# Central Florida Gastroenterology

**Patient Information Sheet:**

This page provides our office with important information such as your insurance carrier, emergency contact and allows us to have permission to bill your insurance company. Please complete this form with current information. Please include your Email address, this will give you access to your medical information electronically. You will initially get an email with a user ID and password and be directed to a website, you will be able to log on to the patient portal portal and access your medical information. You will also be able to email your doctor's nurse. Please fill out these forms in their entirety. All forms are relevant to your medical care.

**Consent and Acknowledgement forms:**

These are known as HIPAA forms (Health Insurance and Portability and Accountability Act). They give us your consent to use or disclose your patient information for treatment, payment, or health care operations. We do not sell or trade your personal information. Please include either a spouse or family member in which we are allowed to speak with. If you do not have one please mark N/A, do not leave blank.

**Insurance Cards:**

Please remember to bring a picture ID and your insurance card(s) to your appointment. If your spouse, parent, or significant other is the primary cardholder, you will be required to provide their date of birth in order to file a claim. Otherwise, you may be required to pay at time of service.

**Initial consultation:**

This first visit allows us to get a better understanding of your health problems. The doctor will decide what will be the best course of action and whether or not you need a procedure done.

# Medication list

Patient name: ______________________________
Nombre Del Pacient

Date of Birth: ____________________
Fecha de nacimiento

Pharmacy Name: ____________________________
Nombre de Farmacia

Pharmacy Phone Number: (   )__________________
Numero de la Farmacia

Please provide your pharmacy phone number if you do not have please provide street and cross street.

| Name of medicine | Dose | Who prescribed rx |
|---|---|---|
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I ______________________________ ( print name)
give permission for Internal Medicine Specialists to obtain my prescription history for the past (2) years. This information will be kept in my confidential medical records.

x______________________________ signature

CENTRAL FLORIDA GASTROENTEROLOGY
a division of internal medicine specialists

PATIENT NAME: ______________________ TODAY'S DATE: ______________

Reason for your visit today: ______________________________

Are you allergic to any medications? ______ Which ones? ______________________

**PREVIOUS TESTS**

| | | When | Ordering physician | Results |
|---|---|---|---|---|
| | Colonoscopy | | | |
| | EGD | | | |
| | CT abdomen/pelvis | | | |
| | Ultrasound/MRI | | | |
| | Liver biopsy | | | |
| | Other | | | |

**MEDICAL PROBLEMS**

*Have you ever received chemo, radiation therapy or other treatment for a condition?* YES / NO

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | High blood pressure | | Anemia | | Epilepsy | | Heart Problems |
| | Diabetes | | Arthritis | | Glaucoma | | Liver Problems |
| | High Cholesterol | | Asthma | | Macular Degeneration | | Kidney Problems |
| | Angina | | Atrial Fibrillation | | Sickle Cell | | Pulmonary Problems |
| | Heart Attack | | BPH (enlarged prostate) | | Gout | | Environmental allergies |
| | Heart Murmur | | COPD | | Bladder problems | | Cancer *type:* |
| | Stroke | | Thyroid Problems | | | | HIV |

**SURGERIES** *(place an "x" next to all that apply)*

| | MO/YR | | | MO/YR | |
|---|---|---|---|---|---|
| | | Appendectomy (appendix) | | | Hip replacement |
| | | Breast (mastectomy, augmentation) | | | Hysterectomy |
| | | Back surgery | | | Knee (replacement, arthroscopy) |
| | | Cataract | | | Open Heart # bypass: |
| | | C-section how many?: | | | Valve replacement |
| | | Gallbladder | | | Pacemaker |
| | | Gastric bypass | | | Plastic surgery |
| | | Hemorrhoidectomy | | | TURP |
| | | Hernia repair | | | |
| | | Other: | | | |

**HOSPITALIZATIONS**

| Dates (mo/yr) | Hospital | Reason |
|---|---|---|
| | | |
| | | |

**FAMILY HISTORY** *(please circle your response and complete the question)*

Any family history of colon cancer, stomach cancer, polyps or GI diseases? Y or N
If yes, list:

Father: alive / deceased Age: Health problems/cause of death:
Mother: alive / deceased Age: Health problems/cause of death:

Sisters/Brothers: # Brothers ___ # Sisters ___ Are they healthy? Y or N
Children: Sons ___ Daughters ___ Are they healthy? Y or N

## SOCIAL HISTORY *(place an "x" and give complete answers to all that apply)*

Marital Status: __ married __ divorced __ single __ widowed __ separated __ life partner

| | Blood transfusion | Y or N | Date(s): |
|---|---|---|---|
| | Cocaine use | | |
| | Recreational drug use | | Never / Current / Past Type(s): |
| | IV Drug Use | | Never / Current / Past |
| | TATTOOS | | How many?: Year they were done: |
| | Sexually active | | |
| | Birth Place | | Where: |
| | Nursing Home resident | | |
| | Occupation | | What do you do? |
| | Tobacco | | How many packs per day? |
| | QUIT tobacco use | | After how many years: How many packs per day? |
| | Alcohol | | How much per day? |
| | Caffeine | | How many cups coffee, cola or tea per day: |
| | Travel outside US | | Where: |
| | Occupational exposure | | What type: |
| | Jehovah's Witness | | |

## HISTORY & PHYSICAL *(place an "X" next to any symptoms that you are currently experiencing)*

| | Allergies | | Weight loss | | Jaundice |
|---|---|---|---|---|---|
| | Itchy eyes | | Nausea | | Urology/Neurology |
| | Runny nose | | Vomiting | | Blood in urine |
| | Scratchy throat | | Heartburn | | Difficulty urinating |
| | Sinus congestion | | Indigestion | | Frequent urination |
| | Allergic reactions | | Difficulty swallowing | | Headache |
| | Dermatology | | Painful swallowing | | Insomnia |
| | Moles | | Constipation | | Seizures |
| | Rash | | Diarrhea | | Psychology |
| | Hives | | Abnormal distension | | Memory loss |
| | Hair loss | | Blood in stool | | Considering suicide |
| | Ophthalmology | | Vomiting blood | | Depression |
| | Blurred vision | | Black, tarry stools | | Anxiety |
| | Eye irritation | | Anal discomfort | | Sleep disturbances |
| | ENT/respiratory | | Bloating | | Musculoskeletal |
| | Nosebleeds | | Gas | | Joint pain |
| | Shortness of breath | | Hiccups | | Leg cramps |
| | Vocal changes | | Stool incontinence | | Gout |
| | Cough | | Fatigue | | Endocrinology |
| | Cardiology | | Feeling full early in meal | | Heat intolerance |
| | Chest pain | | Anorexia | | Excessive thirst |
| | Leg swelling | | Fever | | Excessive sweating |
| | Palpitations | | Sclera | | Hematology |
| | Gastroenterology | | Edema | | Bleeding or bruising |
| | Abdominal pain | | Poor appetite | | Anemia |
| | Rectal bleeding | | Flatulence | | Past transfusion |
| | Change in bowel habits | | Constipation | | |

**Internal Medicine Specialists, Inc.**
**3885 Oakwater Circle**
**Orlando, FL 32806**
**407 851-5600**
**Fax# 407-438-9561**

## Acknowledgment Form

Our 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 us in writing.

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.

**Patient Name**

**(Print)** ______________________________

**(Signature)** ______________________________

**Date:** ______________________________

**Witness:** ______________________________

# CENTRAL FLORIDA GASTROENTEROLOGY

## PATIENT INFORMATION - INFORMACIÓN DEL PACIENTE

| PATIENT NAME<br>NOMBRE DEL PACIENTE | | | | BIRTHDATE<br>FECHA DE NACIMIENTO | SEX<br>SEXO |
|---|---|---|---|---|---|
| ADDRESS<br>DIRECCIÓN | CITY<br>CIUDAD | STATE<br>ESTADO | ZIP CODE<br>ZIP CODE | SOCIAL SECURITY NUMBER<br>NUMERO DE SEGURO SOCIAL | MARITAL STATUS<br>ESTADO CIVIL<br>☐ SINGLE ☐ SOLTERO(A)<br>☐ MARRIED ☐ CASADO(A)<br>☐ DIVORCED ☐ DIVORCIADO(A)<br>☐ WIDOWED ☐ VIUDO(A) |

| HOME PHONE<br>TELEFONO DE CASA | CELL PHONE<br>TELEFONO CELULAR | EMAIL<br>EMAIL | REFERRING PHYSICIAN<br>MEDICO REFERIDO |
|---|---|---|---|
| EMPLOYER PHONE #<br>TELEFONO DEL PATRÓN | EMPLOYER NAME & ADDRESS<br>PATRÓN & DIRECCIÓN | ARE YOU DISABLED<br>ESTÁ USTED INCAPACITADO<br>☐ YES<br>☐ NO | DATE OF DISABILITY<br>FECHA DE INCAPACIDAD |

| SPOUSE/GUARDIAN<br>NOMBRE DEL ESPOSO(A) / NOMBRE DEL CUSTIDIO | EMPLOYER<br>PATRÓN | EMPLOYER PHONE #<br>TELEFONO DEL PATRÓN |
|---|---|---|
| EMERGENCY CONTACT<br>CONTACTO DE EMERGENCIA | ADDRESS<br>DIRECCIÓN | PHONE<br>TELEFONO |

**FOR REPORT PURPOSES ONLY:** RACE ____________ ETHNICITY ____________ LANGUAGE ____________

## PRIMARY INSURANCE INFORMATION - INFORMACIÓN PRIMARIA DEL SEGURO

| NAME OF INSURANCE COMPANY<br>NOMBRE DE COMPAÑIA DE SEGURO | ADDRESS<br>DIRECCION | PHONE<br>TELEFONO |
|---|---|---|

| EFFECTIVE DATE<br>FECHA VIGENTE | PATIENT'S INS. ID #<br>SEGURO DEL PACIENTE ID # | GROUP NAME<br>NOMBRE DEL GRUPO | GROUP NUMBER<br>NÚMERO DE GRUPO |
|---|---|---|---|
| NAME OF SUBSCRIBER<br>NOMBRE DEL SUSCRIPTOR | SOCIAL SECURITY NUMBER OF SUBSCRIBER<br>NÚMERO DE SEGURO SOCIAL DEL SUSCRIPTOR | BIRTHDATE OF SUBSCRIBER<br>FECHA DE NACIMIENTO DEL SUSCRIPTOR | RELATIONSHIP OF SUBSCRIBER TO PATIENT<br>RELACIÓN DEL SUSCRIPTOR AL PACIENTE |

## SECONDARY INSURANCE INFORMATION - INFORMACIÓN DE SEGURO SECUNDARIO

| NAME OF INSURANCE COMPANY<br>NOMBRE DE COMPAÑIA DE SEGURO | ADDRESS<br>DIRECCIÓN | PHONE<br>TELEFONO |
|---|---|---|

| EFFECTIVE DATE<br>FECHA VIGENTE | PATIENT'S INS. ID #<br>SEGURO DEL PACIENTE ID # | GROUP NAME<br>NOMBRE DEL GRUPO | GROUP NUMBER<br>NÚMERO DE GRUPO |
|---|---|---|---|
| NAME OF SUBSCRIBER<br>NOMBRE DEL SUSCRIPTOR | SOCIAL SECURITY NUMBER OF SUBSCRIBER<br>NÚMERO DE SEGURO SOCIAL DEL SUSCRIPTOR | BIRTHDATE OF SUBSCRIBER<br>FECHA DE NACIMIENTO DEL SUSCRIPTOR | RELATIONSHIP OF SUBSCRIBER TO PATIENT<br>RELACIÓN DEL SUSCRIPTOR AL PACIENTE |

## LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE - AUTORIZACION POR VIDA PARA ASIGNACION DE BENEFICIOS Y LIBERACION DE INFORMACION:

I hereby give consent to **Internal Medicine Specialists** to provide whatever treatment they deem necessary to the patient named above. I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to obtain authorization for future treatment and with regard to processing claims.

I certify the information I furnish is true and correct and that I know it is a crime to fill out this form with facts that I know are false or to leave out facts that I know are important.

I assign payment directly to the physicians, nurse practitioners, or physician assistants at **Internal Medicine Specialists** which may be due to me from the Medicare program or other health insurance company. I understand I am financially responsible to **Internal Medicine Specialists** for any non-covered insurance services.

Patient or Responsible Party:____________________Date:__________

All necessary lab work will be billed separately by an independent laboratory. Please notify nurse of special laboratory requirements.

Por este medico doy mi concentimiento a **Internal Medicine Specialists** para proveer cualquier tratamiento que ellos estimen necesario al paciente en referencia. Autorizo cualquier compania de seguro, organizacion, patrono, hospital, medico, dentista o farmaceutico a liberar cualquier informacion requerida para obtener autorizacion para futuro tratamiento y processamiento de reclamos.

Yo certifico que la informacion que estoy dando es cierta y correcta y que estoy conceinte que es una violacion de ley proveer informacion falsa y/o de informar informacion intencionalmente sabiendo que es importante.

Yo assigno pago directo a los medicos, enfermeras practicante (nurse practitioners) y/o assistentes medicos en **Internal Medicine Specialists** que puedan estar debiendome del programa de medicare o cualquier otra compania de serguro. Yo entiendo que soy responsible por cualquier deuda financiera a **Internal Medicine Specialists** por todo servicio no cubierto por servicios de seguro.

Paciente o persona responsible____________________ Fecha__________

Todo trabajo de laboratorio sera facturado por separado por el laboratorio independiente. Favor de notificarle a la enfermera se cualquier requerimiento especial de laboratorio.

## COMMERCIAL INSURANCE - SEGURO COMERCIAL

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Payment is requested at time of service for self pay patients. A bookkeeper can assist you if arrangements must be made. We will be glad to assist with insurance forms. Your policy and coverage is a contract between you and your insurance company. You are responsible for all payments.

Yo autorizo que se ofresca la información necesaria para asi someter un reclamo con mi compañia de seguro y qué los beneficios sean asignados a mi o de otro modo a mi doctor o el grupo indicado en la forma del seguro. Yo tengo entendido que yo soy responsable por cualquier balance que mi seguro no cubra. Una copia de esta firma es valida como la original.

El pago es requerido al tiempo que se rinden los servicios a todo paciente no asegurado. Alguien de nuestro departamento de seguro puede asistirle si necesita un arreglo de pagos mensuales. Nosotros podemos asistirle en llenar las formas para su seguro. Su poliza de seguro es un contrato entre usted y la compañia de seguro. Usted es responsable de los pagos.

Signature / Firma____________________________________ Date / Fecha____________

Witness / Testigo____________________________________ Date / Fecha____________

| FOR OFFICE USE ONLY | CHART #: | INITIALS: | PERCENT NEEDED? ☐ YES ☐ NO | COPAY: | AUTHORIZATION NUMBER: |
|---|---|---|---|---|---|

NEPHROLOGY CONSULTANTS

CENTRAL FLORIDA GASTROENTEROLOGY

a division of internal medicine specialists

3885 Oakwater Circle • Orlando, FL 32806 • 407-851-5600 • Fax: 407-438-9561

## CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by **Internal Medicine Specialists, Inc.** (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardian, health care surrogates, or have power of attorney on behalf of the Patient: **(Patient must fill out) Name/Relationship:**______________________________

________________________________________________________

________________________________________________________

The Patient agrees that the Practice may disclose the following types of information contained in the Patient's medical records (please **initial, do not check,** the appropriate categories listed below):

| Category | Restrictions | Category | Restrictions |
|---|---|---|---|
| ______ HIV/AIDS Information | __________ | ______ Mental Health Information | __________ |
| ______ Substance Abuse Information | __________ | ______ If Patient is under the age of eighteen (18), Pregnancy information | __________ |
| ______ Sexually Transmitted Disease Information | __________ | | |

Patient agrees and consents to the Practice releasing information to Patient in the following alternative manners (please **initial, do not check** the appropriate spaces below):

______ Via e-mail to the Patient's designated e-mail address which is: ____________________.

______ Via Regular Mail with any envelopes being marked personal and confidential and addressed to Patient.

______ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient's name, social security number and date of birth.)

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent. If you revoke this consent, Internal Medicine Specialists will only continue to treat you on an emergency basis, and in that case for 30 days.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

**I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I MAY RECEIVE A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.**

Date:__________ Time:__________ AM / PM

__________________________ __________________________

Signature of Patient/Authorized Representative* Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient. Please attach proof of guardianship with a court document.

________________________________________________________

________________________________________________________

________________________________________________________

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