

PATIENT INFORMATION

NAME: LAST: _____ FIRST: _____ MIDDLE INITIAL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____ WORK: _____ CELL: _____

E-MAIL: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____
(Day/Month/Year)

SOCIAL SECURITY: _____ MARITAL STATUS: _____

REASON FOR VISIT: _____

OCCUPATION: _____ EMPLOYER: _____

NAME OF SPOUSE, PARENT, OR GUARDIAN: _____ TELEPHONE: _____

WHO REFERRED YOU TO OUR OFFICE (how did you hear about us?): _____

YOUR FAMILY DOCTOR: _____ TELEPHONE: _____

EMERGENCY CONTACT NAME: _____ TELEPHONE: _____

PHYSICIAN'S RELEASE AND ASSIGNMENTS

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED BY ME, AND I AGREE THAT IN THE EVENT THAT THIS ACCOUNT IS REFERRED TO COLLECTIONS, I WILL PAY ALL THE COLLECTION EXPENSES, ATTORNEY FEES AND COURT COSTS.

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION REQUIRED BY MY INSURANCE CARRIER(S). A COPY OF THIS AUTHORIZATION MAY BE USED IN LIEU OF THE ORIGINALS. I FURTHER AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM.

I REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION, AND I AGREE THAT IN THE EVENT THAT THIS ACCOUNT IS REFERRED TO COLLECTIONS, TO PAY ALL COLLECTION EXPENSES, ATTORNEY FEES, AND COURT COSTS.

PATIENT SIGNATURE: _____ DATE: _____

IF YOU DO NOT KNOW THE INFORMATION PLEASE WRITE "DO NOT KNOW" ON THE LINE PROVIDED

PRIMARY PHYSICIANS NAME: _____

ADDRESS: _____ TEL. No.: _____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? _____ YES NO

WHY? _____ SINCE WHEN? _____

WHEN WAS YOUR LAST COMPLETE PHYSICAL EXAM?: _____

ARE YOU TAKING ANY MEDICATIONS OR SUBSTANCES? _____ YES NO

(IF YES, PLEASE LIST) _____

DO YOU ROUTINELY TAKE HEALTH RELATED SUBSTANCES (VITAMINS, OR ALTERNATIVE MEDICINE? _____ YES NO

(IF YES, PLEASE LIST) _____

ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES? _____ YES NO

(IF YES, PLEASE LIST) _____

DO YOU HAVE ANY OTHER ALLERGIES? _____ YES NO

(IF YES, PLEASE LIST) _____

DO YOU HAVE ANY PROBLEMS WITH PENICILLIN, ANTIBIOTICS, ANESTHETICS, OR OTHER MEDICATIONS? _____ YES NO

(IF YES, PLEASE LIST) _____

ARE YOU SENSITIVE TO ANY METALS OR LATEX? _____ YES NO

ARE YOU PREGNANT OR SUSPECT YOU MAY BE? _____ YES NO

DO YOU USE ANY BIRTH CONTROL MEDICATIONS? _____ YES NO

DO YOU HAVE REGULAR PERIODS? _____ YES NO

ARE YOU CURRENTLY IN OR HAVE YOU ALREADY BEEN THROUGH MENOPAUSE? _____ YES NO

HAVE YOU EVER BEEN TREATED FOR, OR BEEN TOLD YOU MIGHT HAVE HEART DISEASE? _____ YES NO

HAVE YOU EVER TAKEN THE DIET PILL, PHEN-FEN? _____ YES NO

DO YOU HAVE HIGH OR LOW BLOOD PRESSURE? (PLEASE CIRCLE WHICH) _____ YES NO

DO YOU HAVE A PACEMAKER, AN ARTIFICIAL HEART OR VALVE IMPLANT? (PLEASE CIRCLE WHICH) _____ YES NO

HAVE YOU EVER HAD RHEUMATIC FEVER? _____ YES NO

ARE YOU AWARE OF ANY HEART MURMURS? _____ YES NO

HAVE YOU EVER HAD A SERIOUS ILLNESS OR MAJOR SURGERY? YES NO

(IF YES, PLEASE LIST) _____

HAVE YOU EVER HAD RADIATION OR CHEMO TREATMENT FOR TUMOR, GROWTH, OR OTHER CONDITIONS? YES NO

(IF YES, PLEASE LIST) _____

DO YOU HAVE INFLAMMATORY DISEASES, SUCH AS ARTHRITIS OR RHEUMATISM? YES NO

DO YOU HAVE ANY ARTIFICIAL JOINTS or PROTHESIS? YES NO

DO YOU HAVE ANY BLOOD DISORDERS, SUCH AS ANEMIA, LEUKEMIA, ETC? YES NO

HAVE YOU EVER BLED EXCESSIVELY AFTER BEING CUT OR INJURED? YES NO

DO YOU HAVE ANY STOMACH, KIDNEY, THYROID, OR LIVER PROBLEMS? YES NO

ARE YOU DIABETIC? YES NO

DO YOU HAVE ASTHMA? YES NO

DO YOU HAVE EPILEPSY OR SEIZURE DISORDERS? YES NO

DO YOU HAVE OR HAVE EVER HAD A VENEREAL DISEASE? YES NO

HAVE YOU BEEN TESTED FOR HIV? YES NO

DO YOU HAVE AIDS? YES NO

HAVE YOU HAD OR DO YOU TEST POSITIVE FOR HEPATITIS? YES NO

HAVE YOU EVER BEEN TREATED OR TOLD YOU HAVE LUNG DISEASE OR T.B.? YES NO

DO YOU SMOKE, CHEW OR SNIFF ANY OTHER FORMS OF TOBACCO, INCLUDING CIGARS? YES NO

(IF YES, HOW MUCH DO YOU CONSUME PER DAY? _____)

DO YOU CONSUME ALCOHOLIC BEVERAGES? YES NO

(IF YES, HOW MUCH DO YOU CONSUME PER DAY? _____)

DO YOU HABITUALLY USE CONTROLLED SUBSTANCES? YES NO

HAVE YOU HAD PSYCHIATRIC TREATMENT OR BEEN TREATED FOR MENTAL ILLNESS? YES NO

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED? YES NO

(IF YES, PLEASE LIST) _____

“I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE”

PRINT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE

UNDER FLORIDA LAW, PHYSICIANS ARE GENERALLY REQUIRED TO CARRY MEDICAL MALPRACTICE INSURANCE OR OTHERWISE DEMONSTRATE FINANCIAL RESPONSIBILITY TO COVER POTENTIAL CLAIMS FOR MEDICAL MALPRACTICE. THIS IS PERMITTED UNDER FLORIDA LAW SUBJECT TO CERTAIN CONDITIONS. FLORIDA LAW IMPOSES PENALTIES AGAINST NON-INSURED PHYSICIANS WHO FAIL TO SATISFY ADVERSE JUDGEMENTS ARISING FROM CLAIMS OF MEDICAL MALPRACTICE. THIS IS PROVIDED UNDER PURSUANT TO FLORIDA LAW.

PRINT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I HEREBY GIVE CONSENT TO JHONNY SALOMON, M.D., P.A. AND ALL HEALTH CARE PROVIDERS FURNISHING CARE WITHIN THE PRACTICE TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

MY "PROTECTED HEALTH INFORMATION" MEANS THAT HEALTH INFORMATION, INCLUDING MY DEMOGRAPHIC INFORMATION, COLLECTED FROM ME AND CREATED OR RECEIVED BY MY PHYSICIAN, ANOTHER HEALTH CARE PROVIDER, A HEALTH PLAN, MY EMPLOYER, OR A HEALTH CARE CLEARINGHOUSE. THIS PROTECTED HEALTH INFORMATION RELATES TO MY PAST, PRESENT, AND FUTURE PHYSICAL AND MENTAL HEALTH CONDITION. IT IDENTIFIES ME OR THERE IS A REASONABLE BASIS TO BELIEVE THE INFORMATION MAY IDENTIFY ME.

PLEASE BE ADVISED THAT OUR NOTICE OF PRIVACY PRACTICES PROVIDES MORE DETAILED INFORMATION ABOUT HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION. YOU HAVE THE RIGHT TO REVIEW OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU SIGN THIS CONSENT. WE RESERVE THE RIGHT TO REQUEST AND RESTRICT HOW WE USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. WE ARE NOT REQUIRED TO GRANT YOUR REQUEST, BUT IF WE DO, THE RESTRICTION WILL BE BINDING ON US.

YOU MAY REVOKE THIS CONSENT AT ANY TIME. YOUR REVOCATION MUST BE IN WRITING, SIGNED BY YOU OR ON YOUR BEHALF, AND DELIVERED TO THE OFFICE ADDRESS. YOU MAY DELIVER YOUR REVOCATION BY ANY MEANS YOU CHOOSE BUT IT WILL BE EFFECTIVE ONLY WHEN WE ACTUALLY RECEIVE THE REVOCATION. YOUR REVOCATION WILL NOT BE EFFECTIVE TO THE EXTENT THAT OTHERS ARE OR WE HAVE ACTED IN RELIANCE UPON THIS CONSENT.

PRINT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

IF YOU ARE SIGNING AS THE PATIENT'S REPRESENTATIVE DESCRIBE YOUR AUTHORITY: _____

I AUTHORIZE THE FOLLOWING INDIVIDUAL(S) TO RECEIVE INFORMATION REGARDING MY PROTECTED HEALTH INFORMATION.

Name: _____

FOR OFFICE USE ONLY

Reviewed By: _____ **M.D.** **DATE:** _____