PATIENT INFORMATION

Thank you for choosing Associates of Internal Medicine! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Patient Name_____ Birthdate _____ ***Male*** or ***Female***

Home Phone # _____ Cell Phone # _____ SS# _____

Address _____ City _____ State___ Zip _____

Email _____

Circle appropriate status: ***Single*** ***Married*** ***Divorced*** ***Widowed*** ***Separated***

Circle appropriate status: ***Employed*** ***Unemployed*** ***Retired*** ***Student***

If Employed: Circle One: ***Full time*** ***Part time***

Name of Employer _____ Work Phone _____

Business Address _____ City _____ State ___ Zip _____

If a Student: Circle one: ***Full time*** ***Part time***

Spouse's Name _____ Employer _____ Work # _____

Person to contact in case of emergency _____ Phone _____

Responsible Party if not same as above

Name of guardian or care-giver _____ Relationship to patient _____

Birthdate _____ Home Phone _____ Cell Phone _____

Address _____

Driver's License # _____ Financial Institute _____

Employer _____ Work phone # _____

Is this person a current patient? ***Yes*** or ***No*** (please circle one)

Please provide legal documentation showing legal guardian/ power of attorney

Whom may we thank for referring you? _____

_____ _____ _____

Patient name (print) Patient signature Today's date

INSURANCE INFORMATION

Name of insured _____

Birthdate _____ SS# _____

Insurance Company _____ ID# _____ Group # _____

Insurance Address _____

How much is your insurance deductible? $_____ How much have you met? $_____

Name of Employer and Address _____

Date employed _____

Do you have a secondary insurance? ***Yes*** or ***No*** (please circle one)

Name of secondary insurance: _____

Insurance Company _____ ID# _____ Group # _____

Insurance Address _____

How much is your insurance deductible? $_____ How much have you met? $_____

Responsible Party if not same as above

Name of person responsible for the account _____ Relationship _____

Address _____ Phone # _____

Birth date _____ Driver's license # _____ Financial institute _____

Employer _____ Work Phone _____

I, authorize release of any information concerning my healthcare advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____ _____

Signature of patient Today's date

Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**
- Good general health lately .... No Yes
- Recent weight change..... No Yes
- Fever ..... No Yes
- Fatigue ..... No Yes
- Headaches ..... No Yes

☐ **Eyes**
- Eye disease or injury ..... No Yes
- Wear glasses/contact lenses.... No Yes
- Blurred or double vision ..... No Yes

☐ **Ears/Nose/Mouth/Throat**
- Hearing loss or ringing ..... No Yes
- Earaches or drainage..... No Yes
- Chronic sinus problem or rhinitis No Yes
- Nose bleeds ..... No Yes
- Mouth sores ..... No Yes
- Bleeding gums ..... No Yes
- Bad breath or bad taste..... No Yes
- Sore throat or voice change ... No Yes
- Swollen glands in neck ..... No Yes

☐ **Cardiovascular**
- Heart trouble ..... No Yes
- Chest pain or angina pectoris .. No Yes
- Palpitation ..... No Yes
- Shortness of breath w/walking or lying flat ..... No Yes
- Swelling of feet, ankles or hands No Yes

☐ **Respiratory**
- Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ..... No Yes
- Spitting up blood ..... No Yes
- Shortness of breath..... No Yes
- Wheezing..... No Yes

☐ **Gastrointestinal**
- Loss of appetite..... No Yes
- Change in bowel movements .. No Yes
- Nausea or vomiting..... No Yes
- Frequent diarrhea..... No Yes
- Painful bowel movements or constipation ..... No Yes
- Rectal bleeding or blood in stool No Yes
- Abdominal pain ..... No Yes

☐ **Genitourinary**
- Frequent urination..... No Yes
- Burning or painful urination .... No Yes
- Blood in urine ..... No Yes
- Change in force of strain when urinating..... No Yes
- Incontinence or dribbling..... No Yes
- Kidney stones ..... No Yes
- Sexual difficulty ..... No Yes
- Male - testicle pain ..... No Yes
- Female - pain with periods..... No Yes
- Female - irregular periods ..... No Yes
- Female - vaginal discharge ..... No Yes
- Female - # of pregnancies .... _____
- Female - # of miscarriages.... _____
- Female - date of last pap smear _____

☐ **Musculoskeletal**
- Joint pain..... No Yes
- Joint stiffness or swelling..... No Yes
- Weakness of muscles or joints .. No Yes
- Muscle pain or cramps..... No Yes
- Back pain ..... No Yes
- Cold extremities..... No Yes
- Difficulty in walking..... No Yes

☐ **Integumentary (skin, breast)**
- Rash or itching..... No Yes
- Change in skin color ..... No Yes
- Change in hair or nails..... No Yes
- Varicose veins ..... No Yes
- Breast pain ..... No Yes
- Breast lump..... No Yes
- Breast discharge..... No Yes

☐ **Neurological**
- Frequent or recurring headaches No Yes
- Light headed or dizzy..... No Yes
- Convulsions or seizures ..... No Yes
- Numbness or tingling sensations. No Yes
- Tremors..... No Yes
- Paralysis..... No Yes
- Head injury ..... No Yes

☐ **Psychiatric**
- Memory loss or confusion ..... No Yes
- Nervousness ..... No Yes
- Depression ..... No Yes
- Insomnia..... No Yes

☐ **Endocrine**
- Glandular or hormone problem. No Yes
- Excessive thirst or urination .... No Yes
- Heat or cold intolerance ..... No Yes
- Skin becoming dryer..... No Yes
- Change in hat or glove size .... No Yes

☐ **Hematologic/Lymphatic**
- Slow to heal after cuts..... No Yes
- Bleeding or bruising tendency .. No Yes
- Anemia..... No Yes
- Phlebitis ..... No Yes
- Past transfusion..... No Yes
- Enlarged glands..... No Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics . No Yes
- Morphine, Demerol, or other narcotics..... No Yes
- Novocain or other anesthetics No Yes
- Aspirin or other pain remedies No Yes
- Tetanus antitoxin or other serums ..... No Yes
- Iodine, Merthiolate or other antiseptic ..... No Yes
- Other drugs/medications: _____

_____

Known food allergies: _____

_____

Environmental allergies: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibilty to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date: _____

Patient Name _____ Birthdate _____ Patient # _____

Chief Complaint: _____

History of present illness:

Location: _____
(Where is the pain/problem?)

Quality _____
(Example: normal versus abnormal color, activity, etc.)

Severity _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration _____
(How long have you had this pain/problem?, or, When did it start?)

Timing _____
(Does the pain/problem occur at a specific time?)

Context _____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms _____
(What other associated problems have you been having?)

Modifying factors _____
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray _____			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes	_____		
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes			
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes	_____		
Arthritis	no	yes	Blood or Plasma			Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes	Transfusions	no	yes	Stroke	no	yes	_____		

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications: (Include nonprescription) _____

_____

_____

Have you ever taken Fen-Phen/Redux? no yes

Patient social history:

Marital status	Single:_____	Married: _____	Separated: _____	Divorced:_____	Widowed:_____
Use of alcohol:	Never:_____	Rarely:_____	Moderate:_____	Daily:_____	
Use of tobacco:	Never:_____	Previously, but	quit:_____	Current packs / day: _____	
Use of drugs:	Never:_____	Type/Frequency:	_____		
Excessive exposure at home or work to:	Fumes:_____	Dust:_____	Solvents:_____	Air-borne Particles:_____	Noise:_____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Statement of Patient Privacy Rights

New Federal legislation mandates that certain information about how AIM uses your confidential medical record be provided to you and that we maintain a record of any entity with whom we share your information.

At AIM we have always regarded all medical and personal information as completely confidential. As a result, many of the new federal mandates have not changed the way we handle information other than to tell you how we protect it.

All of our staff signs a confidentially oath. The oath states that your information is to be used only when necessary to provide you with medical care. We take this oath very seriously and strive to treat you and your medical information the way we would want ourselves and our own information to be treated. We also stay current and compliant with all state and federal laws regarding the handling of your confidential personal medical information.

We will record and provide to you upon request, information about any release of your information other than the use of your information for the purpose of providing you with care in our offices, sharing pertinent information with other practitioners involved in your care (specialists, etc.) and you insurance company for the purpose of verifying your treatment so that claims can be paid.

The patient information label that you signed authorizes the use of your information for these purposes. We do not provide information to anyone else unless you have sent us a separate release or if we receive a court order signed by the judge or the clerk of the court. If you want a family member to be able to inquire about you, for example confirming your appointment or checking to see if you are in our office, we will not reveal this information unless you have signed a specific release identifying who you authorize to receive this information.

Our staff will be asking questions when you call our office to verify that you are who you say you are. Please be patient with this process as it is to ensure your privacy.

Our policy insures that your information remains confidential.

Copies of this statement are available as are copies of a lengthier statement describing in great detail how information is handled in specific settings. If you would like a copy of either please ask.

13660 Jog Road Suite B 5 Delray Beach, Florida 33446(561) 498-7474 * fax (561) 819-6466*

Consent To Leave Telephone Message

- I understand that as part of my healthcare, Associates of Internal Medicine, PA may at times need to reach me by phone.
- I authorize AIM to leave messages at my home telephone regarding lab results, X-ray results or laboratory results.
- I authorize AIM to call me at my place of employment.
- I do not authorize AIM to leave messages on my telephone regarding any type of testing results. I will accept the responsibility of contacting the office to obtain any test results.
- I authorize AIM to fax information to me regarding my health care at my home or work.

Home Number _____

Work Number _____

Cell Number _____

I fully understand and accept the terms of this contract

X _____ _____ _____

Patients Signature Patients Printed Name Today's date

13660 Jog Road Suite B 5 Delray Beach, Florida 33446(561) 498-7474 * fax (561) 819-6466*

Why Everyone Should Have A Living Will

A living will is important in case something is to ever happen to you and you are no longer able to speak or make your own medical decisions. Although it can be difficult to think about, advanced directives can help ensure that your family/caregiver do not have to make any medical decisions. Instead, your medical team can follow your living will making sure they are treating you based on your own wishes dictated in your living will.

Do You Have a Living Will?

- o Yes, I have a living will. I will be sure to bring it in at my next appointment.
- o No, I do not have a living will.
- o I do not wish to disclose that information.

X _____ _____ _____

Patients Signature | Patients Printed Name | Today's date

13660 Jog Road Suite B 5 Delray Beach, Florida 33446(561) 498-7474 * fax (561) 819-6466*

ASSOCIATES OF INTERNAL MEDICINE

Authorization to Release Information to Family Members

Many of our patients allow family members, such as their spouse, significant other, parents, or children to call and request results of test results, procedures, and financial information. Under the regulations of H.I.P.A.A., we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members, you must sign this form.

__ I do not authorize the office of Associates of Internal Medicine, PA, to release my records or discuss any information with anyone but myself.
__ I authorize the office of Associates of Internal Medicine, PA, to release my records and any information to the following individuals,

1._____Relationship to patient: _____
2._____Relationship to patient: _____
3._____Relationship to patient: _____
4. _____Relationship to patient: _____

X _____ _____ _____
Patients Signature Patients Printed Name Today's date

13660 Jog Road Suite B 5 Delray Beach, Florida 33446(561) 498-7474 * fax (561) 819-6466*

All payment is expected at the time of service

Payment is required at the time of services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurances companies. This practice accepts cash, personal check (in state only), Visa, Master Card. There is a service charge of $30.00 for returned checks.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments.

Insurance:

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges. Please be advised if you are disputing charges not paid by your insurance company requiring appeals, you will be responsible for monies due until payment is paid in full by your insurance.

Should you need to, your time of service receipt includes information necessary for submitting claims to your insurance company.

If you need assistance or have questions, please contact our billing office between 9:00am and 4:30pm., Monday through Friday at 954-968-5551

Refunds:

Overpayments will be refunded upon written request to the responsible party within 30 days.

Managed Care:

If you are enrolled in a managed care insurance plan (i.e., HMO), you must receive a referral from our office before seeing a specialist. No retroactive referrals will be give

Forms:

Forms that are required to be filled out by the physician represent a cost to us and will be charged at an additional fee of $25.00. The forms should be received 48 hours in advance.

Missed Appointments/Late Cancellations:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments.

I have read and understand the Associates of Internal Medicine Financial Policy. I agree to assign insurance benefits to Associates of Internal Medicine whenever necessary. I also agree that if it became necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or Authorized representative:_____

Date_____

13660 Jog Road Suite B 5 Delray Beach, Florida 33446(561) 498-7474 * fax (561) 819-6466*