Sam S Miller, MD,FACE,PA SAM Clinical Research Center

First Name _____ Middle Initial _____

Last Name _____ Date of Birth _____

Gender ☐ Male ☐ Female Marital ☐ Single ☐ Married

Race ☐ White ☐ Af-American ☐ Asian ☐ Other_____

Ethnicity ___ Hispanic/Latino ___ Not Hispanic

Years of School _____ Occupation _____

Phone Home _____ Work _____Cell_____

Street Address _____ Apt_____

City, State. Zip _____

SS # _____

email _____

Have Caregiver? ☐ Yes ☐ No

Share Health Info?

Physician Name _____ ☐ Yes ☐ No

Physician Phone _____

Physician Fax _____

Contact Name _____ ☐ Yes ☐ No

Contact Phone _____

Contact Name _____ ☐ Yes ☐ No

Contact Phone _____

Protected Health Information

I have read the Notice of Privacy Practices detailing how my personal health information (PHI)
My PHI may be used and disclosed as required or permitted by law and my rights regarding my PHI.
I've been given the opportunity, and I elect **not** to place any restrictions on disclosure of my PHI.

I give Sam S Miller, MD, FACE, PA the following permissions:

1. To request my medical records from any of my past, current, and future healthcare providers.
2. To retain and review my PHI in its databases and files to identify possible research participants.
3. To contact me for any research studies for which I may qualify.
4. To inform and discuss with my PCP of my study participation if I enroll in a clinical research study.

I understand the following about Procedures, Prescriptions and My Medications:

New prescriptions and refills will be handled only in person by Dr. Miller during my visit.
I shall inform Dr Miller of changes in my medical history and will bring my meds to visits.
Dr. Miller is not responsible for insurance denials of procedures or precriptions he recommends.

Understanding and Agreement

I have had opportunities to ask questions about the above, all answered to my satisfaction
I agree to all of the above and understand that I must make any changes to these authorizations in writing.

I am registering for: ☐ Clinical Research
☐ Private Care. I agree to pay for private care services.

_____ _____

Patient Signature Date

STAFF USE ONLY:Entered in Breeze by/date _____ Patient ID _____

√	Illness	Date Onset
□	Seasonal Allergy	_____
□	Angina pectoris	_____
□	Coronary Artery Disease	_____
□	Heart Attack	_____
□	Heart Failure	_____
□	Hypertension	_____
□	Swelling	_____
□	Fever	_____
□	Weight loss	_____
□	Diabetes	_____
□	High Cholesterol	_____
□	High Triglyceride	_____
□	Hyperthyroid	_____
□	Hypothyroid	_____
□	Menopause	_____
□	Glaucoma	_____
□	Retinopathy	_____
□	Chronic Constipation	_____
□	Chronic Diarrhea	_____
□	Chronic Nausea	_____
□	Colon polyps	_____
□	GERD	_____
□	Ulcer	_____
□	Chronic UTIS	_____
□	Chronic vaginal discharge	_____
□	Erectile dysfunction	_____
□	Fibrocystic Breasts	_____
□	Irregular menses	_____
□	Prostatic hypertrophy	_____
□	STD	_____
□	Sterilization	_____
□	Anemia	_____
□	HIV/Aids	_____
□	Gall Stones	_____
□	Hepatitis	_____
□	Carpal Tunnel	_____
□	Chronic Back Pain	_____
□	Chronic Neck Pain	_____

√	Illness	Date Onset
□	Cancer	_____
□	Melanoma	_____
□	Diabetic peripheral neuropathy	_____
□	Fainting	_____
□	Headaches	_____
□	Insomnia	_____
□	Migraines	_____
□	Seizures	_____
□	Stroke	_____
□	TIA	_____
□	Anxiety	_____
□	Bipolar	_____
□	Depression	_____
□	Kidney Failure	_____
□	Kidney Stones	_____
□	Asthma	_____
□	COPD	_____
□	Short of Breath	_____
□	Sleep Apnea	_____
□	Rheumatoid Arthritis	_____
□	Basal cell cancer	_____
□	Osteoarthritis	_____
□	Osteoporosis	_____

Operations	□ None	Date
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____

Patient Initials _____ Date _____

Medication	Dosage	Times Daily	Start Date

Alcohol History				Smoking History			
___Never			#/d	☐ Never			#/d
☐ Current	Start Date	_____	_____	☐ Current	Start Date	_____	_____
☐ Ex	Stop Date	_____	_____	☐ Ex	Stop Date	_____	_____

Family History: Illnesses and Causes of Death

Relationship to you	Illnesses	Causes of Death

Patient Initials _____ Date _____

STAFF USE ONLY: Entered in Breeze by/date _____ Patient ID _____