BROWARD FAMILY MEDICAL group

Patient's Personal History & Health Assessment Date: _____

Patient Name: _____ **D.O.B.** _____ **Gender:** _____

Soc. Sec. #: _____ **Race:** _____ **Language:** _____

Patient Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____ **Cell Phone: (_____)** _____

Communication Preference: Email ☐ **US Mail** ☐ **Home phone** ☐ **Cell phone** ☐ **Work** ☐ **Patient Portal** ☐

Employer: _____ **Employer Phone: (_____)** _____

Nearest Relative/kin: _____ **Relationship:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: (_____) _____ **Work: (_____)** _____

Date of Last Physical Exam: _____ **Physician:** _____

Pharmacy Name: _____ **Address:** _____
City: _____ **Zip Code:** _____ **Phone: (_____)** _____ **Fax: (_____)** _____

Medical Equipment:
Do you use a Cane ☐ Oxygen ☐ Walker ☐ Wheelchair ☐ Nebulizer ☐
Do you own or rent this equipment? _____
Do you use Glasses? Yes ☐ No ☐ Date of last eye Exam? _____ Hearing Aid ☐

Social History:
Alcohol ☐ Smoking ☐ Drugs ☐ Other ☐
Religion: _____

Marital Status:
Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated ☐ Live Alone ☐

Immunizations:

Pneumococcal ☐ Rubella ☐ Tetanus ☐ Influenza ☐ Diptheria ☐ Other ☐

Family History:

	Alive	Dead	Age	Cause of Death
Mother				
Father				
Brother				
Sister				

Living Arrangements **Yes** **No**

Do you own your home ☐ ☐
Do you rent your home? ☐ ☐
Do you live alone? ☐ ☐
Do you have a will? ☐ ☐
Do you have a living will? ☐ ☐
Do you need other legal assistance? ☐ ☐
Do you have an Advanced Directive? ☐ ☐
Do you have surrogate decision letter? ☐ ☐

Personal Habits

Have you ever smoked tobacco? ☐ ☐
Are you a regular smoker now? ☐ ☐

Number of cigarettes per day _____ Cigars ☐ Pipe ☐

How long have you been smoking? _____ Number of years

Check if you regularly drink: Social/ occasional drinker ☐

Hard liquor 1-3 oz. per day ☐ Over 3 oz. per day ☐
Beer 1 bottle per day ☐ 2 bottles ☐ 3 or more ☐
Wine 1 glass per day ☐ 2 glasses ☐ 3 or more ☐
Dou you drink coffee? Yes ☐ No ☐ 3 or more cups ☐

Do you exercise?
Regularly ☐ Occasionally ☐ Rarely ☐

Have you used any of the following:

Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Speed ☐ other similar substances ☐

Lifestyles (optional)	Yes	No
Are you sexually active?		

If yes, please answer the following questions:
Sexual preference-

Partner same sex		
Partner opposite sex		
Partners of both sexes		
Do you consistently use contraceptives?		

Activities of Daily Living	Yes	No
Do you use a catheter for urine?		
Do you have a problem using the toilet? (for urination bowel movement)		
Do you drive?		
Occupational		
Are you presently employed?		
Does or did your work involve unusual work, exposure to dust, noise, radioactivity etc.?		
Are you limited at work because of disability?		
Are you retired?		

Types of work you have done:

_____

_____

_____

Social History

Have you recently lived or traveled outside the U.S.?
Yes ☐ No ☐

Do you eat less than three meals a day?
Yes ☐ No ☐

Do you have special food customs or restrictions?
Yes ☐ No ☐

Do you use any community services now?
Yes ☐ No ☐

Check if you have/had any of the following illnesses. If unsure, leave blank:

Condition/Illnesses	Self	No	Relative
Alcohol overuse			
Allergies (other than medication)			
Anemia			
Arthritis			
Asthma			
Bleeding Tendency			
Cancer			
CVA/TIA			
Colitis			
Heart Disease (CHF, CAD,MI)			
Depression/Anxiety			
Diabetes			
Dialysis			
Emphysema/COPD/Bronchitis			
Epilepsy			
Frequent Kidney/Bladder infection			
Frequent Lung Infections			
Gallbladder Disease			
Cardiac Arrhythmias/ pacemaker			
Gout			

Condition/Illness	Self	No	Relative
Heart Attack			
High Cholesterol			
Hepatitis			
High Blood Pressure			
Intestinal Polyps			
Jaundice			
Leukemia			
Headaches			
Nervous Break Down			
Radiation or Chemotherapy			
Rheumatic Fever			
Sexually Transmitted Disease			
Sickle Cell Anemia			
Stomach Ulcers			
Stroke			
Suicide Attempt			
Thyroid			
Tuberculosis			
Osteoporosis/Fracture history			
Sleep Apnea			

Childhood Illness:

Measles ☐ Mumps ☐ Chicken Pox ☐ Hay Fever ☐ Other ☐

Operations: List and Indicate approximate year.

_____

_____

_____

Serious Injuries: (other than the above) List and Indicate approximate year.

_____

_____

_____

Hospitalizations: (other than operations)

_____

_____

_____

_____

Medications:

Do you take the following:

- ☐ Aspirin, Bufferin, Anacin, Tylenol or similar product
- ☐ Motrin, Advil
- ☐ Vitamins
- ☐ Other prescription or over the counter drugs

List each drug, its amount and how often you take it.

Are you allergic to any medications? Yes ☐ No ☐

If yes, please list the medications and the reaction you had with them:

Do you have any environmental or food allergies? Yes ☐ No ☐

If yes, please list them and the reaction you had to them:

PLEASE BRING ALL YOUR MEDICATION YOU'RE TAKING TO EVERY APPOINTMENT!

Please check "***YES***" to the following questions **ONLY** if the problem is of significant concern in the past (1 month) or unless the question specifically states "***EVER***."

Review of Systems:

General:	Yes	No
Do you usually feel persistently tired or worn out?		
Have you recently been drinking more waters or fluids?		
Has there been any unusual weight gain or loss recently?		
Cardiovascular	**Yes**	**No**
Do you have pain, tightness or pressure in the front or back of your chest?		
Have you been told your electrocardiogram was abnormal?		
Do you have swelling in your feet or ankles?		
Does your heart ever beat fast or irregularly?		
Do you have cramps in the calf muscles when you walk?		
Do your fingers or toes ever get cold, become numb, or get very white or bluish?		
Central Nervous System	**Yes**	**No**
Dou you often have spells of dizziness, faintness or lightheadedness?		
Do you have frequent headaches?		
Have you recently fainted, blacked out, lost consciousness? Do you have trouble remembering recent events?		
Do you ever have convulsions or fits?		
Have you ever wanted to commit suicide?		
Do you ever hear voices or see people when no one is around?		
Eyes	**Yes**	**No**
Do you experience pain in your eyes?		
Did you have glaucoma or cataract?		
Have you experienced changes in your vision?		
Have you experienced halo around lights?		
ENT: (Ear, Nose, Throat)	**Yes**	**No**
Do you have any trouble hearing?		
Do you have ringing or buzzing in your ears?		
Do you have earaches or discharge from your ears?		
Do you have drainage down the back of your throat?		
Do you have frequent or sever nosebleeds?		
Do you have persistent hoarseness?		
Gastrointestinal	**Yes**	**No**
Have you recently had any changes in your eating habits?		
Have you recently noted any trouble in swallowing?		
Do you have a lot of indigestion or heartburn?		
Have you ever vomited blood?		
Are you bothered with constipation?		
Do you have frequent loose stools or diarrhea?		
Skin	**Yes**	**No**
Do you have any changes in the color of your skin?		
Do you have any rashes or itching?		
Do you have any growths or lumps on your skin?		
Do you have any sores or wounds that do not heal?		
Do you have any changes in the color or size of warts or moles?		
Genitourinary	**Yes**	**No**
Do you have burning or pain when you urinate?		
Do you have to pass water frequently?		
Do you have to get up at nights?		
Do you have trouble with loosing urine when you cough or sneeze?		
Have you ever passed blood in your urine?		
Have you ever had an operation to prevent pregnancy? (Vasectomy or sterilization, such as tubal ligation)		
Have you had herpes?		
Musculoskeletal	**Yes**	**No**
Do you have joint pain or stiffness (arthritis)?		
Do you ever have a problem with back pain?		
Does your back pain interfere with your work or activities?		
Do you have trouble walking or using your hip, knee joints?		
Respiratory	**Yes**	**No**
Do you have frequent chest colds or pneumonia?		
Do you have a constant or bothersome cough?		
Do you have blood when you cough?		
Do you have difficulties breathing?		

Do you have wheezing in your chest?		
Women Only	**Yes**	**No**
Did you have any pregnancies?		

Total number of pregnancis? _____

Have you had any lumps in your breast?		

Have you had any abnormal bleeding from the vagina in the past year?		
Have you passed the menopause or change?		
Do you have any prolapse(falling out)of the vagina or uterus?		
Have you had a hysterectomy?		
Do you have any vaginal drainage?		
Men Only: Do you have prostate gland trouble?		

PAIN ASSEESSMENT:

PAIN: YES _____ NO_____ LOCATION:_____

COMMENTS: _____

_____

_____

_____

_____

TREATMENT PLAN: _____

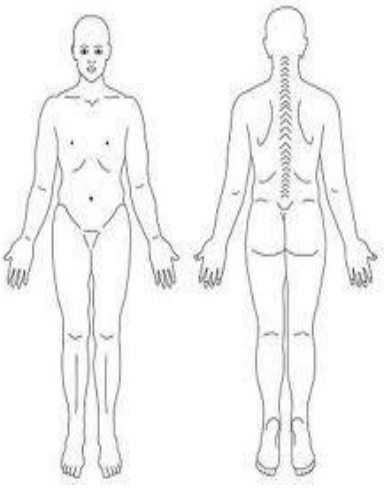
_____

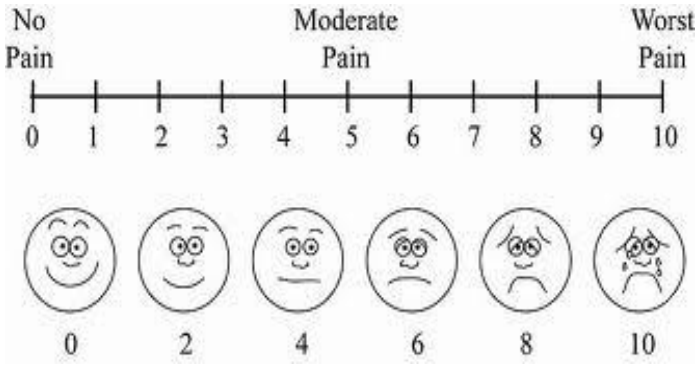
_____

_____

_____

Please draw where the primary pain is located using the diagram below





BROWARD FAMILY MEDICAL group

CONSENT FOR TREATMENT

I HEREBY CONSENT TO AND AUTHORIZE A PHYSICIAN AND/OR ANY HEALTH CARE PROFESSIONAL AT BROWARD FAMILY MEDIAL GROUP TO PERFORM A PHYSICIAL EXAMINATION, DIAGNOSTIC PROCEDURE(S) AND TO PRESCRIBE A THERAPEUTIC REGIMEN. I HEREBY AUTHORIZE THE PHYSIAN(S) OF BROWARD FAMILY MEDICAL GROUP TO RELEASE/COLLECT INFORMATION INCLUDING DIAGNOSIS ACQUIRED IN THE COURSE OF MY EXAM TO/FROM ANY HEALTHCARE FACILITIES, PHYSICIANS, OR INSURANCE CARRIERS.

PATIENT SIGNATURE: _____

DATE: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I HAVE BEEN GIVEN A COPY OF THE PRIVACY PRACTICES AND I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW IT.

PATIENT SIGNATURE: _____

PATIENT NAME: _____

DATE: _____

PATIENT DATE OF BIRTH: _____

2701 NE 14 Street Causeway Suite 5 Pompano Beach, FL 33062
Phone: (954) 545-1560 Fax: (954) 545-1561

INSURANCE INFORMATION AND RELEASE

Patient Name: _____

Who is Responsible for this Account: _____

Date of Birth: _____Social Security Number: _____

Insurance Company: _____

Member Id: _____ Group #:_____

Subscriber's Name:_____

Relationship to Patient:_____

Is the patient covered by additional insurance? _____Yes _____No

Secondary Insurance:_____

Member Id: _____ Group #:_____

Insurance Assignment and Release

I certify that I have insurance with _____, and assign directly to Broward Family Medical Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Broward Family Medical Group, for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____ _____

Printed Name of Patient, Guardian or Personal Representative Relationship to Patient

2701 NE 14 Street Causeway Suite 5 Pompano Beach, FL 33062
Phone: (954) 545-1560 Fax: (954) 545-1561

BROWARD FAMILY MEDICAL group

Waskin
☐ Routine
☐ Archive
☐ STAT

2701 NE 14TH Street Causeway, Ste 5, Pompano Beach, FL 33062

Fax: 954-545-1561

CONSENT TO RELEASE MEDICAL, PSYCHIATRIC, AIDS/ARC/HIV TESTING, ALCOHOL OR DRUG ABUSE PATIENT RECORDS

1. I hereby authorize my Physician at Broward Family Medical Group:
   - To RELEASE copies of my medical records to:_____
   - To RECEIVE copies of my medical records from: _____

     _____

     _____

2. I understand that my records may contain information pertaining to my diagnosis or treatment of my Medical, Psychiatric, AIDS/ARC/HIV Testing, Alcohol or Drug Abuse Condition. I also understand that any topic discussed during my medical treatment was documented, and therefore, will be released.

   _____ _____

   Signature Date

3. Information to be released/requested: (please circle)

   OFFICE NOTES LABS X-RAYS EKG HOLTER ECHO

   D/C SUMMARY OP NOTES DX ALL MEDICAL RECORDS

   DATES OF SERVICE (S): _____

4. I understand that this release can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. To revoke this consent, written notice must be given.

5. This consent expires in : _____

6. Broward Family Medical Group is released from any legal responsibility of liability; for the release of the above information to the extent indicated and authorized herein.

Signed:_____ Date: _____

Print Patient Name: _____

Patient SS#: _____ Date of Birth: _____

Assignment of Benefits Form

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other auto/health/medical plan, to issue payment check(s) directly to Broward Family Medical Group medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Broward Family Medical Group to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Broward Family Medical Group on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature Date

Witness Date

BROWARD FAMILY MEDICAL group

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will allow another person who is waiting for an appointment to be scheduled in that appointment slot.

Office appointments which are cancelled with less than 24 hours notification may be subject to a $25.00 cancellation fee.

Patients who do not show up for their office or blood work appointment without a call to cancel will be considered as NO SHOW. Patients who No-Show three (3) or more times in a 12 month period may be dismissed from the practice and denied any future appointments.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Office Manager, Yesenia Santiago (954) 545-1560.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Signature of Patient or Patient Representative