Ocala Family Care P.A.
3299 SW 34th Street Unit 100B
Ocala, FL 34474 (352) 861-1533

____ Rajnikant Patel, MD ____ Jamie DiPrimo, ARNP

Patient Information:

Patient's Name: _____ SSN: _____

Age: ____ Sex: ___ Date of Birth: ___ / ___ /_____ Marital Status: S M W D

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: (_____) _____ Alternate Phone: (_____) _____

Email Address: _____

Employer: _____ Work Phone: (_____) _____

Emergency Contact Name: _____

Phone Number: (_____) _____ Relation: _____

Race: American Indian/Alaska Native ___ Asian ___ Native Hawaiian ___ White ___

Black/African American ___ Hispanic ___ Other _____

Language: English ___ Spanish ___ Indian (Includes Hindi & Tamil) ___ Other ____

Ethnicity: Hispanic _____ Non-Hispanic _____ Refused to Report _____

Responsible Party Information:

Self: _____ Other: _____ (Please Provide Information If Other Than Self)

Name: _____ Date of Birth: ___ / ___ /_____ Relation: _____

Address: _____ City: _____ State: ___ Zip: _____

SSN: _____ Employer: _____

Work# (____) _____ Home# (____) _____ Alt# (____) _____

I hereby assign all medical, to include major medical benefits, to which I am entitled, including Medicare, and government sponsored programs, private insurances, and any other plan to: Ocala Family Care P.A. This assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid for by my insurance. I hereby authorize said assignee to release all information necessary to secure payment.

****Upon turning in paperwork, please have insurance card(s) license ready****

Person Responsible For Bill, Please Sign Legal Full Name:

Signature: _____ Date: ____/____/_____

Ocala Family Care P.A.

Personal Medical History – 1 of 2

Please Check all That Apply

	Past History	Current History	Never
1. Infectious Diseases			
Chicken Pox	☐	☐	☐
Malaria	☐	☐	☐
Mononucleosis	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Scarlet Fever	☐	☐	☐
Tuberculosis	☐	☐	☐
2. Eyes, Ears, Nose and Throat			
Deafness	☐	☐	☐
Hearing Loss	☐	☐	☐
Seasonal Allergies	☐	☐	☐
Sinus Disease	☐	☐	☐
Wear Glasses or Contacts	☐	☐	☐
Other Visual Problems			
Describe _____			
3. Cardiopulmonary			
Asthma	☐	☐	☐
Bronchitis/pneumonia	☐	☐	☐
Fainting	☐	☐	☐
Heart Disease	☐	☐	☐
Heart murmur	☐	☐	☐
High Blood Cholesterol	☐	☐	☐
High Blood Pressure	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
4. Gastroenteric			
Crohn's Disease	☐	☐	☐
Ulcerative Colitis	☐	☐	☐
Reflux/GERD/Ulcer	☐	☐	☐
Gall Bladder Disease	☐	☐	☐
Hepatitis – Type _____	☐	☐	☐
Hernia	☐	☐	☐
Irritable/Spastic Bowel	☐	☐	☐
Regular Laxative Use	☐	☐	☐
Pancreatitis	☐	☐	☐
5. Urinary			
Cystitis/Bladder Infection	☐	☐	☐
Kidney Disease	☐	☐	☐
Kidney Infection/Pyelonephritis	☐	☐	☐
Kidney Stones	☐	☐	☐

	Past History	Current History	Never
6. Musculoskeltal			
Arthritis	☐	☐	☐
Bone or joint Deformity	☐	☐	☐
Broken Bones	☐	☐	☐
Rheumatoid Disorder	☐	☐	☐
Other _____	☐	☐	☐
7. Hematologic or Oncologic			
Anemia	☐	☐	☐
Hemophilia	☐	☐	☐
Leukemia or Lymphoma	☐	☐	☐
Sickle Cell Disease	☐	☐	☐
Other Blood Disorder	☐	☐	☐
Cancer _____	☐	☐	☐
8. Neuropsychiatric			
ADD/ADHD	☐	☐	☐
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Suicidal Thoughts or Acts	☐	☐	☐
Drug Addiction/Abuse	☐	☐	☐
Epilepsy (Seizures)	☐	☐	☐
Recurrent headaches	☐	☐	☐
Serious Head Injury	☐	☐	☐
9. Metabolic			
Diabetes	☐	☐	☐
Thyroid Disease	☐	☐	☐
10. Birth Defects			
Describe _____			
11. Sexual Health			
Positive HIV Antibody	☐	☐	☐
Abnormal PAP Smear	☐	☐	☐
Breast Lump	☐	☐	☐
DES Exposure (maternal)	☐	☐	☐
Menstrual Abnormalities	☐	☐	☐
Testicular Lump	☐	☐	☐
Undescended or Absent Testicle	☐	☐	☐
Hydrocele or Varicocele	☐	☐	☐

Other Significant Medical Problems:_____

_____

Hospitalization Dates: _____

_____

Surgery History: _____

Signature: _____ Date: ____/____/_____

Ocala Family Care P.A.

Personal Medical History -2 of 2 (Continued)

Please Check all That Apply

****Family History: Has any blood relative suffered from any of the following:**

_____ Diabetes
_____ Glaucoma
_____ Stroke
_____ TB And/Or Exposure
_____ High Cholesterol
_____ Thyroid Problems
_____ Alcoholism
_____ Kidney Disease
_____ Cancer; Please Specify Type _____

_____ High Blood Pressure
_____ Heart Disease
_____ Epilepsy/Convulsions
_____ Gout
_____ Anemia
_____ Hepatitis
_____ Mental Problems
_____ Migraines

Other _____

****Female History:**

Number of Children: _____
Menopause: _____
Sexually Active: YES or NO
Last PAP Smear: _____

Number of Pregnancies: _____
Hysterectomy _____
Birth Control: _____
Last Mammogram _____

**** Social History:**

Exercise: Type _____ Frequency _____

Cigarette/Tobacco Use: YES / NO Age Started: _____ Avg Number/Day _____ Age Stopped: _____

Alcohol Use: YES / NO Average Drinks / Week _____

Caffeine: (Tea, Coffee, soda) YES / NO Frequency _____

Other Substances: _____

****Allergies**

Are you allergic to any medications, dyes, or shellfish? YES / NO

Drug Allergies / Type of reactions: _____

Ocala Family Care P.A.

HIPPA

To our Patients

On April 24th, 2003, the state of Florida passed a Patient Privacy Act. The paperwork that we are asking you to fill out is a Federal Law and must be in all patient charts. If you would like to designate someone to have access to your medical records for any reason, such as appointments, test results, picking up prescriptions, or having any other information in your chart, please list that person on line 3 of the authorization for disclosure of health information form. If you do not wish to have your medical records disclosed to anyone other than yourself and be available to you, please list "self."

Notice of Privacy Act Acknowledgment

I acknowledge that the notice of privacy practices has been given or made available to me upon request by Quick Primary Care P.A.

Advance Directive/Living Will/Power of Attorney

I, _____ notify Ocala Family Care P.A. That I have the following documentation in place for my medical care.

(circle YES or NO for the following)

YES NO I have an Advance directive as of _____

YES NO I have a Living Will as of _____

YES NO I have a Durable Power of Attorney _____

My Power of Attorney is: _____

Signature _____ Date: _____

Witness _____ Date: _____

Ocala Family Care P.A.

Authorization for Disclosure of Health Information

1. I hereby authorize Ocala Family Care P.A., to disclose the following information from the health records of:

Patient Name: _____ Date of Birth _____

Phone Number (____) _____ SSN _____

Address _____ City _____State _____ Zip _____

Covering the health period From: ___/___/_____ Through ___/___/_____

2. Information to be Disclosed:

_____ Complete Health Record _____ Discharge Summary

_____ History and Physical Exam _____ Progress Notes

_____ Consultation Reports _____ Lab Tests

_____ X-Ray reports _____ Photo/Video/Digital Image

_____ Other (Please Specify) _____

I understand that this will include information relating to (Check if Applicable)

___ Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency (HIV) Infection.

___ Behavioral health service/Psychiatric

___ Treatment of Drug Abuse

3. This information can be disclosed to the following Persons: _____

_____

4. I understand this authorization can be revoked in writing at ay time, except to the extent that the action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition; _____

5. Ocala Family Care P.A., it's employees, and Physicians, are hereby released from any legal responsibility or liability for disclosure of it's above information to the extent indicated and authorized herein.

Signature: _____ Date: ____/____/_____

Ocala Family Care P.A.

EFFECTIVE AUGUST 1, 2008

After the confirmation of your scheduled appointment, any no shows, or canceled appointments, with less than twenty hour prior notice will be charged a $55.00 fee.

This fee is the patients responsibility and will not be billed to any insurance company.

Please be advised no medication refills or lab results will be given if you have canceled or missed appointments.

Signature _____

Printed Name _____

Date: ___/___/_____

We would like to know how you heard about us:

___ Phone book/Yellow Pages

___ Newspaper _____

___ Physician, if so name _____

___ Friend _____

___ Website _____

___ Other (Circle) INSURANCE, HOSPITAL, HOSPITAL FOLLOWUP.

Ocala Family Care P.A.
3299 SW 34th Street Unit 100B
Ocala, FL 34474

Phone: (352) 861-1533 Fax: (352) 861-1562

Authorization For the Release of Health Information

I hereby authorize Ocala Family Care P.A. To receive the following information from the health records of: Patient Name: _____

Date of Birth ___/___/_____ SSN: _____

Information to be disclosed:

___	Complete Health Records	___	History and Physical Exam
___	Consultation Reports	___	Radiology Reports/Images
___	Discharge Summary	___	Progress Notes
___	Lab Results	___	Other _____

I understand that this will include information relating to (Check if Applicable)

___ Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency (HIV) Infection.

___ Behavioral health service/Psychiatric

___ Treatment of Drug Abuse

Signature _____ Date: _____

Witness _____ Date: _____

Previous Health Care Provider's Information:

Name _____

Address _____ City _____ State _____ Zip _____

Phone: (____)_____Fax (____)_____

ADVANCED DIRECTIVE

1) Living Will Declaration

I, _____, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below. I do hereby declare that if at any time I should have a terminal condition as defined by Florida Statute, and my attending physician has determined that procedures would serve only to artificially prolong the dying process, I direct such procedures to be withheld or withdrawn. It is my wish that I be permitted to die naturally with the administration of medication or performance of the medical procedures deemed necessary to provide me with comfort care or to alleviate pain.

☐ I DO ☐ I DO NOT ….want to have the tube taken out of my nose or mouth that is connected to a machine that is breathing for me if it has already been inserted.

☐ I DO ☐ I DO NOT …..want to have the tube that is feeding me removed from my nose, mouth or stomach if it has already been inserted.

☐ I DO ☐ I DO NOT .....want CPR.

☐ I DO ☐ I DO NOT ….want a tube placed in my nose or mouth and connected to a machine to breathe for me.

☐ I DO ☐ I DO NOT ….want a tube in my nose or mouth, or surgically placed in my stomach, that is connected to a hanging bag to give me food.

☐ I DO ☐ I DO NOT ….want to have a needle or catheter placed in my body and connected to a hanging bag to give me water and other fluids.

☐ I DO ☐ I DO NOT .....want to die naturally. (To die naturally means I will receive only medicine and treatment that will keep me comfortable. This also means no antibiotics or other treatments that delay my death. I know this care could have side effects that could cause me to die sooner.)

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this declaration shall have no force of effect during the course of my pregnancy.

I understand the full importance of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____ **Date** _____/_____/_____
Witness _____ **Date** _____/_____/_____
Witness _____ **Date** _____/_____/_____

In addition to the provisions of my living will, or instead of a living will, I would like to designate a healthcare surrogate. My healthcare surrogate will have the authority to provide consent for medical treatment and surgical and diagnostic procedures if I am incapacitated and unable to provide such consent myself.

☐ YES ☐ NO If YES, complete next page; if NO, STOP here.

2) Healthcare Surrogate Designation

I, _____, would like to name as my healthcare surrogate:
Name _____
Address _____ Zip _____
Phone: (day) _____ (Evening) _____

If my surrogate is unwilling or unable to perform his duties, I wish to designate as my alternate surrogate: (optional)
Name _____
Address _____ Zip _____
Phone: (day) _____ (Evening) _____

I understand that my healthcare surrogate cannot override any specific wishes I have listed in my living will, but can make healthcare decisions on my behalf in situations not specifically addressed by me in my living will.
Initial: _____

I understand that I need only be incapacitated and unable to make medical decisions for my healthcare surrogate to assume authority.
Initial: _____

I fully understand that this designation will permit my surrogate to make healthcare decisions and to provide, withhold, or withdraw consent on my behalf, to apply for public benefits to defray the cost of healthcare and to authorize my admission to or transfer from a healthcare facility. I further affirm that this designation is not being made as a condition of treatment or admission to a healthcare facility.

Signed _____ Date _____/_____/_____
Witness _____ Date _____/_____/_____
_____ Date _____/_____/_____

One witness CANNOT be a spouse or blood relative. The person designated as surrogate CANNOT be a witness. Keep the original of this document in a safe place where your family and designated surrogates have access to it. Give copies to your designated surrogates, physician, family, minister/rabbi/priest and anyone else you feel is appropriate. Please review annually and initial and date.

Reviewed and updated:
Initial _____ Date _____
Initial _____ Date _____
Initial _____ Date _____