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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Patient Name: ______________________________

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

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

What is the main problem? ______________________________

MEDICATION(s):

____

____

____

____

____

____

____

____

DRUG ALLERGIES (and reaction):

____

____

____

____

PREVIOUS SURGERY & HOSPITALIZATIONS:

____

____

____

____

OTHER ILLNESSES I HAVE:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Other not listed
- ☐ Cancer

____

DISEASES WHICH RUN IN MY FAMILY:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Other not listed
- ☐ Cancer

____

Father Illnesses: ______________________________ Deseased From: ______________

Mother Illnesses: ______________________________ Deceased From: ______________

Smoking: ☐ Yes __________ Packs/Day: ______ ☐ Quit: What Year: _______ ☐ No

Alcohol: ☐ Yes ☐ No

☐ Single ☐ Married ☐ Divorced ☐ Widow

Occupation: ______________________________

SYMPTOMS THAT I HAVE (please check YES or NO for EACH item/symptoms):

Constitutional:
Y N
☐ ☐ Chills
☐ ☐ Fever
☐ ☐ Weight change (Gain or Loss)

Eyes:

☐ ☐ Double/Blurred Vision
☐ ☐ Cataracts
☐ ☐ Glaucoma

Ears, Nose, Throat, Mouth:
Y N
☐ ☐ Hearing Loss
☐ ☐ Ringing
☐ ☐ Swallowing Problems
☐ ☐ Swollen Glands

Respiratory:
Y N
☐ ☐ Asthma
☐ ☐ Emphysema
☐ ☐ Cough

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

Gastrointestinal:
Y N
☐ ☐ Nausea/Vomiting
☐ ☐ Loss of Appetite/Weight Loss
☐ ☐ Abdominal Pain
☐ ☐ Indigestion/Heartburn
☐ ☐ Rectal Bleeding
☐ ☐ Colonoscopys

Endocrine:
Y N
☐ ☐ Diabetes
☐ ☐ Thyroid
☐ ☐ Pancreas

Breast & Skin:
Y N
☐ ☐ Breast Changes
☐ ☐ Nipple Changes
☐ ☐ Mammograms

Neurological:
Y N
☐ ☐ Headache
☐ ☐ Dizziness
☐ ☐ Stroke
☐ ☐ Seizure

Psychological:
Y N
☐ ☐ Depression
☐ ☐ Nervous
☐ ☐ Memory Loss

Other:
Y N
☐ ☐ PSA's
☐ ☐ Paps & Pelvics

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	________________