ORLANDO HEALTH® | Physician Associates

PATIENT INFORMATION SHEET

LINE UP PATIENT I.D. LABEL HERE

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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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 ____ 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

Interpreter Name: _____
Agency & I.D.#: _____
Team Member Name & I.D.#: _____
❑ Video Remote ❑ Tel ❑ In person Language: _____

PATIENT ASSISTANCE PROVIDED

❑ Reader for Visually Impaired
Name: _____

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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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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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HEALTH QUESTIONNAIRE

Patient Name: _____ DOB: _____

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

☐ High Blood Pressure	☐ Asthma	Please list any other medical problems:
☐ Heart Disease	☐ Emphysema/Lung Disease	
☐ Diabetes	☐ Kidney Problems	
☐ Stroke	☐ Anemia	
☐ Cancer	☐ High Cholesterol	
☐ Thyroid	☐ 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: ☐ No ☐ Yes _____ a day Year Quit: _____	Number of years used: _____
Alcohol use: ☐ No ☐ Yes _____ drinks per week Specify: _____	Street Drugs: ☐ No ☐ Yes
Caffeine: ☐ No ☐ Yes _____ cups a day Water: _____ cups a day	Low fat diet: ☐ No ☐ Yes
Exercise: ☐ Yes ☐ No Type: _____ minutes/session: _____	Times a week: _____
# of Children: _____ Do you have a living will? ☐ Yes ☐ No If yes, have you given us a copy? ☐ Yes ☐ No Marital Status: _____ Occupation: _____	

Family History

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

☐ Heart Disease	☐ Stroke	☐ Asthma	☐ Glaucoma
☐ Diabetes	☐ High Blood Pressure	☐ Emphysema/Lung Disease	☐ Mental Health
☐ Thyroid	☐ High Cholesterol	☐ Cancer	☐ Substance Abuse

OVER

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HEALTH QUESTIONNAIRE

Patient Name: _____

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

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):

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.

GENERAL	☐ Fever	☐ Night Sweats	☐ Unexplained Weight Loss or Gain	☐ Fatigue
SKIN	☐ Rashes	☐ Cancers	☐ Change in Hair, Skin or Nails	
EYES	☐ Glasses	☐ Contact Lenses	☐ Pain ☐ Changing Vision	☐ Discharge
EAR NOSE THROAT	☐ Ear Pain ☐ Sore Throat	☐ Change in Hearing ☐ Change in Voice	☐ Persistent Runny Nose ☐ Sinus Trouble	
HEART	☐ Chest Pain	☐ Swelling in Ankles	☐ Palpitations ☐ Heart Murmur	
LUNGS	☐ Cough	☐ Shortness of Breath	☐ Wheezing	
GASTRO-INTESTINAL	☐ Nausea ☐ Ulcers	☐ Blood in Stool ☐ Heartburn	☐ Change in Bowel Movements	
GENITO-URINARY	☐ Blood in Urine **Women:** **Men:**	☐ Painful or Frequent Urination ☐ Sexually Transmitted Disease ☐ Vaginal Discharge ☐ Testicular Pain ☐ Penile Discharge	☐ Incontinence ☐ Change in Menstrual Cycle or Sexual Function ☐ Decreased Urinary Stream ☐ Change in Sexual Function	
ORTHOPEDIC	☐ Painful Joints	☐ Muscle Weakness		
NEURO/PSYCH	☐ Seizures	☐ Tremor	☐ Paralysis ☐ Frequent Headaches	
	☐ Depression	☐ Anxiety		
ALLERGY	☐ Hives	☐ Hay Fever		
CIRCULATION	☐ Leg Swelling	☐ Blood Clots		

Patient/Legal Representative Signature _____ Date _____ Time _____ Clinician Signature _____ Date _____ Time _____