ORLANDO HEALTH® | Physician Associates

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

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HISTORY AND PHYSICAL FORM

Name: ______________________ Date: ____/____/____

HISTORY

Chief Complaint: ______________________

History of Illness:

Onset: ______________________

Location: ______________________

Duration: ______________________

Changes: ______________________

Prior Treatment: ______________________

Family Physician: ______________________

Past Medical History: Check all that apply

☐ Diabetes ☐ Hypertension ☐ Nervous Conditions ☐ Stroke ☐ Sickle Cell Anemia
☐ Skin Problems ☐ Hypotension ☐ Heart Disease ☐ Fainting Spells ☐ Seizure Disorders
☐ Hepatitis ☐ Bleeding Disorder ☐ Rheumatic Fever ☐ Other/Explain: ____________

Past Surgical History:

Hospitalizations/Surgeries	Date	Hospitalizations/Surgeries	Date

Allergies: Check all that apply

☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Tape ☐ Sulfites
☐ Food ☐ Clothing ☐ Iodine ☐ Sulphur ☐ Local Anesthetics
☐ Other/Explain: ______________________
☐ **No Known Allergies**

Medications:

Name:	Illness	Physician	Name:	Illness	Physician

Family History: Check all that apply

☐ Diabetes ____________ ☐ Hypertension ____________ ☐ Bleeding disorders ____________
☐ Circulatory ____________ ☐ Problems w/Anesthesia ____________

Social History: Check all that apply

☐ Tobacco (pkg/day) ____________ ☐ Coffee (cups/day) ____________
☐ Alcohol ____________ ☐ Substance Abuse ____________

By signing this form you agree that all information is correct and up to date. Please fill out form entirely.

______________________ ____________ ____________
Patient/Legal Representative Signature Date Time

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

Physician Associates' Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting your physician's office or by visiting our Web site at www.paof.com.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I have read the Physician Associates Notice of Privacy Practices.

Patient/Legal Representative Signature ______ Date ______ Time ______

Print Name ______

Print Name of Patient ______ Patient Date of Birth ______

****

PHYSICIAN ASSOCIATES USE ONLY

Patient declined signing this acknowledgment form.

Reason given ______

Staff Member Name ______

Office Location ______ Date ______ Time ______

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FINANCIAL AGREEMENT

LINE UP PATIENT I.D. LABEL HERE

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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LINE UP PATIENT I.D. LABEL HERE

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

________________________________ **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 ____________	Name/organization ____________
Address ____________	Address ____________
City, State, Zip ____________	City, State, Zip ____________
Phone ________ Fax ________	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
____ Radiology only
____ Complete Record (charges may apply)
____ All diagnostic test results
____ Consultation/Progress Note(s)
____ Pathology/Operative Report(s)
____ Lab only
____ Other (specify) ____________

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

____ Mental Health
____ Drug and/or Alcohol
____ HIV Testing
____ AIDS Information
____ Genetic Counseling/Testing 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: ____________

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