PRE VISIT AGENDA

I. **Your first appointment will be a consultation with the surgeon**. During this visit, the doctor will review your past medical and surgical history. He/she will perform a physical exam and review records received from other physicians as well as diagnostic studies. The physician will discuss your treatment options and the benefits and risks for any services they recommend. Surgery and/or procedures are not provided on the first visit to our office. To expedite your care please bring the following information to your consultation:

   A. Insurance Cards and photo identification

   B. List of current medications

   C. A disc containing any radiology studies you may have had prior to your visit. The physicians prefer to review films personally rather than simply read a report prepared by another doctor.

II. **Scheduling.** Once a recommendation has been made by the surgeon, you will sit down with our Scheduling Coordinator. She will schedule surgery and/or testing on your behalf and make sure you have a follow up appointment. She will also:

   A. Verify Your Insurance Benefits

   B. Obtain authorization from your Insurance Carrier

   C. Advise you as to what your financial responsibility will be for surgery

III. **Global Period.** Depending on what type of procedure is done, your follow up may be free of charge. Major surgeries have a 90 day "global period" during which you care is provided at no charge and included in the surgical period. Some procedures have no global period or a global period of 10 days.

IV. **Diagnostic/Laboratory Studies.** If you are being sent for additional studies, you will be given a follow up appointment to review those results. We do not provide results over the phone. It is better to meet with the doctor face to face to discuss what the testing showed and determine the best treatment option for you.

V. **Continuity of Care.** Throughout the process a copy of all of your medical records with our office will be sent to the referring provider and any other provider that you specify on your paperwork.

OUR FIRST AND FOREMOST CONCERN IS YOU AND YOUR GOOD HEALTH!

PATIENT INFORMATION FORM

Primary Care Physician: _____ **Referring Physician:** _____

Email: _____ Pharmacy Name/Location: _____

Last Name: _____ First Name: _____ Middle: _____

Local Address: _____
Street City State Zip Code

Home Telephone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: __M __F SSN _____

Race: _____ Ethnicity: _____ Language: _____

Marital Status: M S D W Spouse Name _____

Occupation: _____ Employer: _____
Employer Address: _____
Work Phone Number: _____

Insurance Information

Primary Insurance:
Ins. Co Name: _____
Policy Holder Name: _____
Policy Holder DOB: _____

Secondary Insurance
Ins. Co Name: _____
Policy Holder Name: _____
Policy Holder DOB: _____

Emergency Contact Information

Name of person not living with you: _____ Relationship: _____
Phone Number: _____
Address: _____

I authorize the release of health information to any physician directly involved in my treatment. I authorize the payment of medical benefits to the physician for services described on the claim for benefits form and authorize the release of any information necessary to process the claim. I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I certify that the information I have provided is true and correct to the best of my knowledge. I will notify the office of any changes in my health status or my personal information. _____**PLEASE INITIAL HERE.**

Please list below all parties we are authorized to speak with regarding your account and medical information: (Ex: Name of spouse, Name of mother)

_____ _____ _____

Prior to using or disclosing your protected information to carry out treatment, payment, or health care operations, NORTH ORLANDO SURGICAL GROUP is required by law to obtain consent. Please review this consent. If you understand and agree with its terms, please sign and date this consent below. By signing this consent, you agree that we may use or disclose your protected health information to carry out treatment, payment, or healthcare operation. You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. We are not required to agree to such operations. You are also authorizing us to check your external prescription history as needed.

Privacy Practice Acknowledgement

_____ _____
Patient Signature Date

North Orlando Surgical Group

Patient Medical History Form

Patient Name: _____ **DOB:**_____

For each section below mark Yes, No or Denies All for symptoms you have had in the last Two Weeks

General	O	**Denies All**		
Feeling ill:	O	Yes	O	No
Recent weight loss:	O	Yes	O	No
Fatigue:	O	Yes	O	No
Fever:	O	Yes	O	No
Eyes	O	**Denies All**		
Eye Disease:	O	Yes	O	No
Wear glasses/contact lenses:	O	Yes	O	No
Blurred/Double vision:	O	Yes	O	No
Ears/Nose/Mouth/Throat	O	**Denies All**		
Ringing in ears:	O	Yes	O	No
Hearing loss:	O	Yes	O	No
Earaches/Drainage:	O	Yes	O	No
Chronic sinus problems:	O	Yes	O	No
Nose Bleeds:	O	Yes	O	No
Mouth sores:	O	Yes	O	No
Bleeding gums:	O	Yes	O	No
Bad breath/bad taste:	O	Yes	O	No
Sore Throat:	O	Yes	O	No
Swollen glands in neck:	O	Yes	O	No
Cardiovascular	O	**Denies All**		
Chest pain:	O	Yes	O	No
Palpitations:	O	Yes	O	No
Shortness of breath while lying flat:	O	Yes	O	No
Swollen extremities:	O	Yes	O	No
Respiratory	O	**Denies All**		
Shortness of breath at exercise:	O	Yes	O	No
Shortness of breath at rest:	O	Yes	O	No
Chronic cough:	O	Yes	O	No
Spitting up blood:	O	Yes	O	No
Wheezing:	O	Yes	O	No
Gastrointestinal	O	**Denies All**		
Loss of appetite:	O	Yes	O	No
Change in bowel habits:	O	Yes	O	No
Nausea/ Vomiting:	O	Yes	O	No
Frequent Diarrhea:	O	Yes	O	No
Constipation:	O	Yes	O	No
Rectal Bleeding/Blood in stool:	O	Yes	O	No
Abdominal pain:	O	Yes	O	No
Heartburn:	O	Yes	O	No
Trouble swallowing:	O	Yes	O	No
Genitourinary	O	**Denies All**		
Frequent urination:	O	Yes	O	No
Burning w/ Urination:	O	Yes	O	No
Blood in urine:	O	Yes	O	No
Weak urine stream:	O	Yes	O	No
Trouble w/ control of urination:	O	Yes	O	No
Kidney Stones:	O	Yes	O	No
Urgent urination:	O	Yes	O	No
Sexual difficulties:	O	Yes	O	No
Men Only:				
Male only-Testicle Pain:	O	Yes	O	No
Musculoskeletal	O	**Denies All**		
Joint Pain:	O	Yes	O	No
Joint Stiffness/Swelling:	O	Yes	O	No
Joint/Muscle weakness:	O	Yes	O	No
Muscle pain/cramps:	O	Yes	O	No
Back Pain:	O	Yes	O	No
Cold Extremities:	O	Yes	O	No
Difficulty walking:	O	Yes	O	No

Skin	O Denies All		**Psychiatric**	O Denies All	
Rashes/Itching:	O Yes	O No	Memory loss or confusion:	O Yes	O No
Change in skin color:	O Yes	O No	Nervousness:	O Yes	O No
Change in hair/nails:	O Yes	O No	Depression:	O Yes	O No
Varicose veins:	O Yes	O No	Insomnia:	O Yes	O No
Neurologic	O Denies All		**Endocrine**	O Denies All	
Chronic Headaches:	O Yes	O No	Glandular/Hormone problems:	O Yes	O No
Dizziness:	O Yes	O No	Extreme Thirst:	O Yes	O No
Tingling/Numbness:	O Yes	O No	Cold Intolerance:	O Yes	O No
Tremors:	O Yes	O No	Heat Intolerance:	O Yes	O No
Paralysis:	O Yes	O No	**Hematologic**	O Denies All	
Head Injury:	O Yes	O No	History of Blood clots:	O Yes	O No
			Easy Bruising:	O Yes	O No
			Phlebitis:	O Yes	O No

Past Medical History **Please Mark all that apply**

- O Diabetes
- O High Blood Pressure
- O Cancer
- O Stroke
- O Heart Attack
- O Arthritis
- O Seizures
- O Bleeding tendency/Disorder
- O Acute Infections
- O Digestive Problems
- O High Cholesterol
- O GERD/Heartburn
- O Gynecological Problems
- O Anemia
- O Tuberculosis
- O COPD/Emphysema
- O Ulcer disease
- O Liver Problems
- O Hepatitis
- O Kidney problems
- O Prostate problems
- O Blood Transfusion
- O Thyroid disease
- O Congestive Heart Failure
- O Asthma
- O Angina
- O Congenital/Birth defects
- O Hemorrhoids
- O Diverticulosis
- O Pancreatitis
- O Ulcerative Colitis
- O Coronary Artery Disease
- O Venereal Disease
- O Atrial Fibrillation
- O Sleep Apnea
- O TIA's
- O Fibromyalgia
- O Colon Polyps
- O Vascular Disease
- O Glaucoma

Surgical History **Please Mark All that Apply**

O Colonoscopy
O EGD(Upper endoscopy)
O Pacemaker
O Colon Surgery
O Cholecystectomy
O Appendectomy
O Hemorrhoidectomy
O Bypass Surgery
O Hernia Surgery
O Hysterectomy
O Ovaries Removed
O Breast Cancer Surgery
O Prostate Surgery
O Back Surgery
O Hip Surgery
O Knee Surgery
O Weight Loss Surgery

Family History **Please Mark All that Apply**

Mother O Epilepsy O Thyroid O Osteoporosis O High Cholesterol O Migraine O Hayfever
O Arthritis O Alcoholism O Mental illness O Asthma O Heart Disease O Glaucoma
O Anemia O Stroke O Diabetes O Bleeds easily O Hypertension O Cancer

Father O Epilepsy O Thyroid O Osteoporosis O High Cholesterol O Migraine O Hayfever
O Arthritis O Alcoholism O Mental illness O Asthma O Heart Disease O Glaucoma
O Anemia O Stroke O Diabetes O Bleeds easily O Hypertension O Cancer

Siblings O Epilepsy O Thyroid O Osteoporosis O High Cholesterol O Migraine O Hayfever
O Arthritis O Alcoholism O Mental illness O Asthma O Heart Disease O Glaucoma
O Anemia O Stroke O Diabetes O Bleeds easily O Hypertension O Cancer

Social History **Please Mark All that Apply**

Marital status: O Married O Single O Divorced O Widowed O Life Partner

Occupation: O Full Time O Part Time O Retired O Homemaker O Student O Unemployed O Disabled

Who Lives with you: O Spouse O Children O Partner O Mother O Father O No one

Exercise: O Never O Daily O 1-2 times per week O 3-4 times per week

Diet: O Yes O No O Physician prescribed Diet

Caffeine use: O None O Daily O Occasionally

If yes: O 1 cup/drink a day O 2-3 cups/drinks a day O 4 or more cups/drinks a day

Tobacco use: O Yes O No O Trying to Quit O Previous smoker O Cigarettes O Cigars O Smokeless Tobacco

If yes, trying to quit or previous, mark daily use: O ½ pack O 1 pack O 2 packs O more than 2 packs /day

Number of years: O 0-5 years O 6-10 years O 10-20 years O 20 + years

Alcohol use: O Never O Daily O Social Drinker O Trying to Quit O Previously

If yes: O Less than 12 drinks a month O 1-12 drinks a week O 4-15 drinks a week O more than 2 drinks a day

Recreational Drug use: O Never O Daily O Trying to Quit O Previously

Please list all prescribed drugs and over the counter drug such as vitamins and inhalers

Name of the Drug	Strength	Frequency Taken

Allergies

Name of Drug or Allergy	Reaction

Preventative Care

1. Mammograms are recommended for women 40 and older.

   Have you had a mammogram? Yes or No If yes, Date Received _____

2. Colonoscopy is recommended for patients age 50 and older.

   Have you had a colonoscopy? Yes or No If yes, Date Received _____

3. Have you had a flu shot? Yes or No If yes, Date Received _____

4. Have you had a pneumonia vaccine? Yes or No If yes, Date Received _____

NORTH ORLANDO SURGICAL GROUP
1053 MEDICAL CENTER DRIVE, SUITE 242
ORANGE CITY, FLORIDA 32763
917 RINEHART ROAD, SUITE 2031
LAKE MARY, FLORIDA 32746

Receipt of HIPAA Notice of Privacy Practices Written Acknowledgement Form

I am a patient of North Orlando Surgical Group ("NOSG"). I hereby acknowledge receipt of NOSG's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [**print patient name**]. I hereby acknowledge receipt of NOSG's Notice of Privacy Practices with respect to the patient.

Print Name: _____

Relationship to patient (circle one) Parent Legal Guardian

Signature: _____

Date: _____

North Orlando Surgical Group, Inc.

Practicing General, Vascular, & Thoracic Surgery

Jeremy D. Steinbaum, M.D., F.A.C.S., Dennis F. Diaz, M.D., F.A.C.S., Joan W. Iacobelli, M.D., F.A.C.S.

1053 Medical Center Dr., Suite 242
Orange City, FL 32763
Phone: 386-775-0333
Fax: 386-775-0427

917 Rinehart Road, Suite 2031
Lake Mary, FL 32746
Phone: 407-790-9800
Fax: 386-775-0427

Authorization for use or disclosure of protected health information

Patient Name: _____ Soc. Sec.#: _____

Address: _____ Date of Birth: _____

Telephone: _____

Send information to:

Name: North Orlando Surgical Group, Inc

Attention: _____ Telephone: 386-775-0333 Fax: 386-775-0427

Address: 1053 Medical Center Dr., Suite 242

City: Orange City State: FL Zip: 32763

Purpose of release: _____

Requesting records from: _____ Fax #: _____

☐ Cardiovascular reports ☐ EKG report ☐ Laboratory results ☐ Pathology report ☐ Computer access CFRH

☐ Radiology Reports ☐ History & Physical ☐ Operative Report ☐ Discharge Summary ☐ Computer access FHFM/FHD

☐ Emergency Room ☐ Other _____

Needed for doctor's appointment on: _____

This authorization is for release of medical records and information including diagnosis, treatment, and/or examination related to mental health (psychiatry or psychology), drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmissible diseases.

As required by state and federal law, North Orlando Surgical Group, Inc. may not use or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of the protected health information described on this form.

I understand that this authorization will remain in effect for one year or until I revoke it in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to health information and record management North Orlando Surgical Group, Inc. I further understand that any such revocation does not apply to information already released in response to this authorization.

I understand that state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, but that North Orlando Surgical Group, Inc. cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization.

I understand that I have a right to inspect and obtain a copy of any information disclosed.

I hereby release North Orlando Surgical group, Inc. and its employees from any and all liabililty that may arise from the release of information as I have directed.

I understand that I may be charged a fee of $1.00 per page up to twenty five pages and .25 any page there after. This fee is waived for copies provided to a health care provider for continuing medical care.

I hereby authorize North Orlando Surgical Group, Inc. to release health information as directed above.

Patient's Signature: _____ Date: _____

Signature of parent/guardian: _____ Date: _____