NAME:_____ DATE: _____

HEALTH SCREENING QUESTIONNAIRE

(Please add notes on front face/end of this form/not back of form)

We want to be able to provide our patients with thorough, up to date medical care. We need your assistance to provide this service to you. Please take a few minutes to complete this questionnaire, add dates, frequency of problems, other doctors seen for problems, and other useful information to the right of your answers, circle appropriate responses. All information is confidential.

Thank you!

Current Medications (please list) **Medications Allergic to**

Prescription & over-the-counter (What type of reaction?)

PAST MEDICAL HISTORY

Have you **ever** (including during childhood) had

Mumps

Measles (Rubeolla)

German measles (Rubella)

Chicken pox (Varicella)

Meningitis

Others (Rheumatic Fever, Scarlet Fever, Whooping cough, etc [list])

Neurologic

Are you predominantly **Right** or **Left** handed?

fainting spells

stroke (when? what type of problem did it leave you with?)

transient ischemic attack

seizures/convulsions/epilepsy

tremors

severe or unusual recent headache

migraine, tension, cluster headache

Parkinson's disease

multiple sclerosis

Alzheimer's disease/dementia

frequent loss of memory

hallucinations/psychosis

Depression

Anxiety

difficulty relaxing

Recent Depression/Anxiety

Severe stress

Severe sleep problems

frightening dreams/thoughts

worries a lot

cries often

loses temper

annoyed by little things

work/family problems

recent sexual problems

considered suicide
desired psychiatric help

Eyes

cataracts L R
Have you had cataract surgery/lens implants? L R
glaucoma L R
nearsighted-wear glasses for distance
farsighted-wear glasses to read
other visual problems
blurry vision
double vision
halo's around lights/objects
eye pain
watery or dry eyes
color-blindness

Ears

hearing trouble
ringing in ears
dizzy spells
discharge from ear L R
ruptured eardrum L R
otitis media L R

Nose/Mouth/Throat

sinus allergies/hay fever
sinus infections
nasal polyps/Allergies/Hay Fever
nose bleeds L R
chronic runny nose
chronic sinus congestion
sore throats
chronic hoarseness
tonsillitis
enlarged tonsils
trouble swallowing
trouble talking
periodontal disease or dentures (upper, lower, full, partial?)
problems with teeth/gums
periodontal disease
swellings on gums or jaws
gingivitis
taste changes
mouth/tongue cancer

Neck

diabetes or other endocrine problems
thyroid problems
weight loss or gain

goiter
arthritis
disk disease
throat or larynx cancer

Respiratory

asthma
Have you ever smoked or quit smoking (when) cigarettes?
How many packs/d average?
emphysema
chronic bronchitis
tuberculosis
night sweats
cough & sputum color/change?
coughing up blood
lung cancer
frequent chest colds
pneumonia
wheezing
shortness of breath at rest

CardioVascular

hypertension (when did it start?)
rheumatic fever
palpitations/racing heart
chest pains or discomfort
angina
dizzy spells
shortness of breath
_____pillows needed at night
gets out of bed to breath at night
Heart attack (Myocardial Infarction) (when?)
High cholesterol/fats
congestive heart failure
swollen feet/ankles
heart murmur
pain in legs with walking
Have you ever passed out or nearly passed out during or after exercise?
Have you ever had discomfort, pain, or pressure in your chest during exercise?
Does your heart race or skip beats during exercise?
Has a doctor ever told you that you have high blood pressure, high cholesterol, a heart murmur, or a heart infection?
Has a doctor ever ordered a test for your heart (e.g., electrocardiography, echocardiography)?
Has anyone in your family died for no apparent reason?
Does anyone in your family have a heart problem?
Has anyone in your family died of heart problems or of sudden death before 50 years of age?

Does anyone in your family have Marfan syndrome?

Gastrointestinal

abdominal pain/nausea/vomitting
heartburn
belching
hiatal hernia
esophagitis
gastritis
gastric ulcer
duodenal ulcer
vomit blood
gall bladder problem
hepatitis
yellow jaundice
constipation or diarrhea
diverticulosis
irritable bowel syndrome
Colon or other Cancer
hemorrhoids
black stools or blood in stool
rectal pain/itch

Urinary

kidney stones
difficulty or pain on urination
frequent infections?
night frequency____times
day frequency
weak urine stream
brown, black, or bloody urine
difficulty starting/stopping
lose urine with coughing, etc.
sexual difficulties

Males

prostate trouble
burning or discharge
VD
lumps on testicles
hernia
painful testicles
penile discharge

Females

Age of first period____years
days between periods____regular/irregular
duration of periods____pads/day____
mid-cycle bleeding
birth control

bleeding after intercourse
premenstrual tension
hot flashes
Females (cont.)
birth control pill (brand)_____
vaginal discharge/pain/itch
VD
Pelvic Inflammatory Disease
last Pap smear_____years, normal/abnormal
last mammogram_____years ago
Females (cont.)
number of pregnancies_____
full term_____
premature_____
abortion/miscarriages_____
caesareans_____
pregnancy complications
Musculoskeletal
aching muscles/joints (where?)
gout
swollen joints
back/shoulder/hip pains
painful feet
disabilities
arthritis (where?)
any surgeries or broken bones?
Skin
severe skin problems
acne
itching/burning/rash
bruises/bleeds easily
psoriasis
fungal skin infections
nail problems
General
diabetes-pills (when did it start?)
diabetes-insulin (when did it start?)
diabetes-diet
weight changes
feels hot/cold
doesn't tolerate hot/cold
fatigue
leg cramps
always hungry
not interested in food
more thirsty lately

HIV exposure
frequent urination
sleeping difficulty
lack of exercise
smokes_____packs/day X _____ years Year that you quit_____.
marijuana, cocaine, crack, heroin, LSD
caffinated beverages____/day
alcoholic beverages____/day
does/doesn't use seat belts
Sexual Preferrences/History/Risk Factors (we respect your right to privacy, if you don't wish to answer please initial here)_____

Advance Directives:

Have you completed a Living Will? Yes No

Please let us know of your wishes regarding end of life wishes, if you don't have a Living Will we'll be happy to provide the form to be completed with educational points on how to complete the form, if you wish, you can describe your wishes at the end/back of this.

Past Surgical History

Please list prior surgeries (Eg. tonsils, appendix, etc.) with date of surgery, surgeon, and outcome (Please list at end/on back of forms)
Immunizations & Vaccinations
Year of last Tetanus shot?
Pneumonia vaccine?
Hepatitis vaccines?
Childhood immunizations?
Do you get annual “flu shots”?

Social

Single, Co-Habitating, Married, Divorced/Separated, Widow/Widower,
What year?
Occupation_____
Education (highest level)_____
Lives with (list those you live with)
Primary language spoken;
Pets (types)
Caffeine use
Alcohol use
Drug use

Family Medical History (blood-relatives)

Father Alive/Deceased age_____ cause/problems
Mother Alive/Deceased age_____cause/problems
Siblings health problems
Eg. cardiac disease, diabetes, cancer (where?), thyroid disease, rheumatic disease, gout, allergies, tuberculosis, kidney disease, epilepsy/seizures, migraine headache, blood pressure problems, any other known heritable disease (please list below)
As your primary care providers, we want to be aware of any other care you are

receiving. Is there anything else that we should know about your health, or any questions that you would like the doctor to answer?
Please understand that we make every effort to be as thorough as possible with our care, just as our questionnaire is very detailed, you will probably be getting a physical exam that includes evaluation of all organ systems appropriate for your age.
If there is a part of the exam that you want to decline, please let us know and we'll comply
with your wishes even if your request is counter to the recommendations of all of the academic study groups.

HIPAA NOTICE OF PRIVACY PRACTICES

I. 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.

II. IT IS MY LEGAL DUTY TO PROTECT YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this notice about my privacy procedures. This notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means that when I share, apply, utilize, examine or analyze information within my practice; PHI is disclosed when I release, transfer, give or otherwise reveal it to a third party outside my practice.

With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made, however, I am always legally required to follow the privacy practices described in this notice. I may need to use this information to get your care paid for by the insurer.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies I will immediately change this notice and post a new copy of it in my office. You may also request a copy of this Notice from me.

III. HOW I WILL USE AND DISCLOSE YOUR PHI:

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others however will not. Below you will find the different categories of my uses and disclosures with some examples.

• **Uses and disclosures related to treatment, payment or health care operations do not require your Prior Written Consent.** I may use and disclose your PHI without your consent for the following reasons:

• For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists and other licensed health care providers who provide you with heath care services or are otherwise involved in your care. Example: if a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

• For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality-control-I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants and others to make sure that I am in compliance with applicable laws.

• To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided to you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates such as billing companies, claims processing companies and others that process health care claims for my office.

• Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after the treatment is rendered. In the event that I try to

get your consent but you are unable to communicate with me (for example if you are unconscious or in severe pain) but I thin that you would consent to such treatment if you could, I may disclose your PHI.

• **Certain other uses and disclosures do not require your consent.** I may use and/or disclose your PHI without your consent or authorization for the following reasons:

• When disclosure is required by federal, state or local law; judicial, board, or administrative proceedings or law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.

• If disclosure is compelled by a party to a proceeding before a court or administrative agency pursuant to its lawful authority.

• If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.

• If disclosure I compelled by the patient or the patients representative pursuant to California health and safety codes or t corresponding federal statutes of regulations such as the Privacy Rule that requires this Notice.

• To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.

• If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others and if I determine that disclosure is necessary to prevent this threatened danger.

• If disclosure is mandated by the Child Abuse and Neglect Reporting Law. For example if I have a reasonable suspicion of child abuse or neglect.

• If disclosure is mandated by the Elder/Dependent Adult Abuse Reporting Law. For example if I have a reasonable suspicion of elder abuse or dependent adult abuse.

• If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

• For public health activities. Example; I the event of your death, if a disclosure is permitted or compelled I may need to give the county coroner information about you.

• For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

• For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also I may disclose PHI in the interests of national security such as protecting the President of the United States or assisting with intelligence operations.

• For research purposes. In certain circumstances I may provide PHI in order to conduct medical research

• For Workers Compensation purposes. I may provide PHI in order to comply with Workers Compensation Laws.

• Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options or other health care services or benefits I offer.

• Copays and any outstanding balances must be paid prior to seeing physician. All balances must be kept up to date. Your insurance company by CT State Law has 45 days to pay your claims for services. If not paid by that time, the patient is responsible for the payment of the bill.

• All patients must show up 5-10 minutes prior to Appointment, unless otherwise requested.

• Patients must refrain from using Cell Phones in the office as this leads to delays in Office Staff and Physicians providing care and affects and delays other patients care.

• Patients must be compliant with Physician recommended Diet, Lifestyle and Behavioral Modifications.

• Patients must be compliant with Physician recommended Medical treatments and medical followup.

• Patients must keep all their Demographic (address, phone #s & e-mail addresses) and Insurance Information up to date

• Patients are expected to treat the Office and Exam rooms as if they are in their own home after Cleaning day.

• Patients must be clear on stating the reason for their office visit and address their primary reason for their office visit, additional complaints and issues will be addressed at a future visit or as time permits. Making an appointment for one problem but then requiring the physician to address multiple other issues delays your care and those patients with visits after you, lengthens the day of work for office staff and physicians who have other responsibilities as well.
• Patients must make appointments only for those the appointment is meant for. Add on patients in the same appointment time also delays and lengthens your office visit as well as delays care to patients who have appointments to follow yours

PATIENT CONSENT FORM

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Tequesta Family Practice, P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Tequesta Family Practice describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Tequesta Family Practice, P.A. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Tequesta Family Practice, P.A. Privacy Officer, 395-B Tequesta Drive, Tequesta, FL 33469.

With this consent, Tequesta Family Practice, P.A. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any ca11s pertaining to my clinical care, including laboratory test results, among others.

With this consent Tequesta Family Practice, P.A. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Tequesta Family Practice, P.A. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

By signing this form, I am consenting to allow Tequesta Family Practice, P.A. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has heady made disclosures in reliance upon prior consent. If I do not sign this consent; or late r revoke it, Tequesta Family Practice, P.A. may decline to provide treatment to me.

By signing below, I acknowledge that I have received the Notice of Privacy Practices from Tequesta Family Practice, P.A.

We realize that many families are in a state of change. Divorce, separated, single parent, and blended families are now common. It is the policy of this office that the parent accompanying the child for treatment will be held responsible for all bills. We cannot bill the other parent.

NOTE: In order to keep fees down and contain operative expenses, payment is expected at the time of service. If unpaid after 30 days, a service charge of $5.00 is added monthly to the billing statement.

There is a $30.00 service charge for returned checks.

There is a $25.00 fee accessed to any missed appointment. 24 hours cancellation is required.

Statements are mailed to all accounts with a balance, regardless of whether or not an insurance claim is pending.

I authorize Tequesta Family Practice, P.A to furnish information to Insurance carriers, appropriate health and/or school authorities concerning the illness or medical treatment of my dependent or myself, and I hereby assign to the provider(s) all insurance payments for medical services rendered to myself or my dependents, except those services for which I have already paid prior to the filing of the insurance claim on my behalf. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have to assist me in this responsibility. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.

Due to an increase in patient “No Shows” and appointments cancelled at the last minute, effective May 1,2003 we will assess a $25.00 fee for any missed or cancelled appointments without a 24-hour

notification from the patient.
We are sorry that we find this assessment necessary, but we have turned away patients due to not having any available appointments only to have openings that we were not aware would be available and feel that this is detrimental to you, our patient's medical well-being. We thank you for your cooperation and understanding with the new policy.

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I[understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Patient Name:_____

Patient Signature:_____

Date:_____

May leave message on home phone YES/NO (circle)

May leave message at work phone YES/NO (circle)

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits to be made on your behalf to Tequesta Family Practice, P.A., as appropriate for any particular claim, for any service furnished me by this provider. I authorize any holder of medical information about me to release to the Health Care financing administration, its agents, and any secondary insurance companies including appropriate health authorities, any information needed to determine these benefits or the benefits payable for related services. I further authorize Tequesta Family Practice, P.A. to obtain on my behalf information regarding the status of my Medicare claims for these services. I acknowledge responsibility for payment of medical services rendered to myself or my dependent. If for any reason I the account should become delinquent, I agree to pay for all collection and legal fees.

Signature:_____

_____

(Print Patient's Name) (Print Name of Legal Guardian/relationship, if applicable)

Phone Number:_____

Date:_____

HIPAA (Health Insurance Portability and Accountability Act)

Notice of Privacy Practices

Patient information CANNOT be released to ANYONE without written consent of the patient-with only one exception...

Patient information CAN be released to parent/ guardian of minor patient

Patient Consent Form(signed/dated; by patient or parent/guardian of minor) - patient acknowledges receipt of HIPAA Notice of Privacy Practices -patient permits release of information to insurance for payment of Claim

Authorization Form (signed/dated; by patient or parent/guardian of minor) -patient permits release of information to Specialist (notes, labs, tests)

-patient must list name(s) of person(s) that are permitted to get information in emergency situation.

MEDICAL AUTHORIZATIONS:

I hereby authorize my insurance benefits to be paid directly to the above medical practice & physician. I realize that I am responsible to pay any co-pays, non-covered services and any expense involved in collection attempts. I hereby authorize the release of pertinent medical information to my insurance company to facilitate the payment of my claims, request for change of insurance or new insurance benefits. I also hereby authorize this office to submit copies of my medical records subject to a subpoena issued by the courts for any legal action with which I may be involved now or in the future.

Late Payment Policy

Significant costs are incurred in carrying our patient accounts. To control these costs, and therefore postpone further increases in fees, we will charge interest on all unpaid patient accounts 60 days after the date of treatment. The rate of interest will be 1.5% per month (18% per year). No interest is charged on accounts paid in full within 60 days of treatment date.

If a claim is denied for timely filing or non covered service because the patient intentionally or unintentionally gave us the wrong insurance information, the bill in its entirety will become the patients responsibility.

I have read and understand this authorization.

DATE: _____/_____/_____

RESPONSIBLE PARTY: _____