North Orlando Surgical Group

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## 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 If Married, Spouse's Name _____

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

**Primary Insurance:**

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

**Secondary Insurance:**

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

**Are you Enrolled in Hospice Care: ___ Yes ___ No** **If yes, for what diagnosis:** _____

## 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 operations. 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

**Page Over**

North Orlando Surgical Group
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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 _____

# 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** | | | |
| 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 | | |

**Page Over**

| **Skin** | O | **Denies All** | | |
|---|---|---|---|---|
| Rashes/Itching: | O | Yes | O | No |
| Change in skin color: | O | Yes | O | No |
| Change in hair/nails: | O | Yes | O | No |
| Varicose veins: | O | Yes | O | No |

| **Neurologic** | O | **Denies All** | | |
|---|---|---|---|---|
| Chronic Headaches: | O | Yes | O | No |
| Dizziness: | O | Yes | O | No |
| Tingling/Numbness: | O | Yes | O | No |
| Tremors: | O | Yes | O | No |
| Paralysis: | O | Yes | O | No |
| Head Injury: | O | Yes | O | No |

| **Psychiatric** | O | **Denies All** | | |
|---|---|---|---|---|
| Memory loss or confusion: | O | Yes | O | No |
| Nervousness: | O | Yes | O | No |
| Depression: | O | Yes | O | No |
| Insomnia: | O | Yes | O | No |

| **Endocrine** | O | **Denies All** | | |
|---|---|---|---|---|
| Glandular/Hormone problems: | O | Yes | O | No |
| Extreme Thirst: | O | Yes | O | No |
| Cold Intolerance: | O | Yes | O | No |
| Heat Intolerance: | O | Yes | O | No |

| **Hematologic** | O | **Denies All** | | |
|---|---|---|---|---|
| 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 _____

**Page Over**

## 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 |
|---|---|
| | |
| | |
| | |

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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 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: _____

**~OVER~**

# Patient Consent Form for Electronic Exchange of Individual Health Information (HIE)

**CONSENT**

Signing the consent form means that you are allowing your own electronic health information to be used by health care providers at participating centers and clinics only to provide you with medical treatment and support public health projects.

Sharing your own electronic health information in a health information exchange is your choice. Health care providers will provide you with medical care even if you decide not to share your own electronic health information in the exchange. Your insurance eligibility will not change based on your decision to share your own electronic health information in the health information exchange.

**PURPOSE**

This consent form allows for the exchange of your medical information with external hospitals and practices to enhance your care coordination, treatment planning, and continuity of care. Sharing your own electronic health information will allow your health care provider to review all your medical history and treatments. This will help your health care provider to make better informed decisions about your medical care.

**TYPES OF INFORMATION INCLUDED IN THIS CONSENT**

If you give consent, any participating HIE organization may view and share ALL your electronic health information available through any connected health information exchange. This includes information created before and after the date of your consent form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like x-rays or blood tests), and medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or substance abuse records
- Inherited or genetic conditions
- Mental health conditions
- Birth control, abortion and family planning
- HIV
- Lab results
- Sexually transmitted diseases

**My Consent Choices (CHECK ONE):**

- ○ **Opted In: Send and Receive Documents. I consent to both send and receive my medical documents with external hospitals and practices.**
- ○ **Opted In: Receive Documents Only. I consent to receiving my medical documents from external hospitals and practices but do not permit the sending of my documents.**
- ○ **Opted In: Send Documents Only. I consent to send my medical documents to external hospitals and practices but do not permit the receiving of documents.**
- ○ **Opted Out: I do not consent to any data exchange with external hospitals and practices.**

**Acknowledgment:**

**I understand that by consenting to the selected option, my medical information may be shared with authorized external healthcare providers. I also understand that I can revoke this consent at any time by notifying my healthcare provider in writing.**

**Patient Signature:** _____ **Date:** _____

If signed by someone other than the patient, print name and indicate relationship:

**Authorized Representative:** _____ **Relationship:** _____ **Date:** _____

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**Surgery Cancellation Policy/No Show Policy**
**For Doctor Appointments and Surgery**

1. ***Cancellation/No Show Policy for Doctor appointments***

We understand that there are times when you must miss an appointment due to emergencies or obligations for work and family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

**If an appointment is not cancelled at least 24 hours in advance, then you could be charged a twenty-five-dollar ($25.00) fee; this will not be covered by your insurance company and will be the patient's responsibility.**

2. ***Scheduled Appointments***

We understand that delays can happen, however we must try to keep the other patients and doctors running timely. We will do our best to accommodate rescheduling your visit.

**If a patient arrives more than 20 minutes late, we will have to reschedule the appointment.**

3. ***Cancellation/No Show Policy for Surgery***

Due to the large block of time needed for surgery, last-minute cancellation can cause problems and added expenses for the office and/or facility.

**If surgery is not cancelled or rescheduled at least 48 hours in advance you will be charged a two hundred and fifty dollars ($250.00) fee; this will not be covered by your insurance company.**

4. ***Account balances***

We will require that all patients with balances due pay their account in full prior to receiving additional surgical services by our practice. Our office does not make payment arrangements for elective surgery. Payment for surgery is due at least 48 hours prior unless otherwise instructed by the office.

We thank you for your cooperation and understanding in this matter.

I have read, understand and accept the above policies.

Printed Name: _____ Date: _____

Signature: _____ Date: _____

**~OVER~**

North Orlando Surgical Group

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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 healthcare insurance plan. This includes prescription medicines to treat AIDS/HIV and medicine used to treat mental health issues such as depression.

# ***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., Sarah E. Brehm, M.D.*

*2864 Wellness Ave., Suite 200 Orange City, FL 32763*
*(T): (386) 775-0333 (F): (386) 775-0427*


## Authorization for use or disclosure of protected health information

Patient Name: _____ Soc. Sec.#: _____

Address: _____ Date of Birth: _____

Telephone: _____

Information to:

Name: _____

Attention: _____ Telephone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Purpose of release: _____

Requesting records from: _____ Fax #: _____

| | | | | |
|---|---|---|---|---|
| ☐ Cardiovascular reports | ☐ EKG report | ☐ Laboratory results | ☐ Pathology report | ☐ Computer access HCA Sanford |
| ☐ Radiology Reports | ☐ History & Physical | ☐ Operative Report | ☐ Discharge Summary | ☐ Computer access FHFM/FHD |
| ☐ Emergency Room | ☐ Discuss all aspects of medical care with _____ | | | ☐ 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: _____

# ***North Orlando Surgical Group, Inc.***

*Jeremy D. Steinbaum, M.D., F.A.C.S., Dennis F. Diaz, M.D., F.A.C.S.,*
*Sarah E. Brehm, M.D.*

*2864 Wellness Ave., Suite 200 Orange City, FL 32763*
*Phone: 386-775-0333 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 HCA
☐ 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.

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Signature of parent/guardian: _____ Date: _____