Sun 'N Lake Medical Group

Internal & Pediatric Medicine

Name _____

First **Middle** **Last**

Today's Date_____ **Date of Birth** _____

Address_____

_____

_____

Telephone Number (**home**) (_____)_____

(**cell**) (_____)_____

(**work**) (_____)_____

Filling out this form

■ Answering these questions will help your doctor understand your health and how best to treat you.

■ If you need help filling out this form:

- Bring this form with you to your appointment and a nurse will help you.

OR

- Call the clinic at 863-385-8004 before your appointment and someone can help you over the phone.

Bring to your appointment:

1. This Initial Health History Form and any other important medical records
2. Your insurance information
3. All your medicines (prescription, herbal, over-the-counter pills, liquids, and creams)

We look forward to working with you!

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

Office policies and procedures

Sun 'N Lake Medical Group

Internal & Pediatric Medicine

Office's Hours, Policies and Procedures: Our regular office hours are Monday, Tuesday, Thursday and Friday from 8:00 AM to 5:00 PM and Wednesday from 8:00 AM to 6:00 PM. We close for all major holidays and occasionally open late due to staff meetings.

Phone Messages and Refill Requests: Due to the high volume of call we receive daily, we ask each patient to comply with our policy regarding medication refills and phone calls to the office. All urgent medical calls will be returned the same day, all other calls may take 24 to 48 hours to process. To request a medication refill, please contact your pharmacy and have them fax a request to 863-386-4301. Medication refills will be completed within 24 to 48 business hours of the request. If the prescription must be hand written, leave a detailed message and you will be contacted when it is completed.

After Hours Emergency: For a true medical emergency call 911 immediately or proceed to the nearest Emergency Room. We do have an answering service available for urgent reasons. The phone number is 863-386-4711. The answering service cannot process medication refills. The answering service is intended only for urgent medical issues.

Confidentiality: If you have a family member or friend who you would like us to release information to (including appointment times) we required to have that person on your Authorization to Treat Form.

Medical Records: We are happy to provide you with a hard copy of your records upon receipt of the proper request form. The charge will be $1.00 for the first 25 pages and 0.25 cents for each additional page. Please allow 10 days for your request to be processed.

Paperwork and Miscellaneous Charges: There will be a $15.00 charge, payable in advance for each form the doctor is requested to fill out (i.e. Disability, FMLA, Medical Necessity, etc). These forms should be turned in at the front desk. Please allow 7 business days for processing.

No Show-Fee: A no show-fee of $25.00 will be billed to you if 24 hours notice is not given.

I HAVE READ AND UNDERSTAND SUN 'N LAKE MEDICAL GROUP OFFICE POLICIES AND PROCEDURES OUTLINED ABOVE. I AGREE TO THE GUIDELINES OUTLINED IN THE ABOVE DOCUMENT.

Patient/Guardian Signature: _____ Date: _____

Print Name: _____

Medical Records Request

Sun 'N Lake Medical Group

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Patient Name: _____ **Patient Date of Birth:** _____

Patient Address: _____

_____ **Phone #:** _____

(City, State Zip)

For Record Release or copies: By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information (PHI) about me/my child.

This authorization permits:

_____ To use or disclose to **Sun 'N Lake Medical Group Internal Medicine**

(Provider's Name)

_____ 4958 Sun 'N Lake Blvd Suite A

(Street Address)

_____ Sebring, FL 33872

(City, State, Zip)

_____ **Phone: (863-386-4711)- Fax: (863)386-4301**

(Phone Number)

Information to be released/copied:

( ) All pertinent medical records including immunizations and lab tests

( ) Day sheets- Dates: _____ ( ) Lab Information- Dates: _____

( ) Other: _____

Information to be excluded/not released:

( ) Mental Health Records ( ) Drug/Alcohol Treatment ( ) HIV Testing

( ) Sexual Assault/Victimization records ( ) other: _____

Be sure to review any restrictions prior to copying/releasing

Reason for Record Release or Copy: _____

_____

(Please see below, charges could apply.)

For patient or Guardian Inspection/Copy Requests: ( ) Check Here

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is: $1.00 per page for the first 25 pages, then $0.25 for each page thereafter.

_____ _____

(Parent/Legal Guardian Signature) **(Date)**

_____ *Inspection requests are valid on the date of signature only

(Parent/Legal Guardian Name Printed) *Release/Copy requests expire 30 days from signature date

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentially is protected by law. Any further disclosure is strictly prohibited unless the patient/guardian provides specific written consent from subsequent disclosure of this information. These records may be protected by federal regulation (42 CFR, Part 2).

For Internal Purposes Only: Name and Title of Person Releasing Records: _____

Method of transfer: ( ) Mailed on: _____ **( ) Certified? (Certification #)** _____

( ) Picked up by: _____**/ (Date)** _____ **Form of ID:** _____

( ) Faxed: _____**/ (Date)** _____**Verification of ID Performed: ( ) Yes ( ) No**

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General information:

What is the patient's **gender**? ☐ Female ☐ Male

Patient's **Date of Birth**:_____ **current age**:_____

Patient's **Email**: _____

Who is filling out this form?

- ☐ Self
- ☐ Spouse
- ☐ Other (please explain relationship to patient)_____

Other contact	**Other contact**
Name:	Name:
Relationship to patient: ☐ Spouse ☐ Other _____	Relationship to patient: ☐ Spouse ☐ Other _____
Address: ☐ Same as patient Street Address: _____ _____ City:_____ State:_____ Zip:_____	Address: ☐ Same as patient Street Address: _____ _____ City:_____ State:_____ Zip:_____
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Email:	Email:
Social Security number:	Social Security number:

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General Information

1. **Why did you make this appointment**? (check all that apply)

   ☐ Regular Checkup

   ☐ First appointment to start care with a new doctor

   ☐ Switching doctors (from whom:_____)

   ☐ Have a specific health problem (if so explain _____)

2. In general, what do you consider to be your **main health problem(s)**? (Place a check by all that apply)

Stomach problems	Skin Problems	Headaches
Heart Problems	Asthma (wheezing)	Diabetes (sugar)
Joint Problems	Other breathing problems	Cancer
Epilepsy (fits, seizures)	Depression	Liver Trouble
Ear/nose/throat problems	High Blood Pressure	Anxiety
Other:	Other:	Other:

3. How would you **describe your health?**

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

4. Do you have a ☐ Donor Card ☐ Living Will ☐ Durable Power Of Attorney for Health Care

5. Are you taking and **prescription medicines?**

   ☐ No, I do not take any medications

   ☐ Yes – Please list the patient's medicines below **OR** ☐ I brought my pill bottles

Name of medicine:	**Dose:**	**How many pills or doses do you take at:**
Ex: Furosemide	20 mg	2 morning 2 noon evening bedtime
		morning noon evening bedtime
		morning noon evening bedtime
		morning noon evening bedtime
		morning noon evening bedtime
		morning noon evening bedtime
		morning noon evening bedtime
		morning noon evening bedtime
		morning noon evening bedtime

(please use the back of this form if you have more medicines that your doctor has given you)

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6. What **over-the-counter medicines** do take regularly?

☐ Vitamins(please list):_____

☐ Pain Reliever (for examples: Tylenol, Advil, Motrin, Aleve, Aspirin)

☐ Antacids

☐ Herbal medicines(please list):_____

☐ Other(please list):_____

☐ None, I do not take any over-the-counter medicines

7. Have you ever had any **allergic reaction (bad effect)** from any of the following?

☐ Outside or Indoor allergies (ex. Grass, pollen, cats …) _____

☐ Food allergies (peanuts, milk, wheat…) _____

☐ Medicine or shots (please list below)

☐ No, I have no allergies that I know of.

Medicines or Shots I am allergic to:	What happens when I take the medicine?

8. Have you ever been a **patient in a hospital** overnight ☐ YES ☐ NO

I was in the hospital because:	When:
Examples: Heart Attack	6 years go

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9. Have you ever had a **colonoscopy** (a test to look at your insides by sending a camera through your bottom)?

☐ No ☐ Yes (if so when _____)

10. Have you ever had a **blood transfusion** (when you are given extra blood)?

☐ No ☐ Yes (if so when _____)

Shots

11. When was your last **Tetanus** shot? Year _____ ☐ Never ☐ I don't know
12. When was your last **Pneumonia** shot? Year _____ ☐ Never ☐ I don't know
13. When was your last **Flu** shot? Year _____ ☐ Never ☐ I don't know
14. When was your last **Shingles** shot? Year _____ ☐ Never ☐ I don't know

For Women Only

15. Have you ever been **pregnant**? ☐ Yes ☐ No

How many times? _____?

How many children have you given birth to? _____

16. Have you ever had a **pap smear**? ☐ Yes ☐ No

Date of last one _____

17. Have you ever had a **pap smear that was not normal**? ☐ Yes ☐ No

18. Have you had a **mammogram** (breast X-ray) ? ☐ Yes ☐ No

Date of last one _____

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Social History

1. **Circle** the **highest grade** you finished in school?

1 2 3 4 5 6 7 8	9 10 11 12	GED	1 2 3	1 2 3 4+
Grade School	Highs school		Vocational School	College

2. What **language** do you prefer to speak? ☐ English ☐ Spanish ☐ Other _____

3. How well can you read? ☐ Very well ☐ Well ☐ Not well ☐ I cannot read

4. **What do you do during the day?**

   ☐ Work full-time
   ☐ Work part-time
   ☐ Attend school
   ☐ Take care of children/grandchildren at home
   ☐ Go our most days (shop, visit, appointments)
   ☐ Stay at home most days
   ☐ Other _____

5. Have you ever **smoked cigarettes, cigars, used snuff or chewed tobacco**?
   ☐ No
   ☐ Yes, which one? _____

   When did you start? _____
   How much per week? _____
   Have you quit? ☐ No ☐ Yes, when? _____
   Do you want to quit? ☐ No ☐ Yes

6. Do you drink **alcohol**?

   ☐ No
   ☐ Yes, if so

   Have you ever felt you ought to cut down on your drinking? ☐ No ☐ Yes

   Have people ever annoyed you by criticizing your drinking? ☐ No ☐ Yes

   Have you ever felt bad or guilty about your drinking? ☐ No ☐ Yes

   Have you ever had a drink first thing in the morning? ☐ No ☐ Yes

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7. Have you ever **used drugs?**

☐ No
☐ Yes, which one? _____

When did you start? _____

How much per week? _____

Have you quit? ☐ No ☐ Yes, when? _____

Do you want to quit? ☐ No ☐ Yes

8. Are you ☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widowed

9. Who lives in your house? _____

10. Do you have **sex** with ☐ men ☐ women ☐ both ☐ neither

How many partners have you had in the last 12 months? _____

11. Race (select multiple if they apply):

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian ☐ Pacific Islander ☐ Caucasian/White
☐ Hispanic ☐ More than once race ☐ Refuse to report
☐ Other _____

12. Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other: _____

13. Country of Origin if other than the United States _____

14. Gender Identity:

I was born a ☐ male ☐ female, BUT I identify as a ☐ male ☐ female ☐ other:_____

15. I prefer the following pronouns:

☐ he/him/his ☐ she/her/hers ☐ they/their/theirs ☐ it/its ☐ Other: _____

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16. Do you have any beliefs or practices from your religion, culture, or otherwise that your doctor should know? For example:

☐ I do not accept blood/blood products because of personal or religious beliefs.

☐ **I do not use birth control** because of personal or religious beliefs.

☐ I **fast** (go without food) for periods of time for personal or religious reasons.

☐ I do not eat meat ☐ I do not eat anything that comes from an animal.

☐ Other special diets or eating habits. (Please describe.)_____

☐ I use traditional medicines or treatments, such as acupuncture or herbs.

☐ Other beliefs_____

☐ **No**, I have no specific beliefs or practices that change the course of my health care

17. Check any of the following things you use to **help you walk or move around?**

☐ Cane ☐ Walker ☐ Wheelchair ☐ Other_____ ☐ I do not need help walking

18. Check any of the following types of **help at home** you receive (paid help or family and friends)

☐ Help with cleaning/laundry ☐ Help with shopping

☐ Help with personal care (bathing, dressing) ☐ Help with taking my medicines

☐ I do not have use help at home ☐ I do not use help at home **BUT** I need help

19. In the past year, have you been **emotionally or physically abused** by your partner or someone important to you? ☐ Yes ☐ No

20. In the past year have you been **hit, pushed, shoved, kicked or threatened** by your partner or someone else important to you? ☐ Yes ☐ No

21. **EXERCISE**

Describe what kind of exercise you do? (check all that apply)	How many times per week do you exercise?	For how long do you exercise daily?
Walking ○	Once per week ○	Less than 15 min ○
Biking ○	Twice per week ○	15-30 min ○
Swimming ○	3 times a week ○	30-45 min ○
Weight training ○	4 times a week ○	45 min – 1 hour ○
Yoga ○	5 times a week ○	Over 1 hour ○
Other ○	6 times a week ○	
I do not exercise ○	7 times a week or more ○	

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Family History

Relative	Age (if living)	Age at death	Medical Problems
Mother			☐ Diabetes (sugar) ☐ High Blood Pressure ☐ Cancer ☐ Heart Problems ☐ Other _____
Father			☐ Diabetes (sugar) ☐ High Blood Pressure ☐ Cancer ☐ Heart Problems ☐ Other _____
Brothers			☐ Diabetes (sugar) ☐ High Blood Pressure ☐ Cancer ☐ Heart Problems ☐ Other _____
Sisters			☐ Diabetes (sugar) ☐ High Blood Pressure ☐ Cancer ☐ Heart Problems ☐ Other _____

History of Medical Conditions

Have you ever had any of the following conditions? (Circle all that apply)

ADD/ADHD	Anxiety	Thyroid problems	High Blood pressure
Anemia (low iron)	Alcohol problems	Back problems	High Cholesterol
Asthma	Prostate problems	Headaches	Breathing problems
Arthritis	Stomach problems	Diabetes(sugar issues)	Stroke
Gynecological problems	Kidney problems	Liver problems	Neurological problems
Blood Clots	Osteoporosis	Skin problems	Seizure problems
Colon problems	Depression/Anxiety	Broken bones	Allergies/Hay fever
Cancer	Migraines	Heart Attack	Other:

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Review of Symptoms			
		Yes	**No**
Sleeping	Do you **feel tired** a lot?		
	Do you have **trouble falling or staying asleep?**		
	Do you have **other problems with sleep?**		
Eating	Have you lost weight in the last year without trying?		
	Have you **lost weight** in the last year without trying?		
	Do you **eat too much** or **have you gained weight** recently?		
	Do you have **other problems with eating?**		
Throat	Do you have **sore throats** a lot?		
	Do you have **other problems with your throat**		
Ears	Do you have **trouble hearing**?		
	Do you wear a **hearing aid?**		
	Do you have constant **ringing or noises** in your ears?		
	Do you have **other problems with your ears?**		
Back	Do you have **back pain?**		
	Do you have any **other problems with your back?**		
Eyes	Do you have **trouble with your vision or seeing?**		
	Do you **wear glasses or contacts?**		
	Do you have **other problems with your eyes?**		
Nose and Sinuses	Do you have a **runny or stopped up nose** a lot?		
	Do you have **other problems with your nose or sinuses?**		
Teeth and Mouth	Do you have **sore or bleeding gums?**		
	Do you wear **plates or false teeth?**		
	Do you have **other problems with your teeth and mouth?**		
Heart or Breathing	Do you ever have **pain/tightness in your chest** when working or exercising?		
	Do you **wake up at night with trouble breathing**?		
	Do you have **a racing or skippng heartbeat** at times?		
	Do you have **other hear or breathing problems?**		
Bowel Movements	Do you have **bowel movements (poop) that are black, like tar or bloody?**		
	Do you have any **other problems with your bowel movements (poop)?**		

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Review of Symptoms			
		Yes	**No**
Peeing and Kidney Stones	Do you have **trouble passing your urine (peeing)?**		
	Does it **burn when you pass urine (pee)?**		
	Do you have to **pee more than 2 times a night?**		
	Do you **leak Uring (pee)?**		
	Have you ever passed **kidney stones?**		
	Do you have an **other problems with your peeing?**		
Joints	Do you have **swollen and painful joints?**		
	Do you have any **other problems with your joints?**		
Head, Balance, Fever and Weakness	Do you have**frequent or severe headaches?**		
	Have you ever **fainted (passed out)?**		
	Have you **lost your balancec and fallen** recently		
	Do you have **weakness** in any part of your body?		
	Have you had **fever** within the past month?		
	Do you have any **other problems with your head or balance?**		
Emotional Health	Do you get **upset easily?**		
	Do **frightening thoughts** keep coming into your mind?		
	Have you ever been **hospitalized for nerves, thoughts or moods?**		
	During the past 2 weeks, have you often been bothered by having **little interest of pleasure in doing things?**		
	During the past 2 weeks, have you often been bothered by feeling **down, depressed, or hopeless?**		
	Do you have any **other problems with your emotional health?**		
MEN ONLY	Have you ever had **prostate problems?**		
	Do you have any **other male problems?**		
WOMEN ONLY	Do you have **pain or lumps in your breast?**		
	Do you have unusual **vaginal discharge or itching?**		
	Do you or have you taken **hormones (such as birth control pills)?**		
	Do you have any **other female problems?**		

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Please list all of the other doctors that you see on a regular basis:

Type of Doctor Example: Cardiologist (heart doctor)	Name of the Doctor Example: Dr Jones

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Consent to Treat Form

1. I _____ (parent/guardian/patient) give permission for Sun 'N Lake Medical Group to give me medical treatment.

2. I allow Sun 'N Lake Medical Group to file for insurance benefits to pay for the care I receive.

I understand that:

- Sun 'N Lake Medical Group will have to send my medical record information to my insurance company
- I must pay my share of the costs
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance

3. I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

Patient's Signature_____ Date_____

Parent or Guardian Signature _____ Date_____
(for children under 18)

_____ _____
Print name

Emergency Contact

Name of close relative not living with you: _____

Relationship to patient: _____

Address:_____

Phone number:_____

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PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Unless other arrangements have been made in advance by yourself or your health coverage carrier, full payment for office services are due at the time of service. For your convenience we will accept VISA, MasterCard, and Discover.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor- in other words you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with whom we have an agreement and will only require you to pay the copayment at the time of service. We will collect the copayment when you arrive for your appointment.
- If you have insurance coverage with a plan with whom we do not have a prior agreement, we will prepare and sent the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of service.
- All health plans are not the same and don not cover the same services. In the event your health plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.
- In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment.
- *I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.*

_____

Signature of Patient or Responsible Party **Date**

_____

Please Print Patient’s Name

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HIPPA compliance patient consent form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our Notice before signing this consent.
The terms of the Notice3 may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree whit this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES** **NO**
May we leave a message on your answering machine at home or on your cell phone? **YES** **NO**
May we discuss your medical condition with any member of your family? **YES** **NO**
If **YES**, please name the members allowed

Name and Last Name:	**Relationship:**	**Phone Number:**
1.		
2.		
3.		
4.		
5.		
6.		

This consent was signed by: _____
(PRINT NAME PLEASE) **(D.O.B)**
Signature: _____ Date: _____

FOR OFFICE USE ONLY

_____ _____
(Witness Signature) **(Date)**