

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

PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	Previous Name (if applicable)
Mailing Address			
Home Phone:	Cell Phone:	Work Phone:	
Are we allowed to leave a voicemail? If so: (Please select only one option)			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of Birth:	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Family Physician:
Marital Status:		Social Security Number:	
Employer Name:		Emergency Contact Name:	
Emergency Contact Phone Number:		Relationship to Patient:	
<b>Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)</b>			
Email Address:		Can we leave message regarding your medical care and test results?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Race (Please Select):		Ethnicity (Please select one):	
<input type="checkbox"/> White <input type="checkbox"/> American Indian Or Alaska <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline		<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline	
Preferred Pharmacy Name and Location:			
<b>PRIMARY MEDICAL INSURANCE</b>		<b>SECONDARY MEDICAL INSURANCE</b>	
Insurance Company Name:		Insurance Company Name:	
Policy Holder Name:		Policy Holder Name:	
Policy Holder's Date of Birth:		Policy Holder's Date of Birth:	
Policy Holder's Social Security Number:		Policy Holder's Social Security Number:	
Patient's Relationship to Policy Holder:			

Centro de Artritis de Florida, PL  
147 Parliament Loop, Suite 1005  
Lago María, FL 32746



Centro de Artritis de Florida, PL  
609 N. Charles Richard Beall Blvd.  
Debary, FL 32713

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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 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.

#### Appointment Reminders:

Leave a message / Voicemail:  Home Phone  Cell Phone  Work Phone  Telephone Number

#### Lab Results:

Results may be giving to patient ONLY:  Or patients designated person

#### Medicine Prescriptions / Orders:

Scripts / Orders may be given to the following:

Patient ONLY:  Or patients designated person

Designated person(s) if selected:

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Print name and Relationship of the Designated Person(s)

#### Signature

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Patient of 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 a 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 Number: \_\_\_\_\_ Pharmacy Fax Number: \_\_\_\_\_

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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 symptoms 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 experienced any or all of the following symptoms:

- |                           |                        |                      |                 |
|---------------------------|------------------------|----------------------|-----------------|
| 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: \_\_\_\_\_