JEFFREY A. ALPER, M.D., P.A.

○ JEFFREY A. ALPER, M.D ○ ALAIN ALVAREZ, M.D. ○ TERRY L. SMITH, ARNP

○ NATHAN WARDER, ARNP ○ KATE GRIGOL, NP

PATIENT:

LAST: _____ FIRST: _____ MI: _____ D/O/B _____

ALLERGIES

DO YOU HAVE ANY MEDICATION ALLERGIES? YES _____ NO _____

IF YES, TO WHAT? _____

TYPE OF REACTION: _____

YOUR MEDICATION LIST: LIST ANY MEDICATIONS YOU ARE TAKING AT THIS TIME. **INCLUDING** SUCH ITEMS AS ASPIRIN, VITAMINS, LAXATIVES, AND CALCIUM SUPPLEMENTS & ETC.

NAME OF DRUG	DOSE/STRENGTH # OF PILLS/DAY	HOW LONG HAVE HAVE YOU BEEN ON IT?	DID IT HELP? A LOT	SOME	NOT AT ALL
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

PHARMACY NAME:

_____

ADDRESS: _____

TELEPHONE: _____

PATIENT SIGNATURE: _____ DATE: _____/ _____/ _____

REVIEWED BY: _____

JEFFREY A. ALPER M.D., P.A.

REQUEST MEDICAL RECORDS

○ JEFFREY A. ALPER, M.D ○ ALAIN ALVAREZ, M.D. ○ TERRY L. SMITH, ARNP
○ NATHAN WARDER, ARNP ○ KATE GRIGOL, PA

○ **NAPLES** ○ **BONITA**

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION:

PATIENT NAME: _____ **D/O/B:** _____/_____/_____

PREVIOUS NAME: _____ **SOCIAL SECURITY#:** _____-_____-_____

I REQUEST AND AUTHORIZE

_____ TO:

RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO:

☐

JEFFREY A. ALPER M.D., P.A.
6605 HILLWAY CIR, UNIT 101
NAPLES, FL 34112
FAX: (239) 261-9658

☐

JEFFREY A. ALPER M.D., P.A.
9410 FOUNTAIN MEDICAL COURT
BONITA SPRINGS, FL 34135
FAX: (239) 261-9658

THIS REQUEST AND AUTHORIZATION APPLIES TO:

☐ HEALTHCARE INFORMATION RELATING TO THE FOLLOWING TREATMENT, CONDITION OR DATES: _____

_____

☐ ALL HEALTHCARE INFORMATION

☐ OTHER_____

PATIENT SIGNATURE: _____ **DATE:** _____/_____/_____