FORT LAUDERDALE SURGICAL SPECIALISTS, PA
JONATHAN S. LEVINE MD, FACS / LEANDRA BAZAN, MMS, PA-C
4801 N. FEDERAL HIGHWAY, SUITE 101
FORT LAUDERDALE, FL 33308
TELEPHONE: 954.202.0242 FACSIMILE: 954.202.0243

Name: _____

Local Address: _____

City/State: _____ Zip Code: _____

Home Phone: _____ Cell #: _____

Preferred Language _____ Race _____ Ethnicity _____ Gender _____

Date of Birth: _____ Age: _____

Marital Status: M - S - W - D Spouse's Name: _____

Referred By: _____ PCP if different: _____

Employer: _____ Work #: _____

Occupation: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Social Security No: _____ Email Address: _____

Primary Insurance Co: _____

Policy No: _____ Group Number: _____

Secondary Insurance Co: _____

Policy No: _____ Group Number: _____

Nearest Living Relative, Name/Address/Phone: _____

_____

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 fhe doctor's office of any changes in my medical status or demographic changes. I also authorize the healthcare staff to perform the necessary services I may need. In addition, I authorize release of any pertinent information in obtaining payment on my account.

_____

Signature/Date

Please list the medications you are taking with their dosages and frequency

HEALTH HISTORY

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

Date: _____

Patient Name _____

Chief Complaint: _____

History of present illness:

Location: _____
(Where is the pain/problem?)

Severity _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Timing _____
(Does the pain/problem occur at a specific time?)

Associated signs/symptoms _____

_____
(What other associated problems have you been having?

Duration _____
(How long have you had this pain/problem?, or, When did it start?)

Modifying factors _____

_____

_____

_____
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History
Have you ever had the following: **CIRCLE "YES", TO WHAT APPLIES**

Measles	No	Yes	Anemia	No	Yes	Back trouble	No	Yes	Date of last mammogram		
Mumps	No	Yes	Bladder Infections	No	Yes	High Blood Pressure	No	Yes	Date of last colonoscopy		
Chickenpox	No	Yes	Epilepsy	No	Yes	Low Blood Pressure	No	Yes	Hepatitis	No	Yes
Whooping Cough	No	Yes	Migraine Headaches	No	Yes	Hemorrhoids	No	Yes	Ulcer	No	Yes
Scarlet Fever	No	Yes	Tuberculosis	No	Yes	Date of last chest x-ray			Kidney Disease	No	Yes
Diphtheria	No	Yes	Diabetes	No	Yes	Asthma	No	Yes	Thyroid Disease	No	Yes
Smallpox	No	Yes	Cancer	No	Yes	Hives or Eczema	No	Yes	Bleeding Tendency	No	Yes
Pneumonia	No	Yes	Polio	No	Yes	AIDS or HIV+	No	Yes	Any other disease	No	Yes
Rheumatic Fever	No	Yes	Glaucoma	No	Yes	Infectious Mono	No	Yes	(please list):		
Heart Disease	No	Yes	Hernia	No	Yes	Bronchitis	No	Yes			
Arthritis	No	Yes	Blood or Plasma			Mitral Valve Prolapse	No	Yes			
Venereal Disease	No	Yes	Transfusions	No	Yes	Stroke	No	Yes			

Previous Surgeries Procedures When? Hospital/ City/ State

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

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:	_____		

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother	_____	_____	_____
	_____	_____	_____
Sister	_____	_____	_____
	_____	_____	_____
Son	_____	_____	_____
	_____	_____	_____
Daughter	_____	_____	_____
	_____	_____	_____

Review of Systems: **CIRCLE "YES", TO WHAT APPLIES**

☐ Constitutional Symptoms
- Good general health lately ..... No Yes
- Recent weight change ..... No Yes
- Fever ..... No Yes
- Fatigue ..... No Yes
- Headaches ..... No Yes

☐ Eyes
- Eye disease or injury ..... No Yes
- Wear glasses/contact lenses ..... No Yes
- Blurred or double vision ..... No Yes

☐ Ears/Nose/Mouth/Throat
- Hearing loss or ringing ..... No Yes
- Earaches or drainage ..... No Yes
- Chronic sinus problem or rhinitis ..... No Yes
- Nose bleeds ..... No Yes
- Mouth sores ..... No Yes
- Bleeding gums ..... No Yes
- Bad breath or bad taste ..... No Yes
- Sore throat or voice change ..... No Yes
- Swollen glands in neck ..... No Yes

☐ Cardiovascular
- Heart trouble ..... No Yes
- Chest pain or angina pectoris ..... No Yes
- Palpitation ..... No Yes
- Shortness of breath w/walking or lying flat ..... No Yes
- Swelling of feet, ankles or hands ..... No Yes

☐ Respiratory
- Chronic or frequent coughs ..... No Yes
- Spitting up blood ..... No Yes
- Shortness of breath ..... No Yes
- Wheezing ..... No Yes

☐ Gastrointestinal
- Loss of appetite ..... No Yes
- Change in bowel movements ..... No Yes
- Nausea or vomiting ..... No Yes
- Frequent diarrhea ..... No Yes
- Painful bowel movements or constipation ..... No Yes
- Rectal bleeding or blood in stool ..... No Yes
- Abdominal pain ..... No Yes

☐ Cenitourinary
- Frequent urination ..... No Yes
- Burning or painful urination ..... No Yes
- Blood in urine ..... No Yes
- Change in force of strain when urinating ..... No Yes
- Incontinence or dribbling ..... No Yes
- Kidney stones ..... No Yes
- Sexual difficulty ..... No Yes
- Male - testicle pain ..... No Yes
- Female - pain with periods ..... No Yes
- Female - irregular periods ..... No Yes
- Female - vaginal discharge ..... No Yes
- Female - # of pregnancies ..... _____
- Female - # of miscarriages ..... _____
- Female - date of last pap smear .... _____

☐ Musculoskeletal
- Joint pain ..... No Yes
- Joint stiffness or swelling ..... No Yes
- Weakness of muscles or joints ..... No Yes
- Muscle pain or cramps ..... No Yes
- Back pain ..... No Yes
- Cold extremities ..... No Yes
- Difficulty in walking ..... No Yes

☐ Integumentary (skin, breast)
- Rash or itching ..... No Yes
- Change in skin color ..... No Yes
- Change in hair or nails ..... No Yes
- Varicose veins ..... No Yes
- Breast pain ..... No Yes
- Breast lump ..... No Yes
- Breast discharge ..... No Yes

☐ Neurological
- Frequenter recurring headaches ..... No Yes
- Light headed or dizzy ..... No Yes
- Convulsions or seizures ..... No Yes
- Numbness or tingling sensations ..... No Yes
- Tremors ..... No Yes
- Paralysis ..... 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
- Slow to heal after cuts ..... No Yes
- Bleeding or bruising tendency ..... No Yes
- Anemia ..... No Yes
- Phlebitis ..... No Yes
- Past transfusion ..... No Yes
- Enlarged glands ..... No Yes

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_____ _____

Signature of Patient, Parent or Guardian Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

FORT LAUDERDALE SURGICAL SPECIALISTS, PA
JONATHAN S. LEVINE MD, FACS / LEANDRA BAZAN, MMS, PA-C
4801 N. Federal Highway
Suite 101
Fort Lauderdale, FL 33308

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Authorized Person: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

FORT LAUDERDALE SURGICAL SPECIALISTS, PA
JONATHAN S. LEVINE MD, FACS / LEANDRA BAZAN, MMS, PA-C

FINANCIAL POLICY

We are committed to providing you with the best medical and surgical care. We will be happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

We will gladly file all insurance claims as a courtesy to you, our patient.

- All patients must complete all of our patient information forms and present a valid picture ID along with insurance cards before seeing a doctor.
- Full payment is expected at time of service unless prior arrangements have been made with our office.
- All co-pays, deductibles and/or 20% of all charges are due at the time of service dependent upon your insurance plan. There is a $5.00 charge if not paid at time of service.
- We accept Cash, Check, Visa, Master Card, Discover and American Express.
- Any account over 90 days without any activity is subject to being sent to a collection agency and additional collection fees, a 35% fee will be added to outstanding balances, attorney fees and court costs will be added to the account. No additional collection fees will be waived on any account. If the amount owed is not fully satisfied by the due date, then a fee of 35% of the outstanding balance (as calculated on the due date) will be added to the outstanding balance, and sent to our collection agency. To avoid these fees we encourage you to pay at time of service.
- We will send 2 statements and make one attempt to place a courtesy call prior to sending an account to a collection company. It is your responsibility to ensure that your account is paid in a timely manner and communicate any problems or concerns with our billing office.
- There is a $25.00 charge for all returned checks.

I understand that I am ultimately responsible for any services not covered or not paid by my insurance company.

I authorize any holder of medical or other information about me to release to my insurance carrier or its intermediaries any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

_____

Patient/Guardian Signature Date

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records, and other individually identifiable health information used or disclosed by us in another form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.