

PATIENT INFORMATION

Date _____

Name _____ Maiden Name _____
Last First MI

Sex: M _____ F _____ Age _____ Birthdate _____ SSN _____ - _____ - _____ Martial Status _____

Address _____

City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email Address _____ Contact preference: _____

Race _____ Preferred Language _____ Hispanic Non-Hispanic Other

Smoker: Yes No Student Status: Full Time Part Time Not A Student Veteran: Yes No

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

In case of emergency who should be notified? _____ Relationship _____ Phone _____

How did you hear about us? _____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____
Last First MI

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

PRIMARY INSURANCE

Insurance Company _____ Policy # _____ Group# _____

Policy Holder's Name _____ Relation to Patient _____ Birthdate _____ SS# _____

Policy Holder Employed by _____ Business Phone _____

ADDITIONAL INSURANCE

Insurance Company _____ Policy # _____ Group# _____

Policy Holder's Name _____ Relation to Patient _____ Birthdate _____ SS# _____

Policy Holder Employed by _____ Business Phone _____

ASSIGNMENT AND RELEASE

I the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Brian Shaheen, M.D., 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Patient Signature

Date

Patient Name _____

Date _____

What brings you in today? _____

Current Medications: List medications and dose that you take.
 Please list prescription as well as Over-The-Counter (OTC) medications, vitamins, supplements and herbs.

Name of current Medication	How much? (dose)	How often? (frequency)	For treatment of:	Prescribed by:
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Medication Allergies: I do not have any known allergies to medication.
 Codeine Penicillin Sulfa Other _____

Reaction: _____

Preferred Pharmacy/Mail Order: _____

For Chronic Medications: 30 Day Supply 90 Day Supply

Secondary Pharmacy (short term meds): _____

CONSENT FOR TREATMENT

I consent to treatment ordered and performed by these physicians and/or their practitioners under the physician's direction within this office. I understand that treatment will be explained fully to me before the treatment is performed. This consent shall be in effective until I notify Bay Medical Sacred Heart Family Medicine of its cancellation.

 Patient or Patient or Authorized Person's Signature

 Date

Patient Name _____ DOB _____ Date _____

Patient Medical and Social History Questionnaire

What doctors have you seen in the past 3 years (list name – specialty)?

Medical History: Please mark next to any medical conditions or symptoms that you have now or have had in the past (use the space provided for details: how long, etc.):

Heart Disease (if yes, explain below):

- No Yes Abnormal EKG _____
- No Yes Chest Pain or Angina _____
- No Yes Heart Attack or positive stress test _____
- No Yes Angioplasty _____
- No Yes Heart or Valve Surgery _____
- No Yes Rheumatic/Scarlet Fever _____
- No Yes Palpitations _____
- No Yes Congestive Heart Failure or swelling of legs _____
- No Yes Heart Murmur _____
- No Yes High Blood Pressure _____
- No Yes High Cholesterol _____
- Other _____

Respiratory Disease (if yes, explain below):

- No Yes Asthma _____
- No Yes Bronchitis _____
- No Yes Pneumonia _____
- No Yes Emphysema _____
- No Yes COPD _____
- No Yes TB /Tuberculosis _____
- No Yes Sleep Apnea and CPAP _____
- No Yes Shortness of Breath at rest or on exertion (Circle one if applies to you) _____
- Other _____

Gastrointestinal or Kidney (if yes, explain below):

- No Yes Acid Reflux/Heartburn _____
- No Yes Gallbladder Disease or removed _____
- No Yes Hiatal Hernia _____
- No Yes Stomach Ulcers _____
- No Yes Pain or trouble swallowing _____
- No Yes Change in appetite _____
- No Yes Weight loss or gain _____
- No Yes Chronic Diarrhea or Constipation (Circle ones that apply) _____
- No Yes Hepatitis or Liver Disease _____
- No Yes Urinary track, Kidney infections, Kidney stones (Circle ones that apply) _____
- No Yes BPH (enlarged prostate) or Trouble urinating _____
- No Yes Urinary frequency, hesitancy, urgency, incontinence (Circle ones that apply) _____
- No Yes Dialysis or Chronic renal insufficiency _____
- Other _____

Patient Name _____ DOB _____ Date _____

Neurological or Musculoskeletal Disease

(if yes, please explain below):

- No Yes Stroke/TIA/Paralysis _____
- No Yes Seizures or Epilepsy _____
- No Yes Tremors _____
- No Yes Carpal Tunnel Syndrome _____
- No Yes Chronic Headaches or Migraines (if yes, frequency) _____
- No Yes Vision problems _____
- No Yes Neuropathy _____
- No Yes Fainting Spells _____
- No Yes Loss of Memory _____
- No Yes Speech Disorder _____
- No Yes Arthritis _____
- No Yes Gout _____
- No Yes Lupus _____
- No Yes Muscular dystrophy _____
- Other _____

Miscellaneous

- No Yes **Diabetic** (if yes, controlled with) _____ A. Diet _____ B. Insulin _____ C. Oral Medication
- No Yes **Thyroid Disorder** (if yes, what type) _____
- No Yes **Glaucoma or Cataracts** (Circle ones that apply) _____
- No Yes **Bleeding disorder** (if yes, please explain) _____
- No Yes **Blood Clots** (if yes, please explain) _____
- No Yes **Use of any recreational drugs?** (if yes, what type) _____
- No Yes **Mental Health Disorder** (if yes, explain) _____
- No Yes **Could you be pregnant?** (*Women only*) _____
- No Yes **Reactions to Anesthesia** (please describe) _____

Women Only

- No Yes Could you be pregnant? _____
- No Yes Pre-Menopause: _____
- No Yes Hot Flashes/Sleep problems: (Please specify which ones): _____
- No Yes Irregular/Heavy periods: (Please specify which ones): _____

Preventative Health Maintenance:

Screening	Date	Result
Pap		
Mammogram		
Colonoscopy		
PSA		
Digital Rectal Exam		
Labs (Where done)?		
Diabetic Eye Exam (if applicable)		
DEXA Scan		
EKG (for Blood Pressure, Diabetes or Coronary Artery Disease)		
Monthly Self Breast or Testicular Exams		
Tetanus Vaccine		
Pneumonia Vaccine		
Shingles Vaccine		
Flu Vaccine		
Hemoccult		

Patient Name _____ DOB _____ Date _____

Family History: Please check any medical illness or history that runs in your family:

- | | | |
|---|--|---|
| <input type="checkbox"/> Attention Deficit | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pain disorder |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Low Blood Pressure | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Heart Attack before 50 | <input type="checkbox"/> Obesity | |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Osteoarthritis | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Vascular Disease | |

Surgical History:

Please list any surgery you have had in the past and the approximate date of your surgery.

Surgery	Date	Physician	Facility

If back/neck surgery: Fusion or Laminectomy or Discectomy?

Back: Lumbar or Thoracic?

Was it due to an accident? Yes No

Social History:

Marital Status: Single Married Divorced Separated Widowed

No Yes I never smoked cigarettes or used any tobacco products.

No Yes I smoke cigarettes, cigars, or chew tobacco. (Circle one if applies to you)

No Yes I currently smoke _____ packs a day for _____ years.

No Yes I quit smoking _____ years ago and used to smoke _____ packs a day for _____ years

Do you currently or have a history of alcohol use? _____ / What type? _____ Frequency? _____

Do you use drugs or have a history of drug use? _____ / What type? _____ Frequency? _____

What is /was your occupation? _____

I am currently working: Full time part time limited duty I am unable to work

I have been on disability since _____

Please mark your highest level of education:

- Did *not* complete high school (HS)
- Completed HS
- Some college
- Bachelor's degree
- Advanced degree
- Other _____

1. Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
2. *This information may be disclosed to the following individual.*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____

Signature of patient or legal representative Date: _____

2. Notice of Privacy Practices (HIPAA)

The undersigned certifies that he/she has received a copy of the Notice of Privacy Practices.

If you did not received these documents, or have misplaced them, please ask for another copy. This signature page is in reference to the Federal HIPAA privacy Regulations requirements.

The HIPAA Notice of Privacy Practices document can also be found at www.baymedical.org

Signature of patient or legal representative Date

Authorization for Use and/or Disclosure of Protected Health Information

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone: _____

Information To Be Released - Covering the Periods of Health Care

From (date) _____ to (date) _____

From (date) _____ to (date) _____

Please check type of information to be released:

- Entire medical record • Pathology report • Discharge summary • History and physical exam • Consultation reports • Progress notes
- Laboratory test results/reports • X-ray reports • X-ray films / images
- Operative report • Emergency room record • Itemized bill
- Other, (specify) _____

Purpose of Request

- Treatment or consultation • At the request of the patient • Billing or claims payment
- Other, (specify) _____

Person Authorized to Receive Information

Name: _____

Address: _____

Drug and/or Alcohol Abuse and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check One:** • Yes • No
_____ Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. **Check One:** • Yes • No
_____ Initials

Time Limit and Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Bay Medical Center Sacred Heart Health System 615 N Bonita Ave Panama City FL 32401. Unless revoked, this authorization will expire on the following date or event _____.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that Bay Medical Center Sacred Heart Health System may not condition my treatment on whether I sign this authorization from unless specified above under Purposes of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize _____ to use and disclose the protected health information specified above. (Name of Facility or Provider)

Signature _____: Date: _____

Authority to Sign if not patient: _____

Identity of Requestor Verified via: • Photo ID • Matching Signature • Other, specify

Verified by: _____