Call ☐ Email

Marital Status: _____

Race: _____Ethnicity: _____Religion: _____

Emergency Contact

Name: _____Relationship: _____

Phone: _____

Address: _____

Next of Kin (if different)

Name: _____Relationship: _____

Phone: _____

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Patient Name: _____ DOB_____

Insurance Information

Primary Insurance

Insurance Name: _____Plan Name: _____
Subscriber ID: _____Group #: _____
Primary Insured Name: _____DOB: _____
Relationship to Insured: _____SSN: _____
Phone: _____Driver's License: _____

Secondary Insurance

Insurance Name: _____Plan Name: _____
Subscriber ID: _____Group #: _____
Secondary Insured Name: _____DOB: _____
Relationship: _____SSN: _____
Phone: _____

Pharmacy

Preferred Pharmacy: _____
Location & Phone: _____

Employment

Employment Status: _____Job Title: _____

Employer: _____

Work Phone: _____

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Patient Name: _____ DOB_____

HEALTH HISTORY

Previous Providers

Previous Primary Care Provider
Name: _____
Clinic: _____
Phone: _____
Fax: _____
Address: _____
City: _____State: _____Zip: _____

Specialists (last 2–3 years)

1. Name: _____
   Specialty: _____
   Phone: _____Fax: _____
2. Name: _____
   Specialty: _____
   Phone: _____Fax: _____
3. Name: _____
   Specialty: _____
   Phone: _____Fax: _____

Previous Medical Facilities

1. Facility: _____
   Type: _____
   Phone: _____Fax: _____
2. Facility: _____
   Type: _____
   Phone : _____Fax: _____

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Patient Name: _____ DOB_____

Patient Acknowledgment of Accuracy

I understand that the information I provide in this form is important for my medical care. I certify that the information I provide is complete and accurate to the best of my knowledge.

Current Medical Conditions

Please check any conditions you have been diagnosed with:

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

Past Surgeries or Hospitalizations

Please list surgeries or hospitalizations with approximate year if known:

Medications

Please list all medications you currently take, including prescriptions, over-the-counter medications, vitamins, and supplements:

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Patient Name: _____ DOB_____

Allergies

Do you have any allergies to medications, foods, or environmental factors?

☐ No ☐ Yes → Please list:

Reaction(s):

Family Medical History

Please indicate if any immediate family member has had the following conditions:

☐ Diabetes ☐ High blood pressure ☐ heart disease

☐ Stroke ☐ Cancer

☐ Other: _____

Detailed Family History

List medical conditions and/or cause of death if applicable:

Mother: _____
Father: _____
Siblings: _____
Spouse: _____
Children: _____
Additional: _____

Comments:

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Patient Name: _____ DOB_____

Lifestyle

Do you currently smoke?

☐ No

☐ Yes → How much? _____

Do you drink alcohol?

☐ No / No

☐ Yes → How often? _____

Do you use recreational drugs?

☐ No

☐ Yes → Please list: _____

Do you exercise regularly?

☐ No

☐ Yes → Type, frequency, intensity _____

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Patient Name: _____ DOB_____

Review of Systems

System 1: General Health

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Arthritis	☐	☐	Back Pain	☐	☐	Bone Fracture	☐	☐
Cancer	☐	☐	Diabetes	☐	☐	Foot Pain	☐	☐
Gout	☐	☐	Headaches	☐	☐	Joint Pain	☐	☐
Memory Loss	☐	☐	Muscle Weakness	☐	☐	Numbness / Tingling	☐	☐
Obesity	☐	☐	Osteoporosis	☐	☐	Rheumatic Fever	☐	☐
Weight Loss	☐	☐	Fever / Chills	☐	☐	None	☐	☐

System 2: Skin, Hair, & Nails

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Abnormal Pigmentation	☐	☐	Boils	☐	☐	Brittle Nails	☐	☐
Dry Skin	☐	☐	Eczema	☐	☐	Frequent Infections	☐	☐
Hives	☐	☐	Itching	☐	☐	Jaundice	☐	☐
Psoriasis	☐	☐	Rash	☐	☐	Skin Disease	☐	☐
Hair/Nail Changes	☐	☐	None	☐	☐			

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Patient Name: _____ DOB_____

System 3: Respiratory

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Any Lung Troubles	☐	☐	Asthma or Wheezing	☐	☐	Bronchitis	☐	☐
Chronic / Frequent Cough	☐	☐	Shortness of Breath	☐	☐	Difficulty Breathing	☐	☐
Pleurisy / Pneumonitis	☐	☐	Spitting up blood	☐	☐	URI (Cold) Now	☐	☐
None	☐	☐						

System 4: Cardiovascular

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Awakening in night smothering	☐	☐	Chest Pain / Angina	☐	☐	Congestive Heart Failure	☐	☐
Cyanosis	☐	☐	Difficulty walking 2 blocks	☐	☐	Edema / Swelling	☐	☐
Heart Attacks	☐	☐	Heart Murmur	☐	☐	Heart Trouble	☐	☐
High Blood Pressure	☐	☐	Irregular Heartbeat	☐	☐	Pain in legs	☐	☐
Palpitations	☐	☐	Poor Circulation	☐	☐	Varicose Veins / Phlebitis	☐	☐
None	☐	☐						

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System 5: Gastrointestinal

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Abdominal Pain	☐	☐	Appetite Changes	☐	☐	Black Stools	☐	☐
Bleeding with Bowel Movements	☐	☐	Blood in Vomit	☐	☐	Crohn's Disease / Colitis	☐	☐
Constipation	☐	☐	Cramping / Abdominal Pain	☐	☐	Difficulty Swallowing	☐	☐
Diverticulosis	☐	☐	Gallbladder Disease	☐	☐	Gas / Bloating	☐	☐
Heartburn / Indigestion	☐	☐	Hemorrhoids / Piles	☐	☐	Hepatitis	☐	☐
Hernia	☐	☐	Liver Trouble	☐	☐	Nausea / Vomiting	☐	☐
Painful Bowel Movements	☐	☐	Peptic Ulcer	☐	☐	Frequent Diarrhea	☐	☐
Recent change in bowel habits	☐	☐	None	☐	☐			

System 6: Genitourinary

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Blood in Urine	☐	☐	Bright's Disease	☐	☐	Burning or Painful Urination	☐	☐
Decrease in force/flow	☐	☐	Frequent Urination	☐	☐	Kidney Stones	☐	☐
Kidney Trouble	☐	☐	Night time Urinating	☐	☐	Prostate Problems	☐	☐
None	☐	☐						

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Patient Name: _____ DOB_____

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

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Blurring	☐	☐	Double Vision	☐	☐	Eye Disease or Injury	☐	☐
Eye Pain / Discharge	☐	☐	Glasses	☐	☐	Glaucoma	☐	☐
Itchy Eyes	☐	☐	Vision Changes	☐	☐	Ear Disease	☐	☐
Ear Infections	☐	☐	Ears ringing	☐	☐	Hearing problems	☐	☐
Impaired Hearing	☐	☐	Chronic Sinus Trouble	☐	☐	Itchy Nose	☐	☐
Nosebleeds	☐	☐	Postnasal drip	☐	☐	Sinusitis	☐	☐
Sneezing / Runny Nose	☐	☐	Gum Bleeding	☐	☐	Hoarseness	☐	☐
Loss of Taste	☐	☐	Sore Throat	☐	☐	Mononucleosis	☐	☐
Sores	☐	☐	None	☐	☐			

System 8: Hematologic & Endocrine

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Become colder than before	☐	☐	Changes in Hair Growth	☐	☐	Changes in hat	☐	☐
Fatigue	☐	☐	Sweating / Night Sweats	☐	☐	Fever / Chills	☐	☐
Frequent infections	☐	☐	Goiter	☐	☐	Heat / Cold intolerance	☐	☐
Hormone Therapy	☐	☐	Lymph Node Enlargement	☐	☐	Sleep Problems	☐	☐
Abnormal Bruising	☐	☐	Anemia	☐	☐	Blood Disease	☐	☐
Excessive bleeding after tooth extraction	☐	☐	Phlebitis	☐	☐	Slow to heal	☐	☐
Thyroid Disease	☐	☐	Weakness / Paralysis	☐	☐	Weight Change	☐	☐
None:	☐	☐						

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Patient Name: _____ DOB_____

System 9: Neurological

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Convulsions / Seizures	☐	☐	Dizziness	☐	☐	Fainting Spells	☐	☐
Gait / Coordination /	☐	☐	Trauma	☐	☐	Headaches / Migraines	☐	☐
Paralysis	☐	☐	Psychiatric Care	☐	☐	Stroke	☐	☐
Tremor / Hand shaking	☐	☐	None	☐	☐			

System 10: Mental Health

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Depression / anxiety	☐	☐	Eating Disorder	☐	☐	Panic when stressed	☐	☐
Appetite Problems	☐	☐	Cry frequently	☐	☐	Attempted suicide	☐	☐
Seriously thought about hurting self	☐	☐	Trouble sleeping	☐	☐	Counseling	☐	☐
Bi-Polar disorder	☐	☐						

System 11: Men Only

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Night urination	☐	☐	Loss of libido	☐	☐	Blood in urine	☐	☐
Kidney/Bladder/Prostate infection (last 12 mo)	☐	☐	Difficulty with erection / ejaculation	☐	☐			

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Patient Name: _____ DOB_____

System 12: Women Only Gynecologic History

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Heavy periods / Irregular / Spotting / Pain	☐	☐	Pregnant / Breastfeeding	☐	☐	Hot flashes / Night sweats	☐	☐
Menstrual tension / Bloating / Irritability	☐	☐	Recurrent vaginal infections	☐	☐	Pain / Bleeding with sex	☐	☐

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	_____		

Additional Comments

Is there anything else your care team should know?

_____

_____

Signature of patient or responsible party: _____

Date: _____

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MEDICAL RECORDS RELEASE FORM

Patient Information

Name: _____
DOB: _____
Phone: _____
Address: _____
_____

Records Release (Office Use Only)
Do NOT complete provider section
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.
FROM Provider/Facility: _____
_____
Address: _____
Phone: _____Fax: _____

TO: Harbor Physicians, 2140 Kingsley Ave Suite 1, Orange Park, FL 32073 Phone: 904-368-6809 Fax: 904-368-6809

Records to be Released:

☐ All ☐ Dates _____ to _____ ☐ Specific _____

Purpose:

☐ Continuity ☐ Personal ☐ Legal ☐ Health Insurance ☐ Other _____

Authorization expires 12 months from signature unless otherwise noted.

Signature: _____ Date: _____
Representative (if applicable): _____
Relationship: _____

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Patient Name: _____ DOB_____

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

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

☐ I do NOT authorize Harbor Physicians to release my PHI to any individual. I understand that I am choosing not to designate any authorized person.

Name: _____
Relationship: _____
Phone Number: _____

(Additional names may be listed if applicable)

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: _____/ _____/ _____

Signature Patient or Representative Signature: _____
Printed Name: _____
Relationship: _____
Date: _____/ _____/ _____

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Patient 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 Rights

- You have the right to inspect and copy your medical and billing records within 30 days of a written request.
- You may request corrections if information is incomplete or incorrect.
- You may request confidential communication.
- You may request restrictions on use or disclosure.
- You may request a list of disclosures.
- You have the right to a paper copy of this notice.
- You may file a complaint if your rights are violated.
- Use and Disclosure
- We may use your information for treatment, payment, and healthcare operations.
- We may disclose information as required by law.

Patient or Representative Signature: _____
Printed Name: _____
Relationship: _____
Date: ____/ ____/ _____

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Patient Name: _____ DOB_____

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

1. Insurance and Appointment Requirements

I understand that it is my responsibility to provide valid insurance information, referral authorization (if required), and applicable copayment at the time of service. Failure to provide required documentation or payment may result in rescheduling or cancellation of my appointment.

2. Copayments and Time-of-Service Payment

I agree to pay all copayments, coinsurance, and any patient-responsible balances at the time of my visit unless prior arrangements have been made.

3. Returned Payments and Administrative Fees

A fee of $25.00 will be charged for any returned or declined payment, including returned checks or failed electronic payments, as permitted by applicable law.

4. Missed Appointments / No-Shows

I understand that missed appointments or late cancellations may result in a no-show fee, and repeated missed appointments may affect my ability to continue care with this practice.

5. Insurance Billing and Patient Responsibility

I authorize this practice to bill my insurance carrier directly. I understand that insurance coverage is a contract between me and my insurance company, and I am financially responsible for all charges not covered by insurance, including deductibles, copayments, coinsurance, and non-covered services.

6. Delinquent Accounts and Collections

Accounts not paid in a timely manner may be referred to a third-party collection agency. I agree to be responsible for all costs of collection, including reasonable collection fees, attorney fees, and court costs, if applicable.

7. Assignment of Benefits

I authorize payment of medical benefits directly to Harbor Physicians for services rendered. This authorization remains valid until revoked in writing.

8. Eligibility Certification

I certify that I am eligible for insurance benefits at the time services are rendered. If this certification is incorrect, I understand that I am financially responsible for all charges incurred.

9. Payment Agreement

I agree to pay any outstanding balances within 30 days unless other arrangements have been approved in writing by the practice.

Patient Signature: _____Date: _____

Staff Witness: _____

Date: _____

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PATIENT CONDUCT & DISCHARGE ACKNOWLEDGMENT

Patient Name: _____
Date of Birth: _____

---

1. Acknowledgment of Standards of Care

I understand that this medical practice is committed to providing safe, professional, and medically appropriate care in accordance with applicable clinical standards and policies. I acknowledge that respectful communication and cooperation are necessary for the delivery of effective medical care.

2. Required Patient Conduct

I agree to:

- Communicate respectfully with all providers, staff, and other patients.
- Follow agreed-upon treatment plans or actively discuss concerns before refusing care.
- Comply with clinic policies, instructions, and scheduled appointments.
- Refrain from behavior that disrupts clinic operations or the delivery of care.

3. Behavior That May Result in Discharge

I understand that the following behaviors are considered incompatible with ongoing care in this practice and may result in discharge from the practice, either immediately or after notice at the provider's discretion:

a. Noncompliance

Repeated refusal to follow medical advice, failure to adhere to treatment plans, or repeated missed appointments that compromise care continuity.

b. Disruptive or Inappropriate Behavior

Verbal abuse, harassment, intimidation, profanity, or disruptive behavior toward staff, providers, or other patients.

c. Threatening or Unsafe Behavior

Any threats of violence, aggressive conduct, or actions that create a perceived or actual risk to safety.

d. Interference with Care Delivery

Any action that interferes with clinical workflow, staff duties, or the safe and effective provision of medical services.

4. Termination of Care Relationship

I understand that the provider reserves the right to terminate the patient-provider relationship when clinically or administratively appropriate. This includes situations involving repeated noncompliance, disruptive behavior, safety concerns, or breakdown of trust necessary for care.

If terminated, I understand I may be provided with written notice and reasonable assistance or resources to transition care to another provider, consistent with applicable regulations and continuity of care standards.

5. Acknowledgment of Understanding

By signing below, I acknowledge that I have read, understood, and agree to comply with the terms outlined in this Patient Conduct and Discharge Policy.

Patient Signature: _____ Date: _____

Staff Witness: _____

Date: _____

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TELEHEALTH CONSENT FORM (Required for Telehealth Visits)

Patient Information

Name: _____ DOB: _____

Consent

I consent to receive healthcare via telehealth (video, audio, or secure electronic communication).
I understand telehealth may be used for evaluation, diagnosis, treatment, and follow-up care, but does not replace all in-person visits.
My provider may require an in-person visit if medically necessary.

Florida Compliance

I understand my provider is licensed in Florida and provides telehealth under Florida Statutes §456.47.
Telehealth services meet the same standard of care as in-person services when clinically appropriate.
Some services, prescriptions, or medications may be limited by Florida law or clinical judgment.

Risks

I understand risks include:

- Technical failure or interruption
- Limited physical examination
- Possible delays in care
- Rare privacy/security risk

Privacy

My information is protected under HIPAA and Florida law, but no electronic system is 100% secure.

Patient Rights

I may refuse or stop telehealth at any time and request in-person care when available.

Emergency Notice

Telehealth is not for emergencies. Call 911 or go to ER if needed.

Consent Statement

I understand and voluntarily agree to telehealth services.

Patient: _____ Signature: _____
Date: _____