Florida Arthritis Center, PL
147 Parliament Loop, Suite 1005
Lake Mary, FL 32746

FLORIDA ARTHRITIS CENTER

Florida Arthritis Center, PL
75 Fox Ridge Ct. Suite G
DeBary, FL 32713

**Phone**: 407-688-9446 or **Fax**: 407-688-9448

**PATIENT INFORMATION**

| | | | |
|---|---|---|---|
| Last Name: | First Name: M.I.: | | Previous Name (if applicable) |
| Mailing Address: Apt# | | | |
| City/State/ZIP: | | | |
| Home Phone: | Cell Phone: | | Work Phone: |
| Are we allowed to leave a voicemail if so : (Please select only one option) ☐ Yes ☐ No | | | |
| Date of Birth: | Sex: ☐ Male ☐ Female | | Family Physician: |
| Marital Status: | Social Security#: | | |
| Employer Name: | Emergency Contact Name: | | |
| Emergency Contact Phone#: | Relationship to Patient: | | |

**ADDITIONAL INFORMATION**

Additional Information (**PLEASE FILL OUT ALL SECTIONS BELOW**)

| | |
|---|---|
| Email Address: | Can we leave message regarding your medical care and test results? ☐ Yes ☐ No |
| Race (Please select): ☐ White ☐ American Indian or Alaska ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline | Ethnicity (Please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline |
| Preferred Pharmacy Name and Location: | |

**INSURANCE INFORMATION**

| **PRIMARY MEDICAL INSURANCE** | **SECONDARY MEDICAL INSURANCE** |
|---|---|
| Ins. Co. Name: | Ins. Co. Name: |
| Policy Holder Name: | Policy Holder Name: |
| Policy Holder's Date of Birth: | Policy Holder's Date of Birth: |
| Policy Holder's Social Security#: | Policy Holder's Social Security#: |
| Patient's Relationship to Policy Holder: | |
| | |

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# Assignment of Benefit

## Release of information /authorization for treatment Prescription (RX) History consent

I hereby assign all insurance benefits to which I am entitled, including Medicare, private insurance, major medical benefits and any other health plan to the assigned physician. This assignment will remain in effect until revoked by me in writing. I understand that **I am financially responsible** for all charges whether or not paid by said insurance. I hereby authorize the said assignee to release all information, including HIV, substance abuse or psychiatric information which may be found in the record and is necessary to secure payment.

**Consent of Treatment**: The patient and/ or authorized representatives does hereby consent to any or all medical treatments which may deem advisable by Florida Arthritis Center, PL.

**RX Consent:** I give Florida Arthritis Center, PL to send and receive my pharmacy history.

Patient/Responsible Party:_____Date:_____

I have read and agreed to the copy of Florida Arthritis Center, PL's Privacy Notice. ☐ (Initials)

I have read and agreed to the patient portal user agreement. ☐ (Initials)

**Signature of Responsible Party: _____Date: _____**

**Printed Name of Responsible Party: _____Date: _____**

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# Patient Consent

**Please give us your contact information below**

I _____, agree that Florida Arthritis Center, PL may contact me or the following individuals that I have designated in the following alternative manners for the following reasons.

**Appointments Reminders:**

Leave a message / Voice Mail ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Telephone Number ☐

**Lab Results:**

Results may be given to patient ONLY ☐ or patients designated person ☐

Leave a message / Voice Mail at contact number provided ☐

**Medicine Prescriptions/Orders:**

Scripts/Orders may be given to the following:

patient ONLY ☐ or patients designated person ☐

Designated Person(s) if selected:

_____

Print name and relationship of Designated Person(s)

**Signature**

_____

**Patient or Guardian Signature**

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Patient's Name: _____Date: _____

Reason for visit:_____

Name of your Primary Care Doctor (PCP): _____

Do (did) any family members have the following conditions: Gout ☐ Psoriasis ☐ Rheumatoid Arthritis ☐
Sjogren Syndrome ☐ Scleroderma ☐ Myositis ☐ Tuberculosis ☐

List of any Surgeries you had: _____

_____

Social History: Single ☐ Married ☐ Divorced ☐ Widow(er) ☐

Are you smoker? No ☐ Yes ☐ If yes, how much Cigarettes per day? _____ For how long? _____

If you ever smoked, when did you quit _____

Do (did) you drink alcohol? No ☐ Yes ☐ If yes, what and how much _____

Do (did) you use illicit drugs? No ☐ Yes ☐ If yes, what drugs are/have you used? _____

Do (did) any of your family members have any of the following illnesses? Diabetes ☐ Heart Disease ☐

Heart Attack ☐ High Blood Pressure ☐ Stroke ☐ High Cholesterol Levels ☐

List any medication allergies you have and your reaction to them _____

_____

**Pharmacy Name:** _____

Pharmacy Phone: _____ Pharmacy Fax: _____

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Please list all medication that you take, both prescription and non-prescription:

| Medication | Dose | How often | Medication | Dose | How often |
|---|---|---|---|---|---|
| 1. | | | 6. | | |
| 2. | | | 7. | | |
| 3. | | | 8. | | |
| 4. | | | 9. | | |
| 5. | | | 10. | | |

Patient's Name: _____ Date: _____

**Review of Systems:**

Please state YES or NO if you have experienced any or all of the following recently:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Fevers | _____ | Chills | _____ | Sweats | _____ | Weight Loss | _____ |
| Rashes | _____ | Photosensitivity | _____ | Mouth Sores | _____ | Chest Pain | _____ |
| Vomiting | _____ | Nausea | _____ | Constipation | _____ | Abdominal Pain | _____ |
| Dark/Bloody Stools | _____ | Diarrhea | _____ | Numbness | _____ | Blood in Urine | _____ |
| Sleeping Problems | _____ | Fatigue | _____ | Anxiety | _____ | Depression | _____ |

**Past Medical History:**

Please state YES or NO if you have ever experienced any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Stomach Ulcers | _____ | Hepatitis | _____ | Reflux Disease | _____ | HIV | _____ |
| Crohn's Disease | _____ | Lyme disease | _____ | Kidney Disease | _____ | Psoriasis | _____ |
| Thyroid Disease | _____ | Asthma | _____ | Gout | _____ | Glaucoma | _____ |
| Heart Attack | _____ | Osteoporosis | _____ | Tuberculosis | _____ | Anemia | _____ |
| High Blood Pressure | _____ | High Cholesterol | _____ | | | | |

**Vaccination Status :**

Please list the date(s) of your last vaccination(s):

Shingles_____ FLU _____ Hepatitis _____ BCG _____ Pneumonia _____

Other _____, if so please list_____

_____

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# OUR OFFICE POLICIES

Appointments are necessary at all times. No walk-ins please. It disrupts the patient care. You are welcome to call and discuss your questions.

All medical record requests for personal use will require 48 hours' notice and the patient will be charged a fee of 15 cents per page. If you are requesting records to be mailed there might be an additional charge.

**PLEASE NOTE**: if records are for another doctor's office and not for the personal use, we will **fax** them over **free of charge**.

**ALL REFILLS** must be requested by your pharmacy 48 hours in advance. No refills will be given without being seen by our office within a 4-month time period. All refills guidelines must be up to date before any refills will be given by our office. If you are requesting a mail order prescription, this requires a 48-72 hour notice. This takes time to acquire a signed prescription from the doctor since he travels to different offices. Your patience in this matter is greatly appreciated.

**ALL REFERRALS** are the responsibility of the patient!!! Please make sure you have a valid referral on file, if necessary with our office before each appointment. If you fail to do so, you will be responsible for the charges incurred for that date of service or you may be rescheduled. It is the sole responsibility of the patient to know their insurance.

**PLEASE NOTE**: FLORIDA ARTHRITIS CENTER, PL reserves the right to discharge you from the practice for frequent missed or cancelled appointment without informing our office 24 hours in advance. Any missed appointments without a 24 hour advance notice will be also require to pay a $50.00 cancellation fee for future appointments. We may also dismiss you from our practice for inappropriate comments or behavior.

$35.00 service charge will be applied to your account if a check is returned from your bank.

**Self-Pay** patients are required a $50.00 deposit to be kept in their account for next appointment.

## I understand the above policies and procedures of Florida Arthritis Center, PL

Patient Signature _____ Date: _____

Print Name _____ Date: _____

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# Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understood Florida Arthritis Center's Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I further understand that Florida Arthritis Center, PL may update its Notice of Privacy Practices at any time and that I may receive an updated copy of Florida Arthritis Center's Notice of Privacy Practices by submitting a request in writing for a current copy of Florida Arthritis Center's Notice of Privacy Practices.

Print Name _____ Date _____

Patient Signature _____ Date _____

***If completed by patient's personal representative, please print name and sign below.***

Patient Personal Representative Print Name_____ Date _____

Patient Personal Representative Signature_____ Date _____

## For Florida Arthritis Center, PL Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Florida Arthritis Center, PL made a good faith effort to obtain patient's written acknowledgement of the Notice of Privacy Practices but was unable to do so for the reasons documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other_____

Employee Name (Printed) _____ Date:_____

Employee Signature _____ Date: _____