ASSOCIATES MD
MEDICAL GROUP

WESTON
1604 Town Center
Suite "C"
Weston, FL 33326
O: 954-384-1800
F: 954-384-1802

DAVIE
The Atrium Centre
4801 S University Dr.
Davie, FL 33328
O: 954-434-1705
F: 954-434-1882

PLANTATION
Medical Arts Building
350 NW 84th Ave.
Suite "200-A"
Plantation, FL 33324
O: 954-424-4321
F: 954-424-0765

PLANTATION
Medical Arts Building
350 NW 84th Ave.
Suite "200-B"
Plantation, FL 33324
O: 954-577-2294
F: 954-577-2297

PERSONAL INFORMATION FORM

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____ _____ M.I.:_____

BIRTH DATE: _____ MALE/FEMAE (M/F):_____ SOC. SEC. #: ____-___-_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT INFORMATION:

HOME PHONE: (____) _____ - _____ CELL PHONE: (_____) _____ - _____

E-MAIL: _____

HEAD OF HOUSEHOLD: _____ PHONE #: _____

HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ PHONE #: (_____) _____ - _____ RELATION: _____ _____

NAME: _____ PHONE #: (_____) _____ - _____ RELATION: _____ _____

EMPLOYER NAME: _____ PHONE #: (_____) _____ - _____ CONTACT: _____ _____

INSURANCE INFORMATION: (PLEASE PROVIDE COPIES OF INSURANCE CARDS & OFFICIAL ID CARD)

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

MOTOR VEHICLE INSURANCE: _____

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Check if you have/had any of the following illnesses. If unsure, leave blank:

	Self	No	Family		Self	No	Family		Self	No	Family
Alcohol Overuse	☐	☐	☐	Frequent Kidney/				Mumps	☐	☐	☐
Allergies (other				Bladder infections	☐	☐	☐	Nervous			
than medications)	☐	☐	☐	Frequent Lung				Breakdown	☐	☐	☐
Anemia	☐	☐	☐	Infections	☐	☐	☐	Radiation	☐	☐	☐
Arthritis	☐	☐	☐	Gallbladder				Treatments			
Asthma	☐	☐	☐	Disease	☐	☐	☐	Rheumatic Fever	☐	☐	☐
Bleeding Tendency	☐	☐	☐	Goiter	☐	☐	☐	Sexually			
Cancer	☐	☐	☐	Gout	☐	☐	☐	Transmitted			
Chicken Pox	☐	☐	☐	Hay Fever	☐	☐	☐	Disease	☐	☐	☐
Colitis	☐	☐	☐	Heart Attack	☐	☐	☐	Sickle Cell			
Congenital Heart				Hepatitis	☐	☐	☐	Anemia	☐	☐	☐
Disease	☐	☐	☐	High Blood				Stomach Ulcers	☐	☐	☐
Depression	☐	☐	☐	Pressure	☐	☐	☐	Stroke	☐	☐	☐
Diabetes	☐	☐	☐	Intestinal Polyps	☐	☐	☐	Suicide Attempt	☐	☐	☐
Dialysis	☐	☐	☐	Jaundice	☐	☐	☐	Thyroid	☐	☐	☐
Emphysema	☐	☐	☐	Leukemia	☐	☐	☐	Tuberculosis	☐	☐	☐
Epilepsy	☐	☐	☐	Measles	☐	☐	☐	Whooping Cough	☐	☐	☐
				Migraine	☐	☐	☐	Other	☐	☐	☐

Operations: List and indicate approximate year.

Serious Injuries: (Other than above) List injuries and give approximate dates.

Hospitalizations: (Other than operations, especially in the last year).

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Medications:

Do you take any of the following:

- ☐ Asthma wheezing medicine
- ☐ Aspirin, Bufferin, Anacin
- ☐ Tylenol or similar products
- ☐ Blood Pressure Pills
- ☐ Cortisone, Prednisone
- ☐ Cough medicine
- ☐ Digitalis or heart medicine
- ☐ Hormones
- ☐ Insulin or diabetic pills
- ☐ Anemia medicine
- ☐ Laxatives
- ☐ Motrin, Advil
- ☐ Sleeping Pills/Tranquilizers
- ☐ Thyroid Medicine
- ☐ Stomach/Digestive medicine
- ☐ Weight-reducing pills
- ☐ Blood thinners or Coumadin
- ☐ Dilantin
- ☐ Water pills, diuretics
- ☐ Antibiotics
- ☐ Phenobarbital / barbiturates
- ☐ Vitamins
- ☐ Other prescription or over the counter drugs

List each drug, its amount, and how often you take it.

_____

_____

_____

_____

_____

_____

_____

_____

Are you allergic to any medications? Yes ☐ No ☐

If yes, please list medications and the reaction you had with them:

_____

_____

_____

_____

_____

PLEASE BRING ALL MEDICINES YOU ARE TAKING TO EVERY VISIT!

Patient Name: _____ Date: _____

Do you have any health complaints that are especially important to you today?

_____

Please check **YES** to the following question **ONLY** if the problem is of significant concern in the recent past (1 month) or unless the question specially state **"EVER"**.

REVIEW OF SYSTEMS:

	YES	NO
1. GENERAL:		
Do you usually feel persistently tired or worn out?	☐	☐
Have you recently been drinking more water or fluids?	☐	☐
Has there been any unusual weight gain or loss recently?	☐	☐
2. CARDIOVASCULAR:		
Do you have pain, tightness or pressure in the front or back of your chest?	☐	☐
Have you been told your electrocardiogram was abnormal?	☐	☐
Do you have any swelling of your feet or ankles?	☐	☐
Does your heart ever beat fast or irregularly?	☐	☐
Do you have cramps in the calf muscles when you walk?	☐	☐
Do your fingers or toes ever get cold, become numb, or get very white or bluish?	☐	☐
3. CENTRAL NERVOUS SYSTEM:		
Do you have frequent or severe headaches?	☐	☐
Do you often have spells of dizziness, faintness or lightheadedness?	☐	☐
Do you sometimes lose the ability to speak?	☐	☐
Have you recently fainted, blacked out, lost consciousness?	☐	☐
Do you have trouble remembering recent events?	☐	☐
Do you ever have convulsions or fits?	☐	☐
Have you ever wanted to commit suicide?	☐	☐
Do you ever hear voices or see people when no one is around?	☐	☐
4. EYES:		
Have you had:		
Any pain in your eyes?	☐	☐
Glaucoma?	☐	☐
Blurry vision?	☐	☐
Halo around lights?	☐	☐
Change in vision?	☐	☐
Cataracts or implants?	☐	☐
Do you wear glasses?	☐	☐
When did you last see an eye doctor?	☐	☐
5. ENT:		
Do you have:		
Any trouble hearing?	☐	☐
Ringing or buzzing in your ears?	☐	☐
Earaches or discharge from your ears?	☐	☐
Drainage down the back of your throat?	☐	☐
Frequent or severe nosebleeds?	☐	☐
Persistent hoarseness?	☐	☐
Bleeding gums?	☐	☐
Do you use a hearing aid?	☐	☐

	YES	NO
6. GASTROINTESTINAL:		
Have you recently had any change in your eating habits?	☐	☐
Have you recently noted any trouble in swallowing?	☐	☐
Do you have a lot of indigestion or heartburn?	☐	☐
Have you ever vomited blood?	☐	☐
Are you bothered with constipation?	☐	☐
Do you have frequent loose stools or diarrhea?	☐	☐
7. SKIN:		
Do you have:		
Any change in the color of your skin?	☐	☐
Any rashes or itching?	☐	☐
Any growths or lumps on your skin?	☐	☐
Any sores or wounds that do not heal?	☐	☐
Any change in the color or size of warts or moles?	☐	☐
8. GENITOURINARY:		
Do you have:		
Burning or pain when you urinate?	☐	☐
To pass water frequently?	☐	☐
To get up at night?	☐	☐
Trouble with losing urine when you cough or sneeze?	☐	☐
A problem with dribbling urine?	☐	☐
Have you ever had an operation to prevent pregnancy? (Vasectomy or sterilization, such as tubal ligation)	☐	☐
Have you ever passed blood in your urine?	☐	☐
MEN: Do you have prostate gland trouble?	☐	☐
Have you had herpes?	☐	☐

	YES	NO
9. MUSCULOSKELETAL:		
Do you ever have a problem with back pain?	☐	☐
Does back pain interfere with your work or activities?	☐	☐
Do you have joint pain or stiffness (arthritis)?	☐	☐
Do you have trouble walking or using your hip, knee joints?	☐	☐
10. RESPIRATORY:		
Do you have:		
Frequent chest colds or pneumonia?	☐	☐
A constant or bothersome cough?	☐	☐
Coughing of blood?	☐	☐
Difficulty breathing?	☐	☐
Wheezing or whistling in your chest?	☐	☐
11. WOMEN ONLY:		
Did you have any pregnancies?	☐	☐
How many?	☐	☐
Have you had any lumps in your breast?	☐	☐
Have you had any abnormal bleeding from the vagina in the past year?	☐	☐
Have you passed the menopause or change?	☐	☐
Do you have any prolapsed ("falling out") of the vagina or uterus?	☐	☐
Have you had a hysterectomy?	☐	☐
Do you have any vaginal drainage?	☐	☐
Have you had herpes?	☐	☐

LIVING ARRANGEMENTS:

	YES	NO
Do you own your home?	☐	☐
Do you rent your home?	☐	☐
Do you live alone?	☐	☐
Do you have a Will?	☐	☐
Do you have a Living Will?	☐	☐
Do you need other legal assistance?	☐	☐

PERSONAL HABITS:

Have you ever smoked tobacco?	☐	☐
Are you a regular smoker now?	☐	☐

Number of cigarettes per day: _____

Cigars ☐ Pipe ☐

How long have you been smoking? _____ Years

Check if you regularly drink:

Hard liquor (per day): 1-3oz ☐ Over 3oz ☐

Beer (per day): 1 bottle ☐ 2 bottles ☐ 3 or more ☐

Wine (per day): 1 glass ☐ 2 glasses ☐ 3 or more ☐

Do you drink coffee?	☐	☐
Do you drink more than 3 cups of coffee a day?	☐	☐
Do you exercise?	☐	☐

Regularly ☐ Occasionally ☐ Rarely ☐

Have you used any of the following:

Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐

Speed ☐ Other similar substances ☐

LIFESTYLES: (OPTIONAL)

Are you sexually active?	☐	☐

If yes, please answer the following questions:

Sexual Preference:

Partner same sex	☐	☐
Partner opposite sex	☐	☐
Partners of both sexes	☐	☐
Do you use contraceptives?	☐	☐

ACTIVITIES OF DAILY LIVING:

	YES	NO
Do you use:		
A cane?	☐	☐
A walker?	☐	☐
A wheelchair?	☐	☐
A hearing aid?	☐	☐
A catheter for urine?	☐	☐
Are these aids in good order?	☐	☐
Do you have a problem using the toilet? (for urination and bowel movement)	☐	☐
Do you drive?	☐	☐
If not, are you dependent on:		
A relative and/or friend?	☐	☐
Public transportation?	☐	☐

OCUPATIONAL:

Are you presently employed?	☐	☐
Does or did your work involve unusual work, exposure to dust, noise, radioactivity, etc.?	☐	☐
Are you limited at work because of disability?	☐	☐

Types of work you have done: _____

_____

_____

_____

SOCIAL HISTORY:

Have you recently lived or traveled outside the U.S.?	☐	☐
Do you eat less than three meals a day?	☐	☐
Do you have special food customs or restrictions?	☐	☐
Do you use any community services now? (VNA, Meals on Wheels, Sr. Citizens Ctrs., Transportation, etc.)	☐	☐

ASSOCIATES IN FAMILY PRACTICE OF BROWARD, L.L.C.

PATIENT CONSENT AND AUTHORIZATION

I, _____, UNDERSTAND THAT ASSOCIATES IN FAMILY PRACTICE HAS A "NO-SHOW" FEE OF $25.00 FOR ANY AND ALL APPOINTMENTS MISSED. I AM FINANCIALLY RESPONSIBLE TO THEM FOR THAT AMOUNT. I UNDERSTAND THAT THIS POLICY, OF ASSOCIATES IN FAMILY PRACTICE, REQUIRES A CANCELLATION NOTICE OF AT LEAST 24 HOURS IN ADVANCE OF THE SCHEDULED APPOINTMENT TIME. THANK YOU IN ADVANCE FOR YOUR COOPERATION WITH, AND UNDERSTANDING OF, OUR "NO-SHOW" POLICY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I FURTHER ACKNOWLEDGE THAT IN THE EVENT ASSOCIATES IN FAMILY PRACTICE IS FORCED TO RETAIN THE SERVICES OF A COLLECTION AGENCY AND/OR ATTORNEY; I WILL BE RESPONSIBLE FOR THE COLLECTION AND/OR LEGAL FEES. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE MEDICAL INFORMATION TO MY INSURANCE COMPANY TO SECURE PAYMENT OF BENEFITS. I ALSO AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS AND AS AUTHORIZATION FOR PAYMENTS TO BE SENT TO ASSOCIATES IN FAMILY PRACTICE AT *4801 S. UNIVERSITY DR. STE. 104, DAVIE, FL, 3328.*

I HEREBY CONSENT TO THE FOLLOWING TREATMENT:
ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS, PERFORMANCE OF SUCH PROCEDURES, USE OF PRESCRIBED MEDICATION, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TEST AND CULTURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT. PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TEST THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEES. I FULLY UNDERSTAND THAT THIS IS GIVEN IN ADVANCE OF ANY SPICIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT TO BE CONTINUING IN NATURE EVEN AFTER A SPECIFIC DIAGNOSIS HAS BEEN MADE AND TREATMENT RECOMMENDED. THE CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING. I, THE UNDERSIGNED, ACKNOWLEDGE THAT ASSOCIATES IN FAMILY PRACTICE WILL USE ABD DISCLOSE MY INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS AS DESCRIBED IN THE NOTICE OF PRIVACY PRACTICE. A PHOTOCOPY OF THIS CONSENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. MEDICARE PATIENTS: I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE ASSOCIATES IN FAMILY PRACTICE NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT IF I HAVE QUESTIONS OF COMPLAINTS THAT I SHOULD CONTACT THE PRIVACY OFFICIAL. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENTS.

Patient Consent, Authorization and Assignment of Benefits:
I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO ASSOCIATES IN FAMILY PRACTICE OF BROWARD, L.L.C., I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, a/k/a Personal Injury Protection and Medical Payments policy of insurance to the above captioned health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits and to seek damages from the insurer per Florida statue § 627.428.

Receipt of Notice of Privacy Practices.

I, _____, have received a copy of Associates in Family Practice's Notice of Privacy Practices.
The physicians and staff of Associates in Family Practice have my permission to speak to the following family members/friends in reference to my medical care:

_____ Relationship to Patient _____

_____ Relationship to Patient _____

_____ Relationship to Patient _____

The physicians and staff of Associates in Family Practice have my permission to leave a message on my home answering machine.
☐ Yes ☐ No, and/or to call me at my place of work: ☐ Yes ☐ No.

_____ _____
Signature of Responsible Party Date