FLORIDA HEALTHCARE ASSOCIATES

MITCHELL LAMPERT, M.D. ROOPTAZ SIBIA, M.D. ALEX ZOPO, M.D. CHRISTOPHER HUNT, M.D.
AARON COHEN, M.D. NICOLLE MELENDEZ, P.A. ORLY MATHESON, P.A.

Welcome to our office. Please fill out the following papers so that we may provide you with efficient and accurate healthcare.

PERSONAL INFORMATION

NAME:_____ **DATE:** ____/____/_2021__

ADDRESS: _____

CITY:_____ **STATE:** _____ **ZIP:**_____

ADDRESS OUT OF STATE:_____

CITY: _____ **STATE:** _____ **ZIP:** _____

SOCIAL SECURITY No.:_____ **DATE OF BIRTH:** ____/____/_____

GENDER: [ ]MALE [ ]FEMALE [ ]OTHER

HOME PHONE: _____-_____-_____ **(OUT OF STATE)**_____-_____-_____
◯ **preferred contact #**
WORK PHONE: _____-_____-_____ **CELL PHONE:** _____ _-_____-_____
◯ **preferred contact #** ◯ **preferred contact #**

EMAIL ADDRESS:_____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ _____

PHARMACY NAME:_____

PHARMACY ADDRESS: _____

MARITAL STATUS: ___MARRIED ___SINGLE ___DIVORCED ___WIDOWED ___DOMESTIC PARTNER

SPOUSE'S NAME: _____

NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU:

NAME: _____ **RELATIONSHIP:** _____

ADDRESS: _____

CITY: _____ **STATE:**_____ **ZIP:** _____

HOME PHONE: _____-_____-_____ **ALTERNATE PHONE:** _____-_____-_____

IS ANYONE IN YOUR IMMEDIATE FAMILY CURRENTLY A PATIENT HERE? YES OR NO

NAME: _____ **RELATIONSHIP:** _____

FLORIDA HEALTHCARE ASSOCIATES

NAME: _____ **AGE:**_____

REFERRED BY:_____

REASON FOR TODAY'S VISIT:_____

_____

MEDICAL HISTORY

HEALTH PROBLEMS (PLEASE INCLUDE YEAR)

_____
_____
_____
_____

PREVIOUS HOSPITALIZATION (PLEASE INCLUDE YEAR)

1._____
2._____
3._____
4._____

PREVIOUS SURGERIES (PLEASE INCLUDE YEAR)

1._____
2._____
3._____
4._____
5._____

LIST ALL MEDICATIONS AND MILLIGRAMS THAT YOU ARE CURRENTLY TAKING

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____

[ ] SEE MEDICATION LIST ATTACHED.

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DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF HEART DISEASE?
IF SO, WHO? _____

DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF CANCER?
IF SO, WHO? _____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? PLEASE LIST: _____
_____

PLEASE CIRCLE ALL THAT APPLY TO YOU

ULCERS
WEIGHT LOSS
WEIGHT GAIN
NIGHT SWEATS
HEARING IMPAIRED
NOSE BLEEDS
VERTIGO
CATARACTS
GLAUCOMA
VISION IMPAIRED
RASH
ITCHING
SHORTNESS OF BREATH
COUGH
CHEST PAIN
PALPITATIONS
FAINTING
PAIN IN LEGS WHEN WALKING
PHLEBITIS
HIGH CHOLESTEROL
HIGH BLOOD PRESSURE
ANKLE SWELLING
RHEUMATIC FEVER

HAVE YOU HAD COVID-19 _____
IF YES, DATE_____

HAVE YOU HAD COVID-19 VACCINE _____
IF YES, DATE & TYPE _____
_____

HAVE YOU EVER HAD AN ECHOCAR-
DIOGRAM DONE?_____
WHEN?_____

HAVE YOU EVER HAD A STRESS
TEST DONE? _____
WHEN?_____

NAUSEA/VOMITING
DIARRHEA
CONSTIPATION
HEARTBURN
REFLUX
BLOOD IN STOOL
CHANGE IN BOWEL HABITS
FREQUENT URINATION
PAINFUL URINATION
BLOOD IN URINE
KIDNEY STONES
SEIZURES
NUMBNESS
WEAKNESS
TREMORS
COLD INTOLERANCE
HEAT INTOLERANCE
DIABETES
EXCESSIVE THIRST
BRUISE EASILY
ARTHRITIS
OTHER_____

DO YOU DRINK ALCOHOL? _____
HOW MUCH?_____

DO YOU DRINK COFFEE/TEA? _____
HOW MUCH? _____

DO YOU SMOKE ANY TOBACCO
PRODUCTS? _____
HOW MUCH? _____

DO YOU USE STREET DRUGS? _____
HOW OFTEN? _____

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MEDICAL INFORMATION

PREVIOUS MEDICAL DOCTOR

NAME: _____

ADDRESS: _____

PHONE:_____ **FAX:**_____

CITY: _____ **STATE:**_____ **ZIP:** _____

INSURANCE INFORMATION

PRIMARY:

NAME OF INSURANCE: _____

NAME OF POLICY HOLDER: _____

DATE OF BIRTH_____/_____/_____

SOCIAL SECURITY # OF POLICY HOLDER:_____-_____-_____

IDENTIFICATION/POLICY # _____ **GROUP #** _____

SECONDARY:

NAME OF INSURANCE: _____

NAME OF POLICY HOLDER: _____

DATE OF BIRTH_____/_____/_____

SOCIAL SECURITY # OF POLICY HOLDER: _____-_____-_____

ASSIGNMENT OF BENEFITS: I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ALL CLAIMS OR, IF NECESSARY, FOR MY MEDICAL BENEFIT. I AUTHORIZE THE RELEASE OF PAYMENT FOR MEDICAL BENEFITS TO FLORIDA HEALTHCARE ASSOCIATES. I PERMIT A COPY OF THESE AUTHORIZATIONSTO BE USED IN PLACE OF THE ORIGINAL. I ACCEPT THE RESPONSIBILITY FOR ALL CHARGES INCURRED AND I AM RESPONSIBLE FOR PAYMENT. WHERE APPLICABLE, REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFIRS APPLY. I REQURE THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE PAYABLE TO THE DOCTORS.

SIGNATURE_____ **DATE**_____/_____/__2021_

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MEDICAL RECORDS RELEASE

I, _____request all medical records including but not limited to: EKGS, BLOOD RESULTS, X-RAY AND ULTRASOUND REPORTS, OPERATIVE REPORTS, CARDIAC CATH REPORTS,
PACER AND DEFIBRILLATOR STRIPS AND SETTINGS, THALLIUM STRESS TEST REPORTS, PSYCHIATRIC RECORDS and any other information pertaining to my health to be released to:

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11195 JOG ROAD, SUITE 3
BOYNTON BEACH, FL 33437
PHONE (561) 733-9690
FAX (561) 733-9626

709 S. FEDERAL HWY, STE 5
BOYNTON BEACH, FL 33435
PHONE (561) 836-8600
FAX (561) 736-7191

PRINT PATIENT'S NAME: _____
DATE OF BIRTH: _____
LAST 4 DIGITS OF SSN:_____
SIGNATURE: _____
WITNESS: _____

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West Office
11195 Jog Road, Suite #3
Boynton Beach, FL 33437
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F: (561) 733-9626

Acknowledgment of receipt of Notice of Privacy Practices

****You may refuse to sign this acknowledgment****

I, (please print your name)_____,
have received a copy of this office's Notice of Privacy Practices.

Signature:_____

Date:_____/_____/_2021_

For Office use only

Signature not obtained due to:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgment

____ An emergency situation prevented us from obtaining acknowledgment

____ Other_____

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REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

The following information is required in order for us to provide a family member (i.e. spouse, parent, son or daughter) or caretaker any of your personal medical information. This includes, but is not limited to, diagnosis(s), test results, medications or anything else pertaining to your care within our practice. Please fill out the information below listing the person(s) name that is authorized to receive your private information. If this does not apply to you currently, please disregard; however, should the need arise for you to fill out this form in the future, please ask someone at the front desk and we will be happy to assist you.

Patient Name: _____

Patient Address: _____

Date of Birth: _____

I _____ allow the following persons(s) to view my protected health information.

Name/Telephone#:_____

_____

_____

Patient please note: The practice is not required to agree to your request. Please see our Notice of Privacy Practices for more information regarding such requests.

Patient's signature: _____ Date: _____/_____/__2021_

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CONSENT FOR PELVIC EXAMINATION

Under Florida law, prior to performing a pelvic examination, consent must be obtained. By signing below, the patient (or the patient's legal representative) acknowledges that he/she has been given the opportunity to ask questions about the examination before signing this Informed Consent and that the patient (or the patient's legal representative) has voluntarily agreed to the external genitalia examination by a health care practitioner. If the patient lacks the capacity to sign this Informed Consent, this form will be signed by the person authorized to consent for the patient.

The components below are included in the Florida law and may be performed at this examination:

- External genitalia examination including: the penis, scrotum, vagina, rectum, perianal area and/or labia
- Administration of a suppository or other rectally administered medication
- Placement of a Urinary Catheter
- Collection of rectal or vaginal samples via swab for laboratory analysis

The **RISKS** to the examination include (but are not limited to): discomfort or infection. The **RISKS** associated with failing or refusing to undergo the examination elements above include: the inability to obtain a diagnosis and/or delay in diagnosis of a medical condition; the inability for the health care provider to have accurate and complete information necessary to appropriately treat the patient.

The **REASONABLE ALTERNATIVES** include a refusal for the intervention assessment. In such case, shared decision making between the patient and his/her provider is vital to ensure health and wellbeing.

The **BENEFITS** include ability to obtain a diagnosis of a medical condition and the ability for the health care provider to have accurate and complete information necessary to appropriately treat the patient.

I acknowledge that this consent was given freely and voluntarily. By signing below, I confirm that I have read, fully understand, and consent to my health care provider conducting a pelvic examination. I also acknowledge that I understand the information in this form, including the purpose, risks, and benefits of the pelvic examination, and that I have had my questions answered. I acknowledge that this consent was given freely and voluntarily.

Patient Name: (Please Print) _____

_____ _____

Signature of Patient Date:

1 Florida Statutes §456.1 (Consent for Pelvic Examinations) broadly defines Pelvic Examination to include all of the following: examination of the vagina, rectum, OR external pelvic tissue OR organs using any combination of modalities which many include the health care practitioner's gloved hand OR instrumentation