Mid Florida ENDOCRINE

PATIENT INFORMATION

NAME: _____DOB: _____
HOME ADDRESS: _____
CITY/STATE/ZIP: _____
MAILING ADDRESS (IF DIFFERENT): _____
HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____
EMAIL ADDRESS: _____ MARITAL STATUS: _____ GENDER: M OR F
EMPLOYER: _____ OCCUPATION: _____ SEDENTARY: Y OR N
PCP AND/OR REFERRING MD: _____ PHONE: _____ FAX: _____
PREFERRED PHARMACY (LOCAL): NAME: _____ PHONE: _____ FAX: _____
PREFERRED PHARMACY (MAIL ORDER) NAME: _____ PHONE: _____ FAX: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____
MEMBER ID #: _____GROUP #: _____
SUBSCRIBER NAME: _____
(IF SUBSCRIBER OTHER THAN SELF) GUARANTOR NAME: _____ DOB: _____
GUARANTOR ADDRESS (IF DIFFERENT THAN PATIENTS): _____
RELATIONSHIP TO GUARANTOR: _____ GUARANTOR DOB: _____
SECONDARY INSURANCE NAME: _____
MEMBER ID #: _____ GROUP #: _____
SUBSCRIBER NAME: _____
(IF SUBSCRIBER OTHER THAN SELF) GUARANTOR NAME: _____ DOB: _____
GUARANTOR ADDRESS (IF DIFFERENT THAN PATIENTS): _____
RELATIONSHIP TO GUARANTOR: _____ GUARANTOR DOB: _____

EMERGENCY CONTACT

NAME: _____ PHONE: _____
ADDRESS: _____
RELATIONSHIP: _____

213 S. DILLARD ST., SUITE 130
WINTER GARDEN, FL 34787
PH: 407-614-1644 FAX: 407-614-1635

Mid Florida ENDOCRINE

NAME: _____ DOB: _____
REASON FOR VISIT: _____
ALLERGIES: _____
SURGERIES/HOSPITALIZATIONS: _____

MEDICATIONS (RX & OTC):

NAME	STRENGTH	FREQUENCY

FAMILY HISTORY:

MEDICAL HX	**SELF**	**PARENT/AGE**	**SIBLING/AGE**	**OTHER RELATIVE**
HEART DISEASE				
HIGH BLOOD PRESSURE				
CANCER (KIND)				
DIABETES				
DEPRESSION				
THYROID DISEASE				
OTHER				

PERSONAL HISTORY:

DO YOU SMOKE? __ QUANTITY DAILY: ___ PREVIOUSLY: __ HOW LONG: ___ QUIT YEAR: ___
DO YOU DRINK ALCOHOL? __ SOCIAL? __ QUANTITY: _____ DO YOU USE ILICIT DRUGD? _____
WHEN WAS YOUR LAST FLU SHOT? _____ PNEUMONIA SHOT? _____ SHINGLES VACCINE? _____

REVIEW OF SYSTEMS MARK (**Y**)ES OR (**N**)O and (**S**)elf or (**R**)elative

213 S. DILLARD ST., SUITE 130
WINTER GARDEN, FL 34787
PH: 407-614-1644 FAX: 407-614-1635

Mid Florida ENDOCRINE

CONDITIONS	Y/N	S/R		CONDITIONS	Y/N	S/R		CONDITIONS	Y/N	S/R
GENERAL				**NECK**				**CHEST/HEART/LUNGS**		
FEVER				SWELLING				IRREGULAR HEARTBEAT		
CHILLS				LUMPS				SHORTNESS OF BREATH		
LOSS OF MEMORY				OTHER*				LOW EXERCISE TOLERANCE		
GENERAL WEAKNESS				**GASTROINTESTINAL**				HEART FLUTTERS		
OTHER*				CONSTIPATION				CHEST PAINS		
HEAD				APPETITE POOR				FREQUENT COUGH		
EYE PAIN				INIGESTION/HEARTBURN				NIGHT SWEATS		
DOUBLE VISION				NAUSEA				SWOLLEN ANKLES		
LIGHT FLASHES				ABDOMINAL PAIN/CRAMPS				LEG CRAMPS		
BLURRED VISION W/O GLASSES				DIARRHEA				OTHER*		
HALOS AROUND LIGHTS				CHANGES IN BOWEL HABITS				**MALES ONLY**		
SEVERE HEADACHES				OTHER*				ERECTION DIFFICULTIES		
BUZZING/RINGING IN EARS				**KIDNEY**				LUMP IN TESTICLES		
SINUS PROBLEMS				NIGHTTIME URINATION				PENIS DISCHARGE		
SWALLOWING PROBLEMS				TROUBLE CONTROLLING URINE				BREAST LUMP		
PERSISTENT HOARSENESS				BURNING/PAIN WHEN URINATING				OTHER*		
OTHER*				PROBLEMS PASSING URINE				**FEMALES ONLY**		
SKIN				OTHER*				NIPPLE DISCHARGE		
RASH				**NEUROMUSCULAR**				NON PERIOD BLEEDING/SPOTTING		
DRYNESS				DIZZINESS				HOT FLASHES		
PIGMENTATION				FAINTING SPELLS				PAIN WITH INTERCOURSE		
OTHER*				SPEECH PROBLEMS				POSSIBLY PREGNANT		
BONE/JOINT				OTHER*				CHANGES IN PERIODS		
JOINT PAINS/SWELLING				**ENDOCRINE**				PAINFUL BREASTS		
MUSCLE LUMP/SWELLING				CONSTANT THIRST				OTHER*		
MUSCLE STRENGTH LOSS				CONSTANTLY COLD						
				OFTENTIMES WARM						
				VERY SLUGGISH/TIRED						
				JUMPY/NERVOUS						

213 S. DILLARD ST., SUITE 130
WINTER GARDEN, FL 34787
PH: 407-614-1644 FAX: 407-614-1635

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT AND/OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my individually identifiable health information ('protected health information") and medical record information by Mid Florida Endocrine (the "Practice") in order to carry out treatment, payment or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms of the Notice of Privacy Practices,

You may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restrictions, such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have Power of Attorney on my behalf.

I agree that the Practice may also disclose the following types of information contained in my medical record (please initial the appropriate categories listed below)

_____ HIV/AIDS information
_____ Mental Health Information
_____ Substance Abuse Information
_____ Sexually Transmitted Disease Information
_____ If patient id under the age of eighteen (18), Pregnancy Information

I agree and consent to the Practice releasing information to me in the following alternative manners (please initial the appropriate spaces below)
_____ Via email to the Patient's designated email address which is: (NOTE: I am responsible for notifying the Practice of any changes to my email) _____
_____ Via regular mail, with envelope marked Personal & Confidential, addressed to me.
_____ Via telephone, once caller is properly identified as myself.
_____ Via fax, to my designated fax number which is: _____

213 S. DILLARD ST., SUITE 130
WINTER GARDEN, FL 34787
PH: 407-614-1644 FAX: 407-614-1635

Mid Florida ENDOCRINE

CONSENT (continued from prior page)

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice **in writing.** The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign the Consent Form. If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this Consent. I have received of this Consent and I am the patient or the authorized party to act on behalf of the patient to sign this document verifying Consent to the above terms.

DATE: _____ TIME: _____ am/pm

_____

Signature of the Patient or Authorized Representative

_____

Please print name of person signing

If person signing is other than the patient, kindly explain the Representative's Authority to act on behalf of the Patient:

_____

_____

_____

213 S. DILLARD ST., SUITE 130
WINTER GARDEN, FL 34787
PH: 407-614-1644 FAX: 407-614-1635

Mid Florida ENDOCRINE

ACKNOWLEDGEMENT FORM

NO SHOW FEE

Please be advised that you will be charged a $25.00 NO SHOW FEE if you miss a scheduled appointment. To avoid this fee, we kindly request a 24-hour notice of cancellation.
My signature below acknowledges that I understand this office policy.

Print Name: _____
Sign Name: _____
Date: _____ Signature of Witness: _____

213 S. DILLARD ST., SUITE 130
WINTER GARDEN, FL 34787
PH: 407-614-1644 FAX: 407-614-1635

Mid Florida ENDOCRINE

RELEASE OF RECORDS REQUEST (PRINT OUT TO USE)

TO:
NAME OF PRACTICE/MD:_____
PHONE: _____
FAX: _____

PLEASE RELEASE MY MOST RECENT OFFICE NOTES, LAB REPORTS, RADIOLOGY REPORTS AND ANY OTHER RECENT PERTINENT INFORMATION AS IT RELATES TO MY ENDOCRINE CONDITION.

SEND THESE RECORDS TO: MID FLORIDA ENDOCRINE
ATTN: MEDICAL RECORDS
213 S. DILLARD ST. SUITE 240
WINTER GARDEN, FL 34787
PHONE: 407-614-1644
FAX: 407-614-1635

MY NAME/INFORMATION IS AS FOLLOWS:

NAME: _____ PRINT NAME: _____
ADDRESS: _____
PHONE: _____ DOB: _____
MY APPOINTMENT IS SCHEDULED: _____

Mid Florida ENDOCRINE

Our amazing staff would like to take this opportunity and genuinely thank you for choosing Mid Florida Endocrine for your healthcare needs!!

In an effort to ensure that your first visit with our practice is beneficial, we ask that you arrive at least 15 minutes prior to your appointment time to allow time for the check in process. The next 3 pages are fully interactive, you can complete them online and they will then be forwarded by our webmaster to our office. The remaining pages are for review only as you will be asked to sign them while in our office. You are invited, however, to print out the Release of Records, as noted below.

Here are some important things to note:

1) All copays, co-insurances, deductibles are collected at the time of the visit. We accept personal checks, credit/debit cards and cash. It is your responsibility to know your insurance benefits! If the plan you have chosen is an HMO plan that requires referrals or authorizations for Specialists, you are responsible for obtaining these and tracking their use.
2) You must bring with you to your appointment the following:
    - Federally issued photo ID (driver's license, passport, state ID)
    - Current, valid Insurance cards
    - Records (recent office notes, current lab reports etc.) or have confirmed that we have received them.

There is a Release of Records form on our website, which we invite you to print, fill in and fax to your PCP/Referring Physician to request your records be sent to our practice.

Unfortunately, if we do not have all of the above at the time of the appointment, you may be asked to reschedule your appointment until everything needed is provided. If for any reason you are unable to keep this appointment, please call us 48 hours in advance to allow us to offer this appointment to another patient.

We look forward to seeing you in our practice and having the opportunity to care for you and your healthcare needs.

213 S. DILLARD ST., SUITE 130
WINTER GARDEN, FL 34787
PH: 407-614-1644 FAX: 407-614-1635