ADVANCED INTERNAL MEDICINE CARE

REGISTRATION FORM

Date: _____ Chart #_____

(PLEASE PRINT) PATIENT INFORMATION

Last Name:	**Birth date:** / /	**Age:**	**Sex:** M F	**Ethnicity:** Refuse to report
First: **Middle:**				Latino Non Latino

Race: American Indian or Alaska Native Asian Native Hawaiian or other pacific Islander White Black or African American Hispanic Other Race	**Marital status** (circle one) Single / Mar / Div / Sep / Widow	**Email:**

Street address:	**P.O. box:**	**City:**	**State:**	**ZIP Code:**	**Primary Language:** English Spanish Other

Home phone: ( )	**Cell phone:** ( )	**Occupation:**	**Employer:**	**Employer phone no.:** ( )

Chose clinic because/Referred to clinic by: Dr. Insurance Plan Hospital Family Friend Yellow Pages Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance MEDICARE MEDICAID BCBS UHC CIGNA AETNA HUMANA POLK PLAN SELFPAY

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

RELEASE OF MEDICAL INFORMATION CONSENT

☐ I do not wish that any information regarding my health or results of any kind be released to anyone other than myself or my legal personal representative.

☐ I give permission to Advanced Internal Medicine Care, P.A. to release medical information to the person listed below to regard to appointments, lab results, diagnostic test results, etc. The only exception to this permission is results pertaining to sexually transmitted diseases or HIV as this requires my additional consent.

Name _____ Relation to Patient _____

Authorization to treat/Medication acknowledgment/Pay benefits to physician/Release information/Release medical records

By signing below, I give full authorization to Dario Cardona, MD, his staff and professional association (Advanced Internal Medicine Care) to treat me for the condition/illness

I also consent all laboratory exams and office procedures they may consider necessary for my treatment. I also agree to read any and all package inserts of any medication prescribed to me and ask all the questions before taking such medications. If any samples are provided to me, I further agree to ask all questions risks and benefits and ask for the package insert and to read in detail before taking these samples. I also agree to comply with the medical recommendations and follow up appointments given to me; failure to do so may affect seriously my health and my life. I also agree if I missed two appointments in a consecutive basis I may be dismissed from the practice for failure to follow up.

I authorize payments directly to Advanced Internal Medicine Care of the medical benefits, if any, otherwise payable to me for their services as described, realizing I am responsible to pay non-covered services and co-payments as required by my insurance. I understand that my co-pay/co-insurance/deductible must be collected before services are rendered.

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

I hereby also authorize Dario Cardona, MD to release any information acquired in the course of my treatment necessary to process insurance claims and to any consulting physician I may be referred to. If my insurance is an HMO or PPO, it is my responsibility to ensure Dario Cardona, MD is listed as my primary care physician.

I permit a copy of this authorization to be used in place of the original. The authorization is in force until it is either canceled or changed by me and so noted in writing.**By signing below, I agree that I have read carefully the above statements and agree with all provisions and authorizations set forth in said statement.**

Patient signature: _____ Date: ___/___/_____

ADVANCED INTERNAL MEDICINE CARE

PATIENT QUESTIONNAIRE

Pateint's Name: _____ **DOB:** ____/____/_____ **Date:** ____/____/_____

Do you need help with: Grooming **Y/N** Dressing **Y/N** Toilet Use **Y/N** Housework **Y/N** Shopping **Y/N**
Prepare meals **Y/N** Feeding **Y/N** Walking **Y/N** Bathing **Y/N** Transferring (in and out of chairs) **Y/N**

Do you need help to walk? **Y/N** If yes, please circle one: Another person; Cane; Walker; Wheel Chair or scooter; Prosthetics _____

Do you have any hearing impairment? **Y/N** If yes, any hearing aids or device

Do you have any visual impairment? **Y/N** If yes, please circle: Glasses; Contacts; Cataract; Glaucoma; Macular Degeneration; Diabetic Retinopathy; Other _____
Date of last eye exam: _____ **Done By** _____

Do you try to stay active on a daily basis? **Y/N**

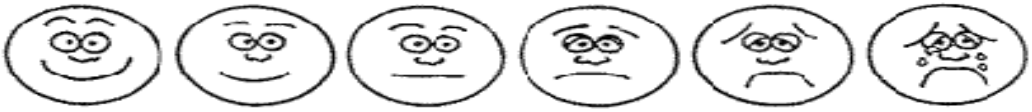
Do you have chronic pain on a daily basis? **Y/N** If yes, please describe below:
Location:_____

CHOOSE A NUMBER FROM 0 TO 10 THAT BEST DESCRIBES YOUR PAIN

No pain Distressing pain Unbearable pain

0	1	2	3	4	5	6	7	8	9	10

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



0	**2**	**4**	**6**	**8**	**10**
NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST

Have you have any falls within the last year? **Y/N** If yes, how many _____

Do you have any problems controlling your bladder? **Y/N** If yes, please discuss symptoms with the doctor

Do you have Advanced Directives: Living will **Y/N** Surrogate Decision Letter **Y/N**
If you don't have any advance directives please discuss your options with the doctor

I you are 50 years or older, have you had a colonoscopy done? **Y/N**
If yes, date test done_____ Done By _____ Result Normal ____ Abnormal ____

I you are a female 40 years or older, have you had a mammogram done? **Y/N**
If yes, date test done_____ Done By _____ Result Normal ____ Abnormal ____

I you are a female, have you had a pap smear done? **Y/N**
If yes, date test done_____ Done By _____ Result Normal ____ Abnormal ____

Advanced Internal Medicine Care

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date _____ **Chart #:**_____

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**

PERSONAL HEALTH HISTORY

Immunizations and dates:	**Hospitalization or Surgeries:**	**Medical problems that other doctors have diagnosed**
☐ Tetanus ☐ Pneumonia ☐ Hepatitis ☐ Influenza		

PHARMACY

Pharmacy Name: _____ **Address:** _____ **Telephone:** _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers	**Allergies to medications Please write the name and reaction you had**

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)	☐ Occasional	☐ Regular			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol? ☐Yes ☐No					
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
Personal Safety	Do you live alone? ☐ Yes ☐ No If No, whom do you live with?					
	Do you have an Advance Directive or Living Will?				☐ Yes	☐ No
	Would you like information on the preparation of these?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	Father	**Mother**	**Grandmother**	**Grandfather**	**Sibling**	**Children**
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Diabetes						
Other						

WOMEN ONLY

Date of last menstruation: _____ Period every _____ days	Date of last mammogram ____/___/____ Normal Abnormal
Are you pregnant or breastfeeding? ☐Yes ☐No No. of pregnancies ___ No. of live births ___	Date of last pap and rectal exam ____/____/____ Normal Abnormal

MEN ONLY

Do you usually get up to urinate during the night? ☐ Yes ☐ No If yes, # of times _____		
Has the force of your urination decreased?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

Advanced Internal Medicine Care, P.A

OFFICE POLICIES

Our office verifies all insurances prior to your first appointment. The information obtained from your insurance carrier is not a guarantee of payment. It is only a review of the patient benefits.

PAYMENT POLICIES

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable co-insurance and co-payments. Our office accepts cash, checks, Visa, and MasterCard. There is a service charge for returned checks of $25.00.
Co-payments are collected at the time of registration. Patient who are unable to pay their copayment will need to reschedule.

Patients with deductibles will be required to pay a deposit of $120.00 for a first time visit and $90.00 for each follow up visit until deductible has been met. Payment must be done at check in. Patient credits will be applied to the next visit or refunded if no other appointment is necessary.

Patients with an outstanding balance, please communicate with our billing and collection staff so that they may assist you to create a financial plan. After the second attempt to collect payment your account will be reported to a collection agency.

REFILL OF MEDICATIONS

Medications must be refilled during your doctor's visit. If you call to request a refill of medications please allow us 48 hours to process your request. No refills will be authorized if patient has not been seen by the doctor for more than 3 months. I have been advised, understand and agree that Advanced Internal Medicine Care has the right to do a medication history check from the pharmacies.

MEDICAL RECORDS

Patients requesting copies of their medical records must first sign a release form. The charge is $1.00 per page for the first 25 pages and $0.50 cents for each additional page thereafter. Records can be picked up with a photo ID; they cannot be mailed. This is to ensure patient confidentiality.

MEDICARE SUPPLEMENT INSURANCE

We are a participating provider with the Medicare Part B program; and as such we are obligated to write off the difference between what Medicare pays us for the services rendered to you (the "allowed amount") and our usual and customary charge.
Medicare pays 80% of the "allowed amount" to us directly. The remaining 20% co-pay and your annual deductibles are the patient's responsibility by federal law.

NO-SHOW

Patients failing to cancel or reschedule an appointment without a 24-hour notice, will be subject to a $25.00 "FAILED APPOINTMENT FEE"

TRAVELERS INSURANCE FOR INTERNATIONAL PATIENTS

Any international patient who have Canadian health care insurance or traveler's insurance, automatically become self pay patients. It is the patient's responsibility to file their claim with the insurance company.

Patient Name: _____

Patient Signature: _____ Date: _____

A COPY WILL BE KEEP IN YOUR MEDICAL RECORDS

Advanced Internal Medicine Care

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize

1. _____ 4._____
2. _____ 5._____
3. _____ 6._____

To release healthcare information of the patient named above to:

Advanced Internal Medicine Care P.A.
5245 US 98 NORTH
LAKELAND FL 33809
Phone (863)644-3585
Fax (863) 644-3171

This request and authorization applies to:

☐ Last 3 months consult , Last Labs , Radiology reports , Last Mammogram , Last Papsmear , Last colonoscopy and FOBT
_____

☐ Other healthcare information

1. _____ 4._____
2. _____ 5._____
3. _____ 6._____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.