the surgery group
PART OF NORTH FLORIDA SURGEONS

Who is your Primary Care Physician? _____

Who referred you to our office? _____

Last Name: _____ First Name: _____ MI: _____

Gender: M ___ F ___ Date of Birth: _____ Social Security #: _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Cell Phone: _____

Consent to text: ☐ Yes ☐ No

Race: _____ Marital Status: Married Single Divorced Widowed

What Insurance should be filed as your Primary Insurance Company? _____

Policyholder Name: _____

Policyholder Date of Birth: _____ Policyholder Social Security # _____

Relationship to Patient: Self Spouse Dependent Other

Policy #: _____ Group #: _____

Is this a group insurance policy? Yes No

If Yes, is the policyholder still employed? Yes No

What Insurance should be filed as your Secondary Insurance Company? _____

Policyholder Name: _____

Policyholder Date of Birth: _____ Policyholder Social Security # _____

Relationship to Patient: Self Spouse Dependent Other

Policy #: _____ Group #: _____

Is this a group insurance policy? Yes No

If Yes, is the policyholder still employed? Yes No

I understand that I am responsible for payment of services rendered to me or my minor child. This includes any balance not paid by my insurance. I understand that *North Florida Surgeons* will file my insurance claim as a courtesy and that I will pay any amount not paid by insurance within 60 days. I understand that I must resolve any disputes with my insurance company. I authorize payment of insurance benefits directly to *North Florida Surgeons* for all services rendered. I authorize release of any medical or other information necessary to process these claims. If the account is in default, I agree to pay all collection agency and attomey fees as well as court costs necessary to collect this debt.

Signature of Patient, Parent or Guardian ✓ _____ Date ✓ _____

FILL OUT THIS SECTION IF PATIENT IS UNDER THE AGE OF 18

Parent Name: _____

Address, If Different: _____

City, State, Zip: _____

RELEASE OF MEDICAL INFORMATION RECORDS:

Before we can discuss your medical condition with anyone (spouse, children, significant other, etc) we MUST have the following authorization on file. This list can be modified by the Patient, Parent or Legal Guardian in writing only. The physicians at North Florida Surgeons and their staff have my permission to discuss my medical condition, treatment, etc., and to release all information they have available to:

______________________ Relationship: ______________
Phone Number: ______________

______________________ Relationship: ______________
Phone Number: ______________

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Phone Number: ______________

______________________ Relationship: ______________
Phone Number: ______________

______________________ Relationship: ______________
Phone Number: ______________

______________________ Relationship: ______________
Phone Number: ______________

______________________ Relationship: ______________
Phone Number: ______________

In case of emergency call: ______________________

Your email address: ______________________

Signature of Patient, Parent or Guardian:

✓ ______________________ Date: ✓ ______________

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PART OF NORTH FLORIDA SURGEONS

Patient Name: _____

DOB: _____ Your Age: _____ Today's Date: ____ / ____ / ____

Primary Care Physician: _____ Who referred you to us: _____

What is the main problem: _____

Drug allergies: Yes / No (lf yes list names): _____ / _____

_____ / _____ / _____ / _____

Do you take any medications: (including over the counter) Yes / No (please circle one) lf yes, please list all:

Do you take Diet pills prescribed or over the counter: Yes / No

Are you on any blood thinners: Yes / No

_____ / ____ MG	_____ / ____ MG	_____ / ____ MG
_____ / ____ MG	_____ / ____ MG	_____ / ____ MG
_____ / ____ MG	_____ / ____ MG	_____ / ____ MG
_____ / ____ MG	_____ / ____ MG	_____ / ____ MG
_____ / ____ MG	_____ / ____ MG	_____ / ____ MG

SURGICAL HISTORY: (type of surgery)

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY: (list family member):

☐ Diabetes: ☐ High Blood Pressure:

☐ Heart Disease: ☐ Other not listed:

☐ Cancer/type: _____

OTHER:

Yes/No - Paps/Pelvic What Year _____

Yes/No - Mammogram What Year _____

Yes/No - Colonoscopy What Year _____

Yes/No - Do you use Sunscreen

MEDICAL HISTORY:

☐ Diabetes ☐ Heart Disease

☐ High Blood Pressure ☐ Thyroid Disorder

☐ Acid Reflux (GERD) ☐ HLD(high cholesterol)

☐ Cancer/type: _____

☐ Others not listed: _____

Father lllnesses: _____ Living: ____ Deceased From: _____ At age ____

Mother lllnesses: _____ Living: ____ Deceased From: _____ At age ____

PLEASE COMPLETE FRONT AND BACK

Smoking: ☐ Never ☐ Yes _____ Packs/Day: X _____ Years Quit: What Year: _____
Alcohol: ☐ No ☐ Yes: How much _____ ☐ Daily ☐ Weekly ☐ Monthly
☐ Married ☐ Divorced ☐ Single ☐ Widow ☐ Separated ☐ Domestic Partner
Occupation: _____ ☐ Retired ☐ Unemployed

SYMPTOMS THAT I HAVE (please check YES or NO on all areas):

Constitutional:

Y	N	
☐	☐	Chills
☐	☐	Fever
☐	☐	Weight change Gain or Loss

Eyes:

Y	N	
☐	☐	Vision Changes
☐	☐	Double/Blurred Vision
☐	☐	Cataracts
☐	☐	Glaucoma

Ears, Nose, Throat, Mouth:

Y	N	
☐	☐	Hearing Loss
☐	☐	Ringing
☐	☐	Dizziness/Spinning
☐	☐	Nosebleed
☐	☐	Sinus Problems
☐	☐	Swallowing Problems
☐	☐	Swollen Glands
☐	☐	Hoarseness

Hematologic:

Y	N	
☐	☐	Anemia
☐	☐	Easy Bruising or Bleeding

Respiratory:

Y	N	
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Bronchitis
☐	☐	Cough
☐	☐	Shortness of Breath

Cardiovascular:

Y	N	
☐	☐	Chest Pain
☐	☐	Palpitations
☐	☐	Irregular Heart Beat
☐	☐	Blood Clots
☐	☐	Ankle Swelling
☐	☐	Murmur

Gastrointestinal:

Y	N	
☐	☐	Nausea/Vomiting
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Indigestion/Heartburn
☐	☐	Rectal Bleeding
☐	☐	Hepatitis

Endocrine:

Y	N	
☐	☐	Pancreas Disease

Breast & Skin:

Y	N	
☐	☐	Breast Changes
☐	☐	Nipple Changes
☐	☐	Skin Tumor/Lump/Bump
☐	☐	Rash

Neurological:

Y	N	
☐	☐	Headache/Migraine
☐	☐	Dizziness
☐	☐	Stroke
☐	☐	Seizure

Psychological:

Y	N	
☐	☐	Depression
☐	☐	Nervous Disorder
☐	☐	Memory Loss
☐	☐	Anxiety

FOR OFFICIAL USE ONLY:

BP: LEFT ___ /___ RIGHT ___ /___ R: _____ P: _____ HT: _____ WT: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEAITH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:
1. The right to inspect and copy your information;
2. The right to request correction to your information;
3. The right to request that your lnformation be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
5. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

lf you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice	North Florida Surgeons 4012 North 9th Avenue Pensacola, Florida 32503 (850) 444-4777
Contact Person	
Phone Number	

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES, I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this NOITCE OF PRIVACY PRACTICES should it be amended, modified, or changed in anyway.

_____
Patient or Representative Name (please print)

_____ _____
Patient or Representative Signature Date

☐ Patient Refused to sign ☐ Patient was unable to sign because

_____

How did you hear about us?

□ Return Patient	□ Location/Street Sign	□ Local businesses	_____
□ Website	□ Facebook/Twitter	□ Family/friend referral	_____
□ Google	□ Family Doctor	□ Other	_____