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: ____________________

_______________________________ Relationship: ____________________
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: ____________

Chief Complaint (the main problem): ______________________________

Where located: ____________ When Began: ____________ How Severe: ____________

What makes it better/worse? ______________________________

MEDICAL HISTORY (list your illnesses):

____
____
____
____
____
____

SURGICAL HISTORY (list your operations & when):

____
____
____
____

FAMILY MEDICAL HISTORY (list family member):

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

Mother deceased from (& age) ____________

Father deceased from (& age) ____________

DRUG ALLERGIES (and reaction):

____
____
____

MEDICATIONS:

____
____
____
____
____
____
____
____
____
____

SOCIAL HISTORY:

Smoking: ☐ Yes ________ Packs/Day: X ________ Years ☐ Quit: What Year: ________ ☐ Never

Alcohol: ☐ Yes: How much/Often ____________ ☐ Quit: What Year: ________ ☐ Never

Other Drugs (nonprescription): ☐ Yes ☐ No

Occupation: ______________________________

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow

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

Constitutional:

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

Eyes:

Y	N	
☐	☐	Vision Changes
☐	☐	Double/Blurred Vision
☐	☐	Cataracts
☐	☐	Blurring/Spots/Flashes

Ears, Nose, Throat, Mouth:

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

Respiratory:

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

Cardiovascular:

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

Hematologic:

Y	N	
☐	☐	Anemia
☐	☐	Easy Bruising or Bleeding
☐	☐	Transfusion (when)

____

Gastrointestinal:

Y	N	
☐	☐	Nausea/Vomiting
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Indigestion/Heartburn
☐	☐	Rectal Bleeding
☐	☐	Hepatitis
☐	☐	Crohn's/Ulcerative Colitis
☐	☐	Last Colonoscopy (when, results)

Endocrine:

Y	N	
☐	☐	Heat/Cold Intollerance
☐	☐	Excessive Thirst/Hunger/Urination
☐	☐	Thyroid Disease
☐	☐	Pancreas Disease

Breast & Skin:

Y	N	
☐	☐	Breast Changes
☐	☐	Nipple Changes
☐	☐	Skin Tumor/Lump/Bump
☐	☐	Rash
☐	☐	Last Mammogram (when, results)

____

Neurological:

Y	N	
☐	☐	Headache/Migraine
☐	☐	Dizziness
☐	☐	Stroke (TIA / RIND / CVA)
☐	☐	Seizure

Psychological:

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

Genitourinary:

Y	N	
☐	☐	Urinary Incontinence
☐	☐	Increased Urination
☐	☐	Bloody Urination
☐	☐	Painful Urination
☐	☐	Kidney Stones
		Last PSA or Pap/Pelvic (when, result)

____

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	________________