Diana Calderone, MD
Glenn MacLean, PA-C
Francine Phillips, PA-C

Florida Medical Clinic Dermatology
Your life. Our specialty.

OFFICE POLICY

1. We see patients age 12 and older. Minors (any persons under the age of 18) MUST be accompanied by a parent or legal guardian on every visit.
2. Please assist us by showing up on time so we can accommodate everyone in a timely manner. We allow a 15 minute grace period from your scheduled appointment time. If you arrive after that period of time, we will need to reschedule your appointment. As a courtesy, if we are running behind schedule we will let you know in advance so you have the option to reschedule your appointment.
3. Our goal is to stay on time; however, many factors play a role in interfering with the schedule. Please assist us in our efforts to stay on schedule by limiting the number of problems you would like to address to one or two at a time. For example, a complete skin exam to check abnormal moles or skin cancer should be the only problem addressed during a visit. It is not uncommon for patients to present the "lists" of problems they have accumulated over time. Attempting to address multiple problems often leads to inadequate counseling, time delays and eventually patient dissatisfaction. Please remember that skin problems often develop over time and will likewise require time for adequate diagnosis and treatment.
4. We can no longer accommodate last minute substitution of appointments for family members or friends due to the time demand of our new software program. We are more than happy to schedule an additional appointment for them in the future.
5. We offer cosmetic services such as Botox and Juvederm. During routine dermatology visits, it is difficult to provide an adequate education on these important topics without interference with the schedule. For your convenience, we provide complimentary consultations on our services. Please contact our office to make an appointment with our cosmetic consultant.
6. For existing patients, you may leave a message with the nursing staff for medical questions, prescription refills and laboratory results. Since we are very busy seeing patients during clinic hours we may not be able to respond to your request until after business hours. We will make every effort to accommodate you. We appreciate your patience.
7. Patients are responsible for their co-payment and/or deductible at the time services are rendered. Payments may be made by cash, check, or credit card. We do not accept temporary checks.
8. Insurance companies do not pay for cosmetic services. They will not cover removal of benign lesions (skin tags, moles, and warty growths) even if clothing or friction irritates the lesions. If coverage is in question, you may be asked to sign a waiver indicting your financial responsibility in the event of non-payment by your insurance company.
9. If a biopsy or surgery is performed, tissue is sent to a separate laboratory facility for processing and examination. These facilities will charge you or your insurance company for this service and its separate and apart from our services. **Phone calls on pathology reports are a courtesy and may take up to three weeks to receive.**
10. We make every effort to obtain payment from your insurance company. If you have questions about your bill, please feel free to contact our billing department at (813) 528-4975. Unpaid balances that are over 60 days overdue are subject to referral to a collection agency. Please be aware that once your account has been turned over to collections, you will incur a 30% surcharged on your existing balance.
11. ALL RETURNED CHECKS ARE SUBJECT TO A $25.00 CHARGE.

Our mission is to provide you with the highest quality care in a friendly comfortable atmosphere. Today's medicine places many challenges before us, both as providers and recipients of care. We ask for your patience and understandings and in return we promise to work hard on your behalf to preserve our mission. Please remember we are on your team!

______________________________	______________________________
PRINT NAME	**PATIENT SIGNATURE**
______________________________	______________________________
WITNESS	**DATE**

PATIENT INFORMATION

FIRST NAME ______________ MIDDLE ______________ LAST NAME ______________

LOCAL ADDRESS ______________ DATE OF BIRTH ____/____/____ SEX ______

CITY ______________ STATE ______ ZIP ______ EMAIL ADDRESS ______________

SOCIAL SECURITY ______________ CELL PHONE ( ) ______________

ETHNICITY: ___ NOT HISPANIC/LATINO ___ HISPANIC/LATINO ___ REFUSED HOME PHONE ( ) ______________

RACE: ___ AMERICAN INDIAN/ALASKA NATIVE ___ ASIAN ___WHITE WORK PHONE ( ) ______________

___ BLACK/AFRICAN AMERICAN ___ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER REFERRING PHYSICIAN ______________

___ OTHER ___OTHER SPECIFIED ______________ PRIMARY PHYSICIAN ______________

PREFERRED LANGUAGE ______________ PHONE ( ) ______________

____ MARRIED ____ SINGLE ____WIDOWED ____ DIVORCED EMPLOYER ______________

____ EMPLOYED ____ RETIRED ____ FULL TIME STUDENT ADDRESS ______________

PERMANENT ADDRESS

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

EMERGENCY CONTACT

NAME ______________ HOME PHONE ( ) ______________

RELATIONSHIP ______________ WORK PHONE ( ) ______________

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? ☐ YES ☐ NO IF NO PLEASE COMPLETE THIS SECTION

RELATIONSHIP ______________ SEX ______ DAYTIME PHONE ( ) ______________

FIRST NAME ______________ MIDDLE ______ EMPLOYER ______________

LAST NAME ______________ ADDRESS ______________

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

CITY ______________ STATE ______ ZIP ______

IS THE REASON FOR YOUR VISIT THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO IF YES PLEASE COMPLETE THIS SECTION

NOTE: NOT ALL FMC OFFICES ACCEPT AUTO OR WORKMAN COMPENSATION PATIENTS.

PLEASE CHECK WHICH TYPE OF ACCIDENT: ☐ WORKMAN COMPENSATION ☐ AUTOMOBILE ☐ OTHER

DATE OF ACCIDENT ____/____/____ Place of accident ______________ How did accident happen? ______________

CLAIM # ______________ CLAIM REPRESENTATIVE/ADJUSTER ______________

IF WORKMAN COMPENSATION PLEASE COMPLETE THIS SECTION

EMPLOYER NAME ______________ EMPLOYER PHONE( ) ______________

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY ______________ INSURED'S DOB ______________

INSURANCE/CARD HOLDER'S NAME ______________ RELATIONSHIP ______________

ID# ______________ GROUP # ______________ PHONE ( ) ______________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY ______________

INSURANCE/CARD HOLDER'S NAME ______________ RELATIONSHIP ______________

ID# ______________ GROUP # ______________ PHONE ( ) ______________

SIGNATURE ______________ DATE ______________

FLORIDA MEDICAL CLINIC, P.A.
Your Life, Our Specialty

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Florida Medical Clinic, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to the conduct health care operations of Florida Medical Clinic, P.A. I understand that diagnosis or treatment of me by Florida Medical Clinic, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Florida Medical Clinic, P.A. *Notice of Privacy Practices* prior to signing this document. The Florida Medical Clinic, P.A. *Notice of Privacy Practices* has been provided to me. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Florida Medical Clinic, P.A. The *Notice of Privacy Practices* for Florida Medical Clinic, P.A. is also provided at 38135 Market Square, Zephyrhills, FL 33542. This *Notice of Privacy Practices* also describes my rights and the duties of Florida Medical Clinic, P.A. with respect to my protected health information. Florida Medical Clinic, P.A. reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices.*

Lifetime Authorization: By signing below I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent or this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. The original authorization will be kept on file by Florida Medical Clinic, P.A.

I may obtain a revised *Notice of Privacy Practices* by requesting in writing from Florida Medical Clinic, P.A. or asking for one at the time of my next appointment.

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Florida Medical Clinic, P.A. (FMC) and or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify FMC of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by FMC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Florida Medical Clinic, P.A. (FMC) for all covered medical services and supplies provided to me during all courses of treatment and care provided by FMC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with FMC, which will authorize and allow for direct payment to FMC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by FMC.

Initials ________

Ownership Disclosure

I understand that Florida Medical Clinic, P.A. is a physician-owned medical practice comprised of the offices of primary care physicians, specialty care physicians and associated ancillary services. These ancillary services include laboratory, pathology, radiology/diagnostic, physical therapy, pharmacy and ambulatory surgery center services. During the course of my care, I may be referred to one or more of these ancillary departments. I have the right to choose where to receive these services. I understand I am not obligated to receive these services at a Florida Medical Clinic ancillary department.

Acknowledgement of Receipt
Notice of Privacy Practices

I acknowledge that I have received a copy of Florida Medical Clinic's Notice of Privacy Practices, which describes how FMC will use and protect my health information. This Notice describes my rights under the Health Insurance Portability and Accountability Act (HIPPA) and FMC's policies on use and disclosure of my protected health information.

______________________________ ______________________________
Name of Patient Name of Guardian or Personal Representative

______________________________ ______________________________
Signature of Patient Signature of Guardian or Personal Representative

____
Date

Florida Medical Clinic, P.A.
Zephyrhills, FL 33542

cg / FMC Consent for Treatment, Payment & Health Care Operations

FLORIDA MEDICAL CLINIC, P.A.
NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this notice, please contact our Privacy Officer at 352-567-0188.

Florida Medical Clinic understands your privacy is important. This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition or payment.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains personal demographic information, your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment;
- Means of communication among the many health professionals who contribute to your care;
- Legal document describing the care you received;
- Means by which you or a third party payer can verify that services billed were actually provided;
- A tool in educating health professionals;
- A source of data for medical research;
- A source of information for public health officials charged with improving the health of the nation;
- A source of data for facility planning and marketing; and
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy;
- Better understand who, what, when, where and why others may access your health information;

- Make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. However, we are not required to agree to the restriction;
- Inspect and copy your health record as provided for in 45 CFR 164.524 and Florida law. Usually this includes medical and billing records, but does not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- Amend your health record as provided in 45 CFR 164.526. To request an amendment, your request must be in writing and must provide a reason that supports your request. We may deny your request if you ask to amend information that:
    - Was not created by us;
    - Is not part of the medical information kept by FMC;
    - Is not part of the information which you would be permitted to inspect or copy; or
    - Is accurate or complete.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528. To request this list or accounting of disclosures, your request must be in writing and must state the time period which may not be longer than six years and may not include dates before April 13, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list.
- Request communications of your health information by alternative means or at alternative locations;
- Receive confidential communications of protected health information as provided in 45 CFR 164.522 (b), as applicable;
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Copies of the regulations cited above may be requested from the Privacy Officer by calling 352-567-0188.

Our Responsibilities:

Florida Medical Clinic is required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction;

- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change significantly, we will post the new notice in each FMC location as well as on our Web site: www.floridamedicalclinic.com. You can also request a copy of our notice at any time.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact FMC's Privacy Officer at (352) 567-0188.

If you believe your privacy rights have been violated, you can file a complaint by contacting FMC's Privacy Officer at 352-567-0188 or you may send a written complaint to the Secretary, U.S. Department of Health and Human Services. FMC's Privacy Officer can provide you with the appropriate address upon request. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Care Operations

We will use your health information for treatment. For example, information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Different departments within Florida Medical Clinic may share medical information about you in order to coordinate different services you need, such as prescriptions, lab work and X-rays. We may also disclose medical information about you to people outside FMC who may be involved in your medical care, such as hospitals, long-term care facilities, ambulatory surgery centers or home health agencies.

We will also provide a referring physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you.

We will use your health information for payment. For example, a bill may be sent to you or an insurance company (third party payer). The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

We will use your health information for regular healthcare operations. For example, in day-to-day business practices, trained staff may handle your physical medical record in order to have the record

assembled or for filing reports into your record. Certain data elements are entered into our

computer system that processes most billing, schedules your appointments and for statistical reporting. As part of our improvement efforts to provide the most effective services, your record may be reviewed by professional staff to assure accuracy, completeness and organization.

This information may be shared by facsimile transmission.

Other Uses or Disclosures

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include our using an outside transcription service to type physicians' dictated notes or a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. So that your health information is protected, however, we require the business associate to agree in writing to appropriately safeguard your information.

Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Coroners, Medical Examiners and Funeral Directors: We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: If you are an organ donor, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law. These programs provide benefits for work-related injuries or illness.

Public Health: As required by law, we may disclose your health information to public health or legal

authorities for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births or deaths;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when you agree or when required or authorized by law.

Correctional Institution: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law:

- In response to a court order, valid subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Clinic; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Other Uses and Disclosures of Your Information by Authorization Only

When you request information to be disclosed to another party or yourself, we will respond according to federal and state law.

We are required to get your authorization to use or disclose your protected health information for any use other than treatment, payment or health care operations, and those specific circumstances outlined above. We use an Authorization to Use/Disclose form that specifically states what information will be given to whom, for what purpose, and is signed by you or your legal representative. You have the ability to revoke the signed authorization at any time by a written statement given to us to that effect.

This Notice of Privacy Practices is effective April 14, 2003.

Florida Medical Clinic Dermatology
Your life. Our specialty.

Diana Calderone, MD
Glenn MacLean, PA-C
Francine Phillips, PA-C

Date:_______________

Patient Name: ____ D.O.B:________________ Sex: ☐ M ☐ F
Address: ____City:__________________State:___ Zip:_______
Cell#:______________________ Home#:___________________Referred by:_______________________________
Height: ______ Weight: _____ Reason for today's visit:____
Allergies to medications and/or food:____
Current Medications/Dosages: ____

PAST MEDICAL HISTORY: Check all that apply and if yes, please explain.

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Bone Marrow Transplant
☐ Benign Prostatic Hyperplasia
☐ Breast cancer
☐ Colon cancer
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ End stage Renal Disease
☐ GERD
☐ Hearing Loss
☐ Hepatitis
☐ Hypertension
☐ HIV/AIDS
☐ Hypercholesterolemia
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Leukemia
☐ Lung cancer
☐ Lymphoma
☐ Prostate cancer
☐ Radiation treatment
☐ Seizures
☐ Stroke

List any other medical conditions/explain:
____
____
____

PAST SURGERIES: Check all that apply and if yes, please explain.

☐ Appendix
☐ Bladder
☐ Mastectomy
☐ Lumpectomy
☐ Breast Implants
☐ Colon Cancer
☐ Inflammatory Bowel Disease
☐ Diverticulitis
☐ Coronary Artery Bypass
☐ Heart Transplant
☐ Knee Replacement
☐ Hip Replacement
☐ Kidney Biopsy
☐ Nephrectomy
☐ Kidney Stone
☐ Kidney Transplant
☐ Endometriosis
☐ Ovarian Cyst
☐ Prostate Cancer
☐ Prostate Biopsy
☐ Skin Biopsy
☐ Basal Cell Carcinoma
☐ Squamous Cell Carcinoma
☐ Melanoma
☐ Spleen - Splenectomy
☐ Testicles - Orchiectomy
☐ Uterus - Hysterectomy

List any other surgeries/explain: _________
____
____

SKIN DISEASE HISTORY: Check all that apply

☐ Acne
☐ Actinic Keratosis
☐ Blistering Sunburns
☐ Dry Skin
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Hay Fever/Allergies
☐ Poison Ivy
☐ Precancerous Moles
☐ Psoriasis
☐ Basal Cell Skin Cancer
☐ Squamous Cell Skin Cancer
☐ Malignant Melanoma

Other:________________________________
____

REVIEW OF SYSTEMS: Check all that apply

☐ Allergy to adhesive
☐ Allergy to lidocaine
☐ Allergy to topical antibiotic ointments
☐ Allergy to latex
☐ Allergy to epinephrine
☐ Artificial heart valve
☐ Artificial joints within past two yrs
☐ Blood thinners
☐ Defibrillator
☐ Hepatitis C
☐ MRSA
☐ Pacemaker
☐ Premedication prior to procedure
☐ Rapid heartbeat with epinephrine
☐ Pregnancy or planning a pregnancy

SKIN HISTORY:

How many hours of sun exposure do you get on a daily basis? ________

With sun exposure, do you: □ Burn easily □ Burn sometimes, tan easily □ Tan easily, never burn

How would you describe your PAST sun exposure? □ Heavy □ Moderate □ Light

How would you describe your PRESENT sun exposure? □ Heavy □ Moderate □ Light

What sun-protection do you use? □ Sunscreens □ Hat □ Protective clothing □ None

Do you wear sunscreen? □ Yes □ No If yes, what SPF? ______ Do you tan in a tanning salon? □ Yes □ No

Do you have a family history of Melanoma? Yes □ No □ If yes, which relative? ________________________

SOCIAL HISTORY:

Do you partake in any outdoor activities (golf, tennis, fishing, gardening, etc.)?

If yes, which one(s):____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Do you currently smoke? □ Yes □ No If yes, how much per day? ______ Have you ever smoked? □ Yes

Do you drink alcohol? □ Yes □ No If yes, how much per day?________

Caffeine use? □ Yes □ No If yes, how much per day? _________

PERSONAL HISTORY & HEALTH ASSESSMENT: Check all that apply.

HEMATOLOGIC
- □ Problems with bleeding

INTEGUMENTARY (Skin)
- □ Problems with healing
- □ Problems with scarring (hypertrophic or keloid)

ALLERGIC/IMMUNOLOGIC
- □ Immunosuppression
- □ Hay fever

CARDIOVASCULAR
- □ Chest pain

CONSTITUTIONAL/SYMPTOM
- □ Fever or chills
- □ Night sweats
- □ Unintentional weight loss

ENDOCRINE
- □ Thyroid problems

EAR, NOSE, MOUTH & THROAT
- □ Sore throat

EYES
- □ Blurry Vision

GASTROINTESTINAL
- □ Abdominal pain
- □ Bloody stool
- □ Bloody urine

MUSULOSKELETAL
- □ Joint aches
- □ Muscle weakness
- □ Neck stiffness

NEUROLOGICAL
- □ Headaches
- □ Seizures

RESPIRATORY
- □ Cough
- □ Shortness of breath
- □ Wheezing

PSYCHIATRIC
- □ Anxiety
- □ Depression

______________________________________ ____________

PATIENT/GUARDIAN SIGNATURE **DATE**

______________________________________ ____________

SIGNED/REVIEWED BY PHYSICIAN/PA-C **DATE**

SKIN HISTORY:

How many hours of sun exposure do you get on a daily basis? ________

With sun exposure, do you: □ Burn easily □ Burn sometimes, tan easily □ Tan easily, never burn

How would you describe your PAST sun exposure? □ Heavy □ Moderate □ Light

How would you describe your PRESENT sun exposure? □ Heavy □ Moderate □ Light

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Do you wear sunscreen? □ Yes □ No If yes, what SPF? ______ Do you tan in a tanning salon? □ Yes □ No

Do you have a family history of Melanoma? Yes □ No □ If yes, which relative? ________________________

SOCIAL HISTORY:

Do you partake in any outdoor activities (golf, tennis, fishing, gardening, etc.)?

If yes, which one(s):____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Do you currently smoke? □ Yes □ No If yes, how much per day? ______ Have you ever smoked? □ Yes

Do you drink alcohol? □ Yes □ No If yes, how much per day?________

Caffeine use? □ Yes □ No If yes, how much per day? _________

PERSONAL HISTORY & HEALTH ASSESSMENT: Check all that apply.

HEMATOLOGIC
- □ Problems with bleeding

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NEUROLOGICAL
- □ Headaches
- □ Seizures

RESPIRATORY
- □ Cough
- □ Shortness of breath
- □ Wheezing

PSYCHIATRIC
- □ Anxiety
- □ Depression

______________________________ ______________________________ ____________

PATIENT/GUARDIAN SIGNATURE SIGNED/REVIEWED BY PHYSICIAN/PA-C DATE

Florida Medical Clinic, P.A.
Authorization to Share Protected Health Information

Patient Name:	Second Form of Identification (DOB/Account#)

I authorize the physicians and staff of:

- ☐ All FMC Departments
- ☐ The following FMC Departments

Specify:

____

____

____

to share protected health information with the following persons:

______________________ Relationship ______________

______________________ Relationship ______________

______________________ Relationship ______________

This includes (please check all areas that apply)

- ☐ All Medical Information
- ☐ Lab Results
- ☐ X-ray Results
- ☐ Medication (RX Renewal and Pickup)
- ☐ Telephone Consults
- ☐ Hospital Information
- ☐ Insurance Information
- ☐ Dialysis Clinic Information
- ☐ Appointment Information
- ☐ Other (please specify)

This authorization will be in effect until authorization is revoked.

Patient's Signature ______________________ Date ______________

Witness ______________________