



LINE UP PATIENT I.D. LABEL HERE

**PATIENT INFORMATION SHEET**

**EVERY LINE ON THIS SHEET MUST BE FILLED OUT.**

**Please print all information and use legal name printed on your insurance card.**

Who is responsible for patient  Self  Parent Other: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Legal Name: \_\_\_\_\_  
Last First Middle

Mothers Name if Minor patient: \_\_\_\_\_ Fathers Name if Minor Patient: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt # City State Zip

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex:  M  F Marital Status:  Single  Married  Divorced  Widowed Other: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Do you have a Living Will or Medical Advance Directive?  Yes  No

**Ethnicity:**  Hispanic  Non-Hispanic  Unknown **Race:**  Black  White  Asian  Hispanic Other: \_\_\_\_\_

Employment Status:  Full-Time  Part-Time  Retired  Unemployed Other: \_\_\_\_\_  Student  Full-Time  Part-Time

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer Phone: (\_\_\_\_) \_\_\_\_\_

Spouse/Parent Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Phone #: \_\_\_\_\_  
Last First

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Their Relationship to You: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (if other than parent/spouse)**

Head of Household or Parent with Custody of Minor: \_\_\_\_\_ Relationship to Parent: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ tel #: \_\_\_\_\_

**POLICY HOLDER (If not patient)**

Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship to Patient: \_\_\_\_\_

**PRIMARY INSURANCE**

**EFFECTIVE DATE:** \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_  
Name Address Phone Number

Policy No.: \_\_\_\_\_ Group No.: \_\_\_\_\_

**SECONDARY INSURANCE**

**EFFECTIVE DATE:** \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_  
Name Address Phone Number

Policy No.: \_\_\_\_\_ Group No.: \_\_\_\_\_

**Authorization for Treatment**

I authorize Physician Associates, LLC to perform procedures and treatment including administration of medicine and local anesthetics along with other surgical and medical procedures that may be medically necessary. I authorize the release of any medical information necessary (including the release of HIV/AIDS, Mental Health, Substance Abuse- to include alcohol and drugs and any reportable communicable diseases), to process a claim and hereby assign benefits payable to Physician Associates, LLC in the event of another health insurance becoming primary over my health insurance. To further provide continuity of care, I authorize the release of medical information to specialty physicians under contract with Physician Associates, LLC. Furthermore, any services not covered by my insurance will become my responsibility for full payment of services rendered by Physician Associates, LLC.

\_\_\_\_\_  
 Patient/Legal Representative Signature Date Time

\_\_\_\_\_  
 Patient/Legal Representative PRINT



ORLANDO HEALTH

Physician Associates

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

LINE UP PATIENT I.D. LABEL HERE

\_\_\_\_\_ hereby authorizes the use or disclosure of the individually
Print Patient/Legal Representative or Parent/Legal Guardian Name

Identifiable health information of \_\_\_\_\_ as described herein.
Print Patient Name Date of Birth

Person/organization authorized to use/disclose the information:
Person/organization authorized to receive the information:
Name/organization
Address
City, State, Zip
Phone Fax

For the purpose of: Legal Request Moving out of Area New Local Physician Other (please specify)

This authorization will expire on the following date, event or condition: \_\_\_\_\_

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information. I further understand that Physician Associates, LLC may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Date(s) of Service: From: \_\_\_\_\_ To: \_\_\_\_\_

Place your INITIALS by each item to be released or reviewed:

Abstract of Record All diagnostic test results Pathology/Operative Report(s)
Radiology only Consultation/Progress Note(s) Lab only
Complete Record (charges may apply) Other (specify)

In addition, place your INITIALS by each specific item: (if applicable)

Mental Health HIV Testing Genetic Counseling/Testing Information
Drug and/or Alcohol AIDS Information STD/Communicable Diseases

Patient/Legal Representative or Parent/Legal Guardian Signature Required Date of Authorization

Patient Date of Birth Social Security Number (optional) Identification Shown

Address City State Zip Code

Official Use Only: Name of Person Releasing Information Date Time

INTERPRETER ONLY PATIENT ASSISTANCE PROVIDED

Interpreter Name:
Agency & I.D.#:
Team Member Name & I.D.#:
Video Remote Tel In person Language:
Reader for Visually Impaired
Name:



**ORLANDO HEALTH** | Physician Associates

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**FINANCIAL AGREEMENT**

In consideration of the patient receiving services from Physician Associates, LLC, I agree:

- I am responsible for all expenses for treating the patient.
- Payment of charges is due at the time of the appointment.
- If Physician Associates files my insurance for me, I agree to pay for non-covered insurance benefits, co-insurance, co-pays and deductibles.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Legal Representative Signature (Parent/Guardian of Minor)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

**AUTHORIZATION TO RELEASE INFORMATION & TO PAY BENEFITS**

I authorize Physician Associates, LLC to release any of my medical information, including drug and alcohol and HIV positive test results, to my insurance company(s), as needed to process my insurance claim.

I authorize my insurance company to make payments directly to Physician Associates, LLC for covered medical and/or surgical services.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Legal Representative Signature (Parent/Guardian of Minor)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time





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**HEALTH QUESTIONNAIRE**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Please indicate each of your chronic medical problems by marking the appropriate box below:**

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	Please list any other medical problems:
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Emphysema/Lung Disease	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Problems	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Anemia	
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Glaucoma	

**Please list all medications that you are now taking, strength (in milligrams) and how often. Include non-prescription medications, vitamins and herbal supplements.**


Are you allergic to any medications?  Yes  No If yes, please list them and the reaction they cause.


Do you require assistance for hearing impaired?  Yes  No

**Social History**

Tobacco use: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ a day Year Quit: _____	Number of years used: _____
Alcohol use: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ drinks per week Specify: _____	Street Drugs: <input type="checkbox"/> No <input type="checkbox"/> Yes
Caffeine: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ cups a day Water: _____ cups a day	Low fat diet: <input type="checkbox"/> No <input type="checkbox"/> Yes
Exercise: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ minutes/session: _____	Times a week: _____
# of Children: _____	Do you have a living will? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, have you given us a copy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status: _____	Occupation: _____

**Family History**

If any blood relative has suffered from the following conditions, check the box and indicate which relative.

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Emphysema/Lung Disease	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Thyroid	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Substance Abuse

**OVER**



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HEALTH QUESTIONNAIRE

Patient Name: \_\_\_\_\_

Please list any surgeries/hospitalizations (including the year):

Table with 2 columns for listing surgeries/hospitalizations.

Are you under the care of any other doctor for any medical problems? \_\_\_\_\_

If so, whom and for what medical problem? \_\_\_\_\_

Year of last: Tetanus Shot \_\_\_\_\_ Flu Shot \_\_\_\_\_ Pneumonia Vaccine \_\_\_\_\_

Women only: Date of first day of last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_ Contraception Type \_\_\_\_\_

Number of: Pregnancies \_\_\_\_\_ Live Births \_\_\_\_\_

Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_

Date of last: PAP \_\_\_\_\_ (Abnormal? \_\_\_\_\_) Mammogram \_\_\_\_\_ (Abnormal? \_\_\_\_\_)

Date of last: Osteoporosis Scan \_\_\_\_\_ Flushing/Menopausal Symptoms  Yes  No

Have you been a victim of abuse?  Yes  No

Men only: Date of last: Prostate Exam \_\_\_\_\_ Last PSA (Prostate Blood Test) \_\_\_\_\_

Procedures (list year):

Table listing procedures: Sigmoidoscopy, Colonoscopy, Stress Test, EKG, Cholesterol (normal Y/N), Sugar (normal Y/N)

Please place a checkmark next to any symptoms that you are currently having and indicate the year if the symptoms occurred in the past.

Large table with categories: GENERAL, SKIN, EYES, EAR NOSE THROAT, HEART, LUNGS, GASTRO-INTESTINAL, GENITO-URINARY, ORTHOPEDIC, NEURO/PSYCH, ALLERGY, CIRCULATION. Each category has associated symptoms with checkboxes.

Patient/Legal Representative Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ Clinician Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_