

ANDREW J. SCOMA, M.D., F.A.C.E., P.A.
1925 MIZELL AVE., SUITE 201
WINTER PARK, FLORIDA, 32789

NEW PATIENT INFORMATION SHEET

NAME _____ AGE _____ BIRTHDATE _____

SOCIAL SECURITY NUMBER _____ PHONE(_____) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME OF SPOUSE _____

YOUR EMPLOYMENT _____ PHONE _____

EMPLOYMENT OF SPOUSE _____ PHONE _____

EMERGENCY CONTACT _____ PHONE _____

REFERRED BY _____

PRIMARY CARE DOCTOR: _____

PRIMARY INSURANCE COMPANY: _____

SECONDARY INSURANCE _____

Services are rendered on a cash basis. To facilitate payment, we accept checks, Visa, and MasterCard. We do not submit insurance claims unless you are in a group with which we participate. We file Medicare. ** Please note, **WE DO NOT FILE SECONDARY INSURANCE.** We collect your 20% and any deductible at the time of your arrival. If you have a known medigap insurance, we do not collect from you at the time of the visit. We do provide your secondary information to Medicare so that Medicare can cross it over; however, ultimately you are responsible for the balance if your secondary does not respond within 60 days.

IF YOUR MEDICAL HEALTH PLAN REQUIRES PREAUTHORIZATION FOR ANYTHING, YOU ARE RESPONSIBLE FOR OBTAINING IT.

*** All co-payments are due at the time of your arrival. *** No exceptions. ***

24 hour notice is required if you do not plan to keep your appointment. There is a \$25.00 fail to show fee if you do not show up and do not call. Your signature below shows that you understand this office policy.

Your signature gives us your authorization to file your insurance claims if indicated, to receive payment for services rendered, and to release your medical records if requested for processing medical claims. Medical records will only be released as stated on the HIPAA forms that you sign.

Your insurance is a contract between you and your insurance company. You are ultimately responsible for all charges incurred at this office. You will be responsible for charges if the insurance denies the claims or if false insurance information is given.

SIGNATURE : States you understand the office policies as written above.

DATE

Please let us take a copy of your driver's license. It is matched with the insurance cards and then kept in the chart. It helps us to associate your name and face when you call in.

RISK FACTORS / MEDICATION SHEET

NAME _____ CHART NUMBER _____ DATE _____

DO YOU NOW OR HAVE YOU EVER HAD:

1. A STROKE OR MINI-STROKE? (IF "YES" WHEN _____) Y___ N___
2. A HEART ATTACK? (IF "YES" WHEN _____) Y___ N___
3. HIGH BLOOD PRESSURE (ON MEDICATION)? Y___ N___
4. HIGH CHOLESTEROL (ON MEDICATION)? Y___ N___
5. DIABETES? (IF "YES" HOW MANY YEARS _____) Y___ N___
6. SEVERE DIZZINESS? Y___ N___
7. UNEXPLAINED HEADACHE? Y___ N___
8. A SUDDEN LOSS OR "SHADING" OF VISION? Y___ N___
9. SUDDEN MEMORY LOSS OR CONFUSION? Y___ N___
10. SUDDEN LOSS OF SPEECH? Y___ N___
11. WEAKNESS OR NUMBNESS OF FACE/ARMS/LEGS? Y___ N___
12. A CARDIAC EVALUATION, OR CAROTID ULTRASOUND? (IF "YES") Y___ N___
 WHEN? _____ WHERE? _____ RESULTS? _____
13. DO YOU OR HAVE YOU SMOKED? (IF "YES") Y___ N___
 HOW LONG? _____ PACKS PER DAY? _____
14. PAIN IN LEGS DURING WALKING THAT IS RELIEVED WITH REST? (CLAUDICATION) Y___ N___
15. CONSTANT LEG PAIN? Y___ N___
16. TINGLING/BURNING OR NUMBNESS OF THE FEET OR TOES? Y___ N___
17. POOR WOUND HEALING OR OPEN SORE ON FOOT OR TOES? Y___ N___
18. ARE YOU CURRENTLY TAKING BLOOD THINNERS? Y___ N___
19. HAVE YOU RECENTLY HAD LAB WORK DONE? Y___ N___
 WHEN _____ WHERE _____

Allergies

Are You Allergic To...	No	Yes	Are You Allergic To...	No	Yes	Are You Allergic To...	No	Yes
<input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa Drugs			Any Foods			<input type="checkbox"/> Perfumes <input type="checkbox"/> Pollens/Grass		
<input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Morphine			Please Explain:			Any Other Drugs		
<input type="checkbox"/> Mycins <input type="checkbox"/> Other Antibiotics						Please Explain:		
<input type="checkbox"/> Tetanus								

PLEASE LIST ALL YOUR PRESCRIPTION MEDICATIONS:
(Use Back Of Paper If Necessary)

PLEASE LIST ALL YOUR NON- PRESCRIPTION MEDICATIONS:
(Use Back Of Paper If Necessary)

Andrew J. Scoma, M.D., P.A.

Patient Questionnaire

Patient's Name _____ Age _____ DOB _____ Sex Single Married Widowed Divorced

Address _____ Phone Number _____

Occupation _____ Insurance _____ Referred By: _____

Personal History

Have You Ever Had...	No	Yes	Have You Ever Had...	No	Yes	Have You Ever Had...	No	Yes
Diphtheria			STD			Broken Bones		
Pneumonia			Seizures			What?		
Pleurisy			Anemia					
Circulation Trouble			Liver Disease / Hepatitis			Blood Disorder		
Heart Disease			Epilepsy			Concussion		
Arthritis			Migraine Headaches			Head Injury		
Stroke			Tuberculosis			Food Poisoning		
Bone Disease			Diabetes			Drug Poisoning		
Joint Disease			High Blood Pressure			Thyroid Disease		
Neuritis			Low Blood Pressure			Adrenal Problems		
Cholesterol			Nervous Breakdown			Testical/Ovary Problems		
Bursitis			Hay Fever			Please Explain:		
Sciatica			Asthma					
Kidney Disease			Hives			Fibromyalgia		
Polio			Pituitary Problem			Any Other Diseases		
Meningitis			Frequent <input type="checkbox"/> Colds <input type="checkbox"/> Sore Throat			Please Explain:		
Cancer Type:			Frequent <input type="checkbox"/> Infections <input type="checkbox"/> Boils					

Family History

	Father	Mother	Brother					Sister					Children						
			1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	6	
Age (If Living)																			
Health (G = Good B = Bad)																			
Cancer Type: _____																			
Diabetes																			
Heart Trouble																			
High Blood Pressure																			
Stroke																			
Epilepsy																			
Nervous Breakdown																			
Thyroid Disease																			
Kidney Disease																			
Sickle Cell / Leukemia																			
Age (At Death)																			
Cause of Death																			

Surgery – Have You Had Surgery On:

	No	Yes		No	Yes	Have You:	No	Yes	Have You:	No	Yes
Tonsils			Ovaries			Had Hernia Repaired			Been Hospitalized		
Appendix			Thyroid			Other Operations			Please Explain:		
Gall Bladder			Prostate			Please Explain:					
Uterus			Transfusion								
			When?								

X-Rays

Ever Have X-Rays Of:	No	Yes	Date	Please explain:
Chest				
CT Scans				
MRI				
Ultrasounds				
Other				

NAME _____

CHART NUMBER _____

DATE _____

Systems

Have you Ever Had...	No	Yes	Have you Ever Had...	No	Yes	Emotions	No	Yes
EYE <input type="checkbox"/> Disease <input type="checkbox"/> Injury <input type="checkbox"/> Impaired Sight			Appendicitis			Are You Often...		
EAR <input type="checkbox"/> Disease <input type="checkbox"/> Injury <input type="checkbox"/> Impaired Hearing			Liver Disease			Depressed		
Any Trouble With <input type="checkbox"/> Nose <input type="checkbox"/> Sinuses			Gall Bladder Disease			Anxious		
Any Trouble With <input type="checkbox"/> Mouth <input type="checkbox"/> Throat			Colitis			Irritable		
Please Explain:			Other Bowel Disease			Jumpy		
Fainting Spells			Hemorrhoids			Jittery		
Dizziness			Rectal Bleeding			Difficulty Concentrating		
Convulsions			Constipation			Women Only:		
Paralysis			Diarrhea			Menstrual History...		
Headaches <input type="checkbox"/> Frequent <input type="checkbox"/> Severe			Black Tarry Stools			Age At Onset _____		
Thyroid:			Any Changes In Bowel Action <input type="checkbox"/> Stools			Date of Last Period _____		
<input type="checkbox"/> Overactive <input type="checkbox"/> Underactive			Please Explain:			Are You...	No	Yes
Enlarged Thyroid			Kidney <input type="checkbox"/> Disease <input type="checkbox"/> Stones			Regular		
Enlarged Goiter			Bladder Disease			Do You Have...		
Other:			Blood In Urine			<input type="checkbox"/> Tension <input type="checkbox"/> Depression		
Cough <input type="checkbox"/> Frequent <input type="checkbox"/> Chronic			Albumin in Urine			<input type="checkbox"/> Hot Flashes <input type="checkbox"/> Pain		
Swelling of: <input type="checkbox"/> Hands <input type="checkbox"/> Feet <input type="checkbox"/> Ankles			Difficulty in Urination			Pregnancies...		
Spitting Up Blood			Narrowed Urinary Stream			Children Born Alive (# _____)		
Night Sweats			Abnormal Thirst			Cesarean Sections (# _____)		
Shortness of Breath <input type="checkbox"/> Exertion <input type="checkbox"/> At Night			Prostate Trouble (Men)			Prematures (# _____)		
<input type="checkbox"/> Chest Pain <input type="checkbox"/> Angina Pectoris			Erectile Dysfunction (Men)			Still Born (# _____)		
<input type="checkbox"/> Palpitations <input type="checkbox"/> Fluttering Heart			Change in <input type="checkbox"/> Appetite <input type="checkbox"/> Eating Habits			Miscarriages (# _____)		
Swelling of: <input type="checkbox"/> Hands <input type="checkbox"/> Feet <input type="checkbox"/> Ankles			Change in Weight			Any Complications:		
Varicose Veins			Loss <input type="checkbox"/> How Much _____ lbs.					
<input type="checkbox"/> Stomach Trouble <input type="checkbox"/> Ulcers			Gain <input type="checkbox"/> How Much _____ lbs.					
<input type="checkbox"/> Gas <input type="checkbox"/> Belching			Extreme <input type="checkbox"/> Tiredness <input type="checkbox"/> Weakness					
			Skin Disease					

Habits

Do You...	No	Yes	Do You Use...	Never	OCC.	FREQ.	Daily
Exercise			Laxatives				
How Often _____			Vitamins				
What Type Of Exercise? _____			Sedatives				
Awaken Rested			Tranquilizers				
Sleep Well			Sleeping Pills, etc.				
Average 8 Hours Sleep (Per Night)			Aspirins				
Have Regular Bowel Movements			Appetite Depressants				
Sex - Entirely Satisfactory			Coffee / Tea (____Cups Per Day)				
Like Your Work (____Hours Per Day)			Alcoholic Beverages				
<input type="checkbox"/> Work Indoors <input type="checkbox"/> Work Outdoors			Tobacco: <input type="checkbox"/> Chewing Tobacco				
Watch Television (____Hours Per Day)			<input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff				
Read (____Hours Per Day)			<input type="checkbox"/> Cigarettes (____Packs Per Day)				
Have a Vacations (____Weeks Per Year)			Thyroid Medication <input type="checkbox"/> No <input type="checkbox"/> Yes In The Past? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Have You Ever Been Treated For Alcoholism			Now On _____				
Have You Ever Been Treated For Drug Abuse			Daily Dose: _____				
Recreation: Do You Participate In Sports or Have Hobbies Which Give You Relaxation At Least 3 Hours Per Week.			Have You Ever Taken...				
			Insulin <input type="checkbox"/> No <input type="checkbox"/> Yes Tablets For Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes				
			Hormone Shots <input type="checkbox"/> No <input type="checkbox"/> Yes Hormone Tablets <input type="checkbox"/> No <input type="checkbox"/> Yes				

Immunizations

Have you had...	No	Yes	Have you had...	No	Yes
Flu Shot (If "YES" What Year? _____)			Pneumonia Vaccination (If "YES" What Year? _____)		
Tetanus Shot (If "YES" What Year? _____)			Hepatitis Vaccination (If "YES" What Year? _____)		
Shingles Vaccination (If "YES" What Year? _____)			Other: (If "YES" What Year? _____)		

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information (“protected health information”) and patient medical record information by Andrew J. Scoma, M.D., P.A., F.A.C.E. (the “Practice”) in order to carry out treatment, payment, or health care operations. The Patient should review the Practice’s Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient’s requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient’s protected health information and patient medical record information to the following individuals who are either the Patient’s family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient: _____

The Patient agrees that the Practice may disclose the following types of information contained in the Patient’s medical records (please initial the appropriate categories listed below):

- _____ HIV/AIDS Information
- _____ Mental Health Information
- _____ Substance Abuse Information
- _____ Sexually Transmitted Disease Information
- _____ If Patient is under the age of eighteen (18), Pregnancy Information

Patient agrees and consents to the Practice releasing information to Patient in the following alternative manners (please initial the appropriate spaces below):

- _____ Via Regular Mail with any envelopes being marked personal and confidential and addressed to Patient.
- _____ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient’s name, social security number and unique personal identifier).

At all times, Patient retains 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 in reliance on the Consent.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to Patient 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 A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date: _____ Time _____ AM/PM

Patient Signature (or Authorized Representative*)

Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient:

