ASSOCIATES OF INTERNAL MEDICINE

PATIENT INFORMATION

Thank you for choosing Associates of Internal Medicine! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Patient Name_____ Birthdate _____ ***Male*** or ***Female***

Home Phone # _____ Cell Phone # _____ SS# _____

Address _____ City _____ State___ Zip _____

Email _____

Circle appropriate status: ***Single*** ***Married*** ***Divorced*** ***Widowed*** ***Separated***

Circle appropriate status: ***Employed*** ***Unemployed*** ***Retired*** ***Student***

If Employed: Circle One: ***Full-time Part-time***

Name of Employer _____ Work Phone _____

Business Address _____ City _____ State ___ Zip _____

If a student: Circle one: ***Full-time Part-time***

Spouse's Name _____ Employer _____ Work # _____

Person to contact in case of emergency _____ Phone _____

Responsible Party if not same as above

Name of guardian or caregiver _____ Relationship to patient _____

Birthdate _____ Home Phone _____ Cell Phone _____

Address _____

Driver's License # _____ Financial Institute _____

Employer _____ Work phone # _____

Is this person a current patient? ***Yes*** or ***No*** (please circle one)

Please provide legal documentation showing legal guardian/ power of attorney

Whom may we thank for referring you? _____

_____ _____ _____

Patient name (Print) Patient signature Today's date

13660 Jog Road Suite B 5 Delray Beach, Florida 33446(561) 498-7474 * fax (561) 819-6466*

ASSOCIATES OF INTERNAL MEDICINE

INSURANCE INFORMATION

Name of insured _____

Birthdate _____ SS# _____

Insurance Company _____ ID# _____ Group # _____

Insurance Address _____

How much is your insurance deductible? $_____ How much have you met? $_____

Name of Employer and Address _____

Date employed _____

Do you have secondary insurance? ***Yes*** or ***No*** (please circle one)

Name of secondary insurance: _____

Insurance Company _____ ID# _____ Group # _____

Insurance Address _____

How much is your insurance deductible? $_____ How much have you met? $_____

Responsible Party if not same as above

Name of person responsible for the account _____ Relationship _____

Address _____ Phone # _____

Birth date _____ Driver's license # _____ Financial institute _____

Employer _____ Work Phone _____

I, authorize the release of any information concerning my healthcare advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____ _____

Signature of patient Today's date

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ASSOCIATES OF INTERNAL MEDICINE

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date: _____

Patient Name: _____ **Date of Birth:** _____

Chief Compliant: _____

_____

Past Medical History:

Have you ever had the following: (Circle "NO" or "YES", leave blank if uncertain)

Name of Condition			Epilepsy		
Measles	No	Yes	Migraine Headaches	No	Yes
Mumps	No	Yes	Tuberculosis	No	Yes
Chickenpox	No	Yes	Diabetes	No	Yes
Whooping Cough	No	Yes	Cancer	No	Yes
Scarlet Fever	No	Yes	Polio	No	Yes
Diphtheria	No	Yes	Glaucoma	No	Yes
Smallpox	No	Yes	Hernia	No	Yes
Pneumonia	No	Yes	Blood or Plasma	No	Yes
Rheumatic Fever	No	Yes	Transfusions	No	Yes
Heart Disease	No	Yes	Back Trouble	No	Yes
Arthritis	No	Yes	High Blood Pressure	No	Yes
Venereal Disease	No	Yes	Low Blood Pressure	No	Yes
Anemia	No	Yes	Hemorrhoids	No	Yes
Bladder Infection	No	Yes	Asthma	No	Yes
Hives or Eczema	No	Yes	Mitral Valve Prolapse	No	Yes
AIDS OR HIV +	No	Yes	Stroke	No	Yes
Infectious Mono	No	Yes	Hepatitis	No	Yes
Bronchitis	No	Yes	Ulcer	No	Yes

Medication List: (Include nonprescription)

Name of Medication	Dosage/Strength	Frequency

Patient Social History:

Marital Status: Single ___ Married ___ Separated ___ Divorced: ___ Widowed ___
Use of alcohol: Never ___ Rarely ____ Moderate ___ Daily ___
Use of tobacco: Never ___ Previously, but quit _____ Current packs/day _____
Use of drugs: Never ____ Type/Frequency _____

Excessive exposure at home or work to:
Fumes ____ Dust ____ Solvents ____ Particles ___ Noise ___ N/A ___

Family Medical History:

	Age	Disease	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Previous Hospitalizations/Surgeries/Serious Illnesses:	Date	Hospital, City, State

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms			**Genitourinary**		
Good general health lately	No	Yes	Frequent Urination	No	Yes
Recent weight change	No	Yes	Burning or painful urination	No	Yes
Fever	No	Yes	Blood in urine	No	Yes
Fatigue	No	Yes	Change in force of strain when urinating	No	Yes
Headaches	No	Yes	Incontinence or dribbling	No	Yes
Eyes			Kidney stones	No	Yes
Eye disease or injury	No	Yes	Sexual Difficulty	No	Yes
Wear glasses/contact lenses	No	Yes	Male – Testicle Pain	No	Yes
Blurred or double vision	No	Yes	Female – Pain with periods	No	Yes
Ears/Nose/Mouth/Throat			Female – Irregular periods	No	Yes
Hearing loss or ringing	No	Yes	Female – Vaginal discharge	No	Yes
Earaches or drainage	No	Yes	Female - # of pregnancies	No	Yes
Chronic sinus problem or rhinitis	No	Yes	Female - # of miscarriages	No	Yes
Nose bleeds	No	Yes	Female – Date of last pap smear	No	Yes
Mouth sores	No	Yes	**Musculoskeletal**		
Bleeding gums	No	Yes	Joint pain	No	Yes
Bad breath or bad taste	No	Yes	Joint stiffness or swelling	No	Yes
Sore throat or voice change	No	Yes	Weakness of muscles or joints	No	Yes
Swollen glands in the neck	No	Yes	Muscle pain or cramps	No	Yes
Cardiovascular			Back pain	No	Yes
Heart Trouble	No	Yes	Cold extremities	No	Yes
Chest pain or angina pectoris	No	Yes	Difficulty in walking	No	Yes
Palpitation	No	Yes	**Integumentary (skin, breast)**		
Shortness of breath while walking or lying flat	No	Yes	Rash or itching	No	Yes
Swelling of feet, ankle, or hands	No	Yes	Change in skin color	No	Yes
Respiratory			Change in hair or nails	No	Yes
Do you have a persistent cough or clearing not associated with a known illness (lasting more than 3 weeks)?	No	Yes	Varicose veins	No	Yes
Spitting up blood	No	Yes	Breast pain	No	Yes
Shortness of breath	No	Yes	Breast lump	No	Yes
Wheezing	No	Yes	Breast discharge	No	Yes
Gastrointestinal			**Neurological**		
Loss of appetite	No	Yes	Frequent or recurring headaches	No	Yes
Change in bowel movements	No	Yes	Light-headed or dizzy	No	Yes
Nausea or vomiting	No	Yes	Convulsions or seizures	No	Yes

Frequent diarrhea	No	Yes	Numbness or tingling sensations	No	Yes
Painful bowel movements or constipation	No	Yes	Tremors	No	Yes
Rectal Bleeding or blood in stool	No	Yes	Paralysis	No	Yes
Abdominal pain	No	Yes	Head injury	No	Yes

Psychiatric

Memory Loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

Endocrine

Glandular or hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

Hematologic/Lymphatic

Show to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusions	No	Yes
Enlarged glands	No	Yes

Allergic/Immunologic

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, Merthiolate, or other antiseptic	No	Yes

Other drugs/ medications: _____

_____

_____

_____

Known food allergies: _____

_____

_____

_____

Environmental allergies: _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date

ASSOCIATES OF INTERNAL MEDICINE

Forms:

Forms that are required to be filled out by the physician represent a cost to us and will be charged an additional fee of $25.00. The forms should be received 48 hours in advance.

Missed Appointments/Late Cancellations:

Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments.

I have read and understand the Associates of Internal Medicine Financial Policy. I agree to assign insurance benefits to Associates of Internal Medicine whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or Authorized representative:

_____

Today's Date: _____

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ASSOCIATES OF INTERNAL MEDICINE

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

All payment is expected at the time of service

Payment is required at the time of service is rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. This practice accepts cash, personal checks (in-state only), Visa, and Master Card. There is a service charge of $30.00 for returned checks.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments.

Insurance:

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges. Please be advised if you are disputing charges not paid by your insurance company requiring appeals, you will be responsible for monies due until payment is paid in full by your insurance.

Should you need to, your time of service receipt includes information necessary for submitting claims to your insurance company.

If you need assistance or have questions, please contact our billing office between 9:00 am and 4:30 pm., Monday through Friday at 561-488-4414

Refunds:

Overpayments will be refunded upon written request to the responsible party within 30 days.

Managed Care:

If you are enrolled in a managed care insurance plan (i.e., HMO), you must receive a referral from our office before seeing a specialist. No retroactive referrals will be given.

Signature of insured/Authorized representative:

_____

Today's Date: _____

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ASSOCIATES OF INTERNAL MEDICINE

Statement of Patient Privacy Rights

New Federal legislation mandates that certain information about how AIM uses your confidential medical record be provided to you and that we maintain a record of any entity with whom we share your information.

At AIM we have always regarded all medical and personal information as completely confidential. As a result, many of the new federal mandates have not changed the way we handle information other than to tell you how we protect it.

All of our staff sign a confidential oath. The oath states that your information is to be used only when necessary to provide you with medical care. We take this oath very seriously and strive to treat you and your medical information the way we would want ourselves and our own information to be treated. We also stay current and compliant with all state and federal laws regarding the handling of your confidential personal medical information.

We will record and provide to you upon request, information about any release of your information other than the use of your information for the purpose of providing you with care in our offices, sharing pertinent information with other practitioners involved in your care (specialists, etc.) and your insurance company for the purpose of verifying your treatment so that claims can be paid.

The patient information label that you signed authorizes the use of your information for these purposes. We do not provide information to anyone else unless you have sent us a separate release or if we receive a court order signed by the judge or the clerk of the court. If you want a family member to be able to inquire about you, for example confirming your appointment or checking to see if you are in our office, we will not reveal this information unless you have signed a specific release identifying who you authorize to receive this information.

Our staff will be asking questions when you call our office to verify that you are who you say you are. Please be patient with this process as it is to ensure your privacy. Our policy ensures that your information remains confidential. Copies of this statement are available as are copies of a lengthier statement describing in great detail how information is handled in specific settings. If you would like a copy of either please ask.

Patient Signature: _____

Today's Date: _____

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Why Everyone Should Have A Living Will

A living will is important in case something is to ever happen to you and you are no longer able to speak or make your own medical decisions. Although it can be difficult to think about, advanced directives can help ensure that your family/caregiver do not have to make any medical decisions. Instead, your medical team can follow your living will making sure they are treating you based on your own wishes dictated in your living will.

Do You Have a Living Will?

- o Yes, I have a living will. I will be sure to bring it in at my next appointment.
- o No, I do not have a living will.
- o I do not wish to disclose that information.

X_____ _____ _____

Patient Name (Signature) Patient Name (Print) Today's Date

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ASSOCIATES OF INTERNAL MEDICINE

Authorization to Release Information to Family Members

Many of our patients allow family members, such as their spouse, significant other, parents, or children to call and request results or test results, procedures, and financial information. Under the regulations of H.I.P.P.A., we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results, and/ or financial information released to any family members, you must sign this form.

- I authorize _____ / who is my _____to discuss and obtain medical information and complete access to my diagnosis and medical care. Their phone number is _____.

- I authorize _____ / who is my _____to discuss and obtain medical information and complete access to my diagnosis and medical care. Their phone number is _____.

- I authorize _____ / who is my _____to discuss and obtain medical information and complete access to my diagnosis and medical care. Their phone number is _____.

- I authorize _____ / who is my _____to discuss and obtain medical information and complete access to my diagnosis and medical care. Their phone number is _____.

I fully understand and accept the terms of this contract

_____	_____	_____
Patient name (Print)	**Patient signature**	**Today's date**

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ASSOCIATES OF INTERNAL MEDICINE

Consent To Leave Telephone Message

- I understand that as part of my healthcare, Associates of Internal Medicine, PA may at times need to reach me by phone
- I authorize AIM to leave messages at my home telephone regarding test results, x-ray results, or laboratory results.
- I authorize AIM to fax information to me regarding my health care at my home or work.

  OR

- I do not authorize AIM to leave messages on my telephone regarding any type of testing results. I will accept the responsibility of contacting the office to obtain any test results.

I fully understand and accept the terms of this contract

_____	_____	_____
Patient name (Print)	**Patient signature**	**Today's date**

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____ I do not authorize the office of Associates of Internal Medicine, PA, to release my records or
discuss any information with anyone but myself.

____ I authorize the office of Associates of Internal Medicine, PA, to release my records and any information to the following individuals,

1._____ Relation to Patient: _____

2._____ Relation to Patient: _____

3._____ Relation to Patient: _____

4._____ Relation to Patient: _____

5._____ Relation to Patient: _____

_____ _____

Patient Name (Print) Patient Signature

___/___/20___
Today's Date

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