

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: _____

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Kidney/				Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (other				Bladder infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous			
than medications)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Lung				Breakdown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder				Treatments			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transmitted			
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell			
Congenital Heart				Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood				Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicide Attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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).

Medications:

Do you take any of the following:

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

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

YES NO

YES NO

6. GASTROINTESTINAL:

- Have you recently had any change in your eating habits? YES NO
- Have you recently noted any trouble in swallowing? YES NO
- Do you have a lot of indigestion or heartburn? YES NO
- Have you ever vomited blood? YES NO
- Are you bothered with constipation? YES NO
- Do you have frequent loose stools or diarrhea? YES NO

7. SKIN:

- Do you have:
- Any change in the color of your skin? YES NO
- Any rashes or itching? YES NO
- Any growths or lumps on your skin? YES NO
- Any sores or wounds that do not heal? YES NO
- Any change in the color or size of warts or moles? YES NO

8. GENITOURINARY:

- Do you have:
- Burning or pain when you urinate? YES NO
- To pass water frequently? YES NO
- To get up at night? YES NO
- Trouble with losing urine when you cough or sneeze? YES NO
- A problem with dribbling urine? YES NO
- Have you ever had an operation to prevent pregnancy? (Vasectomy or sterilization, such as tubal ligation) YES NO
- Have you ever passed blood in your urine? YES NO
- MEN:** Do you have prostate gland trouble? YES NO
- Have you had herpes? YES NO

9. MUSCULOSKELETAL:

- Do you ever have a problem with back pain? YES NO
- Does back pain interfere with your work or activities? YES NO
- Do you have joint pain or stiffness (arthritis)? YES NO
- Do you have trouble walking or using your hip, knee joints? YES NO

10. RESPIRATORY:

- Do you have:
- Frequent chest colds or pneumonia? YES NO
- A constant or bothersome cough? YES NO
- Coughing of blood? YES NO
- Difficulty breathing? YES NO
- Wheezing or whistling in your chest? YES NO

11. WOMEN ONLY:

- Did you have any pregnancies? YES NO
- How many? YES NO
- Have you had any lumps in your breast? YES NO
- Have you had any abnormal bleeding from the vagina YES NO
- in the past year? YES NO
- Have you passed the menopause or change? YES NO
- Do you have any prolapsed ("falling out") of the vagina or uterus? YES NO
- Have you had a hysterectomy? YES NO
- Do you have any vaginal drainage? YES NO
- Have you had herpes? YES NO

LIVING ARRANGEMENTS:

- | | YES | NO |
|-------------------------------------|--------------------------|--------------------------|
| Do you own your home? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you rent your home? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you live alone? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a Will? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a Living Will? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you need other legal assistance? | <input type="checkbox"/> | <input type="checkbox"/> |

PERSONAL HABITS:

- | | | |
|--|--------------------------|--------------------------|
| Have you ever smoked tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you a regular smoker now? | <input type="checkbox"/> | <input type="checkbox"/> |
| Number of cigarettes per day: _____ | | |
| Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> | | |
| How long have you been smoking? _____ Years | | |
| Check if you regularly drink: | | |
| Hard liquor (per day): 1-3oz <input type="checkbox"/> Over 3oz <input type="checkbox"/> | | |
| Beer (per day): 1 bottle <input type="checkbox"/> 2 bottles <input type="checkbox"/> 3 or more <input type="checkbox"/> | | |
| Wine (per day): 1 glass <input type="checkbox"/> 2 glasses <input type="checkbox"/> 3 or more <input type="checkbox"/> | | |
| Do you drink coffee? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink more than 3 cups of coffee a day? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> | | |
| Have you used any of the following: | | |
| Marijuana <input type="checkbox"/> LSD <input type="checkbox"/> Heroin <input type="checkbox"/> Cocaine <input type="checkbox"/> | | |
| Speed <input type="checkbox"/> Other similar substances <input type="checkbox"/> | | |

LIFESTYLES: (OPTIONAL)

- | | | |
|--|--------------------------|--------------------------|
| Are you sexually active? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please answer the following questions: | | |
| Sexual Preference: | | |
| Partner same sex | <input type="checkbox"/> | <input type="checkbox"/> |
| Partner opposite sex | <input type="checkbox"/> | <input type="checkbox"/> |
| Partners of both sexes | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use contraceptives? | <input type="checkbox"/> | <input type="checkbox"/> |

ACTIVITIES OF DAILY LIVING:

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

OCCUPATIONAL:

- | | | |
|--|--------------------------|--------------------------|
| Are you presently employed? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does or did your work involve unusual work,
exposure to dust, noise, radioactivity, etc.? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you limited at work because of disability? | <input type="checkbox"/> | <input type="checkbox"/> |
| Types of work you have done: _____ | | |
| _____ | | |
| _____ | | |

SOCIAL HISTORY:

- | | | |
|---|--------------------------|--------------------------|
| Have you recently lived or traveled outside the U.S.? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you eat less than three meals a day? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have special food customs or restrictions? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use any community services now?
(VNA, Meals on Wheels, Sr. Citizens Ctrs.,
Transportation, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |

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 SPECIFIC 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 AND 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 statute § 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