Specialist Doctors' Group

Date:____________

Patient Information

Last Name	First Name	Middle Initial	Suffix

Date of Birth:________________ Social Security #: ____________________ Age:_______

Sex: _______ Male
_______ Female

Marital Status: _______ Single _______ Divorced
_______ Married _______ Other

Address: ______________________________
____
____

Home Phone Number:________________
Cell Phone Number:________________
Email:________________________

Employer:____________________________

Occupation:________________________

Emergency Contact:____________________

Phone Number:______________________

Guarantor Information

Last Name	First Name	Middle Initial	Suffix

Date of Birth:________________ Social Security #: ____________________ Age:_______

Address: ______________________________
____
____

Home Phone Number:________________
Cell Phone Number:________________
Email:________________________

Employer:____________________________

Occupation:________________________

Insurance Information

Primary Insurance:__________________________
Subscriber's Name:__________________________
Subscribers Address:________________________
____
____

Policy Number:______________________
Subscriber's Date of Birth:______________
Subscriber's SSN:____________________
Subscriber's Phone Number:_____________

Secondary Insurance:________________________
Subscriber's Name:__________________________
Subscribers Address:________________________
____
____

Policy Number:______________________
Subscriber's Date of Birth:______________
Subscriber's SSN:____________________
Subscriber's Phone Number:_____________

Account #: ____________

Specialist

Doctors' Group, LLC

Family Medicine

Medical/Social History

Patient Name:______________________________Guardian/Parent (if applicable)___________________________

Address:____ Date of Birth______________ Age:_______________

____ Phone number:_______________________________

Past and Current Illnesses (Check all that apply)

___Bleeding Disorder ___Congestive Heart Failure ___Coronary Artery Disease(Angina, Heart Attack)

___Diabetes(Diet Control) ___Diabetes(Diet & Pills) ___Diabetes (Insulin Required)

___Disc/Spine Disease ___Gallbladder Disease ___High Blood Pressure

___HIV/AIDS ___Kidney Disease ___Liver Disease

___Lung Disease ___Pancreatitis ___Parkinson's Disease

___Pulmonary Embolism ___Phlebitis ___Rheumatoid Arthritis

___Stomach Ulcers ___Stroke/TIA's ___Thyroid Disorder

___Tumor (Brain) ___Cancer (Describe Below) ___Chemotherapy (Describe Below)

___Other (Describe Below)

Past surgeries/procedures (list below)

List all prescription medications, over the counter medications, vitamins and supplements that you currently take (include dosage and frequency taken).

Do you take aspirin? ___Yes ___No Do you take ibuprofen? ___Yes ___No

List all allergies to medications (check all that apply/and or write in additional information).

___Penicillin ___Amoxicillin ___Erythromycin ___Sulfa ___Keflex

___Other____

Are you allergic to any of the following? (check all that apply and describe reaction)

___Shellfish ___Iodine ___Latex ___MRI Contrast (Dye) ___CT Contrast (Dye)

___IVP Contrast (Dye) ___Angiogram Contrast (Dye) ___Other:___________________________

Are you a smoker?___Yes ___No How many years?(________) How many packs/day?(________).

Do you drink alcohol?___Yes ___No How many drinks per week? (________)

Do you use illicit ("street") drugs? ___ Yes ___No Describe:_________________________________

Do you engage in risky sexual behavior (unprotected)?_____Yes _____ No

Females Only:

Are you pregnant?___Yes ___No Could you be pregnant?___Yes ___No

Number of pregnancies?________ Number of Births?________

When was your last menstral period?______________________

Are you currently on birth control?___Yes ___No If yes, please indicate:______________________________

Do any of your blood relatives have (did have) any of the medical conditions noted below?

(use the following key and circle affected family members for each condition below)

M = Mother F = Father GM = Grandmother GF = Grandfather

A = Aunt U = Uncle S = Sister B = Brother

Condition								
Arthristis	M	F	GM	GF	A	U	S	B
Asthma/COPD	M	F	GM	GF	A	U	S	B
Bleeding Disorder	M	F	GM	GF	A	U	S	B
Cancer	M	F	GM	GF	A	U	S	B
Depression/Anxiety	M	F	GM	GF	A	U	S	B
Diabetes	M	F	GM	GF	A	U	S	B
Heart Disease	M	F	GM	GF	A	U	S	B
GI Disorders	M	F	GM	GF	A	U	S	B
High Blood Pressure	M	F	GM	GF	A	U	S	B
High Cholesterol	M	F	GM	GF	A	U	S	B
Migraines	M	F	GM	GF	A	U	S	B
Seizure Disorder (Epilepsy)	M	F	GM	GF	A	U	S	B
Obesity	M	F	GM	GF	A	U	S	B
Stroke	M	F	GM	GF	A	U	S	B
Tuberculosis (TB)	M	F	GM	GF	A	U	S	B

Patient Name:____**DOB:**______________**DATE:**________________

Have you ever had or currently have: (check all that apply)

General/Constitutional:

___Unexplained weight loss or weight gain
___Excessive fatigue
___Difficulty performing daily activities such as: (bathing, cooking, cleaning)
___Prolonged fever/chills

Head/Eyes/Ears/Nose/Throat

___Frequent or severe headaches
___Wear glasses or contact lenses
___Chronic nasal discharge, drainage or sneezing
___Impaired hearing

Neurological:

___Memory loss
___Fainting, dizziness, seizures, convulsions
___Other:______________________

Musculoskeletal:

___Pain in joint/arthritis
___Chronic back pain or joint
___Other:________________

Endocrine:

___Excessive thirst or hunger
___Cold or heat intolerance, any thyroid problem

Respiratory:

___Chronic cough
___Asthma or wheezing
___Shortness of breath at night
___Shortness of breath at anytime

Emotional:

___Trouble sleeping
___Depression
___Anxiety or nervousness
___Loss of memory

Genitourinary:

___Frequent urination at night
___Frequent or painful urination
___Difficulty holding urine
___Urinary tract infection
___Difficulty stopping or starting urine stream

Skin/Breast:

___Change or new growth mole
___Breast Lump
___Breast nipple discharge
___Other:________________________

Hematologic/Lymph:

___Anemia
___Excessive bleeding or abnormal bruising
___A transfusion
___Any swelling of lymph nodes

Cardiovascular:

___Rheumatic fever
___Pain or pressure in chest
___Any heart trouble
___Palpitation or pounding beat
___Abnormal heart rhythm or murmur
___Swelling of ankles
___High blood pressure

Gastrointestinal:

___Abdominal pain
___Loss of appetite
___Change in bowel habits (constipation or diarrhea)
___Blood in stool
___Hemorrhoids or rectal disease
___Nausea/vomiting
___Other:______________________________

Female:

___Periods regular
___Mid-cycle bleeding
___Pain with intercourse
___Vaginal discharge or sores
___Painful periods
___Sexually transmitted disease
___Problem with sexual function
___Pregnant
___Method of birth control if sexually active/heterosexual

Male:

___Sores or discharge from penis
___Lump or pain of testicle
___Sexually transmitted disease
___Condom use
___Problems with sexual function

Optional:

___Sexually active
___Sexually active with opposite sex
___Sexually active with same sex
___Sexually active with both
___Form of contraception________

The information on these forms provided by the patient and/or family member(s) was personally reviewed and/or amended by:

______________________________ ______________

Provider/Physician Signature –Title *Date*

Patient Name:________________________________ **DOB:**____________ **DATE:**______________

Specialist Doctors' Group

Consent and Authorization Agreement

____ ____/____/____

Patient Name Date of Birth

Please read the "Consent and Authorization and Agreement" form carefully:

I hereby consent and authorize the clinic to provide me treatment and certify that no guarantee or agreement has been made as to the results obtained. ______
Initial

Agreement to pay for services:

I promise to Specialist Doctors' Group, LLC, all undersigned and/or the patient will be responsible for all charges, applicable co-payments and deductibles or charges not paid by my insurance carrier(s). Such payments will be made to Specialist Doctors' Group, LLC upon notification. ______
Initial

Complications:

I understand that it is my responsibility to return to the clinic or follow up with another physician if my condition(s) change. ______
Initial

Privacy Notifications:

I acknowledge that I have read Specialist Doctors' Group, LLC's privacy notice. ______
Initial

Authorization:

I authorize Specialist Doctors' Group, LLC to submit a claim to my insurance company on my behalf. ______
Initial

Telephone and Refill Office Policy

Telephone Messages will have a 48 hour (2 business day) turnaround period. Prescriptions refills should require a 5 business day notice. ______
Initial

Reason for Visit:

____

I have read and understand all above information and agree to comply

____ ____/____/____

Patient/ Guardian Signature Date

Specialist Doctors' Group

Special Release of Patient Information

I, ____, hereby grant permission for ____ to obtain any lab results, X-rays or any other pertinent information regarding my medical care and treatment from the staff of Specialist Doctors' Group, LLC. I understand that this information may be in the form of verbal, and/or written communications, and may include photocopied or faxed information from my patient chart. The above designee may not be required to provide a signature or receive verbal information, but will be required to sign for any documents received. At any time, this designee may also be required to provide proof of their identity to the staff of Specialist Doctors' Group, LLC.

I, ____, hereby grant permission for the Specialist Doctors' Group, LLC to leave information regarding my medical care or condition, including lab results, on my answering machine (   ), fax (   ), voicemail (   ), or email (   ). I understand that the designee of Specialist Doctors' Group, LLC will use information I have provided them in my chart to attempt to contact me and that it is my responsibility to keep this information current.

The patient's express authorization is required to release certain types of records, including alcohol and/or drug abuse treatment and information, HIV testing and treatment and psychiatric treatment. To authorize release of this type of information, please read and sign the following:

I, ____, authorize the release of alcohol and/or drug abuse treatment and information. Confidentiality is protected by FL §397.053 and §396.112 and the Federal Alcohol and Drug Abuse Act.

I, ____, authorize the release of HIV test results and/or HIV treatment information, AIDS and related conditions. Confidentiality is protected by FL §381.609 (2).

I, ____, authorize the release of psychiatric information. Confidentiality is protected by FL §394.59 (g).

In authorizing the release of information identified above, I hereby waive all restrictions or privileges imposed by law in connection with the disclosure or release of any professional record, observation, or communication. I do understand that any information that is being released may be subject to redisclosure by the recipient and may no longer be protected. The release does not force Specialist Doctors' Group, LLC, or it's staff to provide information at any time, should they deem it unreasonable or imprudent to do so.

____ ____

Patient Signature Date

____ ____

Social Security Number Witness

This authorization may be revoked in writing at any time, except to extent that our office has already taken action in reliance upon it. Written authorization to revoke should be sent by certified mail to Specialist Doctors' Group. If not previously revoked in writing, this authorization will not terminate or expire.

Health Care Advance Directives

Please read the information below carefully before signing.

The Patient's Right to Decide

Every competent adult has the right to make decision concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decision due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will be respected, the Florida legislature enacted laws pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the decide to make an anatomical donation after death.

By law, hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives. The state rules that require this include 58A-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code.

What is an advance directive?

It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Three types of advance directives are:

- A Living Will
- A Health Care Surrogate Designation
- An Anatomical Donation

You might choose to complete one, two, or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.

What is a "living will"?

It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your healthcare provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a "health care surrogate designation"?

It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternative surrogate.

Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives. Forms available upon request.

____

Print Patient's Name

______________________________ ____/____/____

Patient/ Guardian Signature Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT INFORMATION BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

________________________________	________________________________
Please ***print*** name of Patient	Please ***sign*** for Patient/Guardian of Patient
________________________________	________________________________
Legal Representative/ Guardian	Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents: ________________________________

____

In signing this HIPAA Patient Acknowledgement Form, you consent to allow Jackson and Lujan to summon you from the reception area by calling out your first and last name. If you prefer to be addressed differently, please let a technician know so that we can place an alert in your file.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ________________ Relationship: ________________

Name: ________________ Relationship: ________________

Name: ________________ Relationship: ________________

Name: ________________ Relationship: ________________

I AUTHORIZE THIS OFFICE TO CONTACT ME VIA CELL, HOME OR WORK PHONE, EMAIL MESSAGE OR U.S. MAIL TO RELAY TREATMENT INFORMATION, BILLING INFORMATION OR INFORMATION ABOUT MY HEALTH.
IF YOU PREFER THAT WE DO NOT CONTACT YOU, PLEASE OPT OUT BELOW:

- ☐ Opt out Cell Phone/ Text
- ☐ Opt out Home Phone
- ☐ Opt out U.S. Mail
- ☐ Opt out Work Phone
- ☐ Opt out Email Message
- ☐ **Opt out all of the above**

I AUTHORIZE THIS OFFICE TO CONTACT ME VIA CELL, HOME OR WORK PHONE, TEXT, EMAIL MESSAGE OR U.S. MAIL TO LET ME KNOW ABOUT MY GLASSES OR CONTACTS ORDER, SPECIAL SERVICES/EVENTS, NEW HEALTH INFO AND YEARLY EXAM REMINDERS.
IF YOU PREFER THAT WE DO NOT CONTACT YOU, PLEASE OPT OUT BELOW:

- ☐ Opt out Cell Phone/ Text
- ☐ Opt out Home Phone
- ☐ Opt out U.S. Mail
- ☐ Opt out Work Phone
- ☐ Opt out Email Message
- ☐ **Opt out all of the above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. If we receive any remuneration, we, under current HIPAA Omnibus Rule, will provide you with this information and obtain your consent first.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because (please describe) ________________________________

Signature of Privacy Officer ________________________________