North Orlando Surgical Group

Excellence is our standard of care

PATIENT INFORMATION

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

Pharmacy: _____ Email: _____

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: _____

Address: _____ Phone Number: _____

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)**

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.

_____ _____

Patient Signature Date

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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!

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Privacy Practice Acknowledgement

Receipt of HIPAA Notice of Privacy Practices Written Acknowledgement Form

To review or obtain a copy of our privacy practices, please visit www.northorlandosurgical.com

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

Signature: _____ Date: _____

I am a parent or legal guardian, Relationship to patient: _____

ADVANCED DIRECTIVES

Do you have an Advanced Directive currently in place? ☐ Yes ☐ No

If you have an **Advance Directive**, it is your responsibility to provide a copy of the document to any organization you are seeking medical/behavioral health services at the time of intake or as soon as possible following your intake. The document will then be placed in a prominent location in your medical record. If you ever revoke or change your Advance Directive, you must inform the office as soon as possible so your information can be updated in your medical record.

To be completed by the patient/Responsible adult

I have been asked about having an Advanced Health Care Directive, and I have been given or offered an Advanced Health Care Directive fact Sheet

Patient Signature: _____ Date: _____

For more information about Advanced Directives, please visit www.caringinfo.org

To be completed by staff

The patient was given a copy of the Advanced Health Directive fact sheet at the face to face or clinic visit. ☐ Yes ☐ No

If no, please indicate why the patient was not given this information:

☐ Patient declined ☐ Patient has an Advanced Directive currently in place ☐ Other _____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Today's Date: _____ Patient's SSN: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Preferred Phone Number for Contact: _____

Describe the information you approve disclosure of:

☐ All aspects of my healthcare as allowed to me under applicable law.
☐ Other: _____

To whom you approve disclosure (spouse, family, friend...):

Name: _____ Relationship: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip Code: _____

Name: _____ Relationship: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip Code: _____

Name: _____ Relationship: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip Code: _____

- I understand that I still have a right to access my PHI as allowed under applicable law.
- I understand that I may receive an accounting of disclosures as explained in North Orlando Surgical Group's Notice of Patient Privacy Practices.
- I understand that my PHI may be disclosed for public policy purposes as stated in the in North Orlando Surgical Group's Notice of Patient Privacy Practices.
- I understand that North Orlando Surgical Group may terminate its agreement to use or disclose any of my PHI at any time but only after I have received notice of such termination.

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 and present my written authorization to North Orlando Surgcial Group Medical records department. I understand that my revocation will not apply to information already released in response to this authorization.

Signature of Patient: _____ Date: _____

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Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included. I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Patient Signature: _____ Date: _____

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression

Patient Medical History Form

Patient Name: _____ **DOB:** _____ **Page 1 of 4**

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

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

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

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
O _____

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 O E-Cigarette/Vaping

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, Type: _____ O Trying to Quit O Previously

Preventative Care

1. Have you had a flu shot? Yes or No If yes, Date Received _____
2. Have you had a pneumonia vaccine? Yes or No If yes, Date Received _____

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Family History **Please Mark All that Apply**

Mother O Alive O Deceased

O Epilepsy O Thyroid O Osteoporosis O High Cholesterol O Migraine O Arthritis

O Alcoholism O Mental illness O Asthma O Heart Disease O Glaucoma O Anemia O Stroke

O Diabetes O Hypertension O Cancer _____

Father O Alive O Deceased

O Epilepsy O Thyroid O Osteoporosis O High Cholesterol O Migraine O Arthritis

O Alcoholism O Mental illness O Asthma O Heart Disease O Glaucoma O Anemia O Stroke

O Diabetes O Hypertension O Cancer _____

Sibling O Alive O Deceased

O Epilepsy O Thyroid O Osteoporosis O High Cholesterol O Migraine O Arthritis

O Alcoholism O Mental illness O Asthma O Heart Disease O Glaucoma O Anemia O Stroke

O Diabetes O Hypertension O Cancer _____

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

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.

2864 Wellness Ave., Suite 200
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: 2864 Wellness Ave Suite 200

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

Patient's Signature: _____ Date: _____

Signature of parent/guardian: _____ Date: _____