



ORTHOPEDIC / SPORTS / HANDS / OCCUPATIONAL HEALTH

PERSONAL MEDICAL HISTORY

The following is for your personal medical history (not family). If you have been treated/diagnosed for any of the following, please briefly describe treatment and/or medications.

Patient Name: _____ Date: _____

Form with YES/NO columns and medical conditions: High Blood Pressure, Heart Disease, Heart Surgery, Heart Attack, Pacemaker, Bleeding Disorders, Circulation Disorders, Stroke, Diabetes, Epilepsy, Problems w/Eyes, Problems w/Ears, Currently Pregnant, Allergies, Asthma, Respiratory Problems, Cancer, Metal Implants, Raynaud's Phenomenon, Infections, Major Surgery, Current Medications, Other/Miscellaneous.

Signed: _____ Date: _____

Persmedhis.rev 5/06

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Signed: _____ Date: _____

CENTERS OF EXCELLENCE

Bellevue Center
10251 S US Hwy 441
Suite #3
Bellevue, FL 34420
352/307-1200
352/307-7812 Fax

Leesburg Center
North Lake Plaza
1708-5 Citrus Blvd
Leesburg, FL 34748
352/315-9006
352/315-9007 Fax

Maricamp Road Center
2620 SE Maricamp Rd
Ocala, FL 34471
352/351-8883
352/351-4219 Fax

West Marion Center
4600 SW 46th Court
Suite #140
Ocala, FL 34474
352/873-3058
352/873-3726 Fax

17th Street Center
1015 SE 17th St
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