Hamptons Medical Associates
Taking care of you and your family since 2006

1590 NW 10th Ave, STE 201
Boca Raton FL 33486
P: 561-368-2714 F: 561-368-9929
www.familydoctorbocaraton.com

Steven Caridi, MD

Emily Finegan, PA-C

Britni Saint John, ARNP

Name (Last, First): _____ DOB: _____/_____/_____

Name of parent/guardian (if under 18 years):
Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Tel # Home: _____ Cell: _____ Work: _____

E-mail: _____to access the patient portal, receive e-mail information and promotions from Hamptons Medical Associates.

SS# _____ Marital Status: S M D W Sep

Emergency contact: _____ Tel # _____ Relationship: _____

Employer Information

Employer: _____ Occupation: _____

INFORMATION, ASSIGNMENT OF BENEFITS & HIPAA INFORMATION

I authorize the release of all medical information necessary to process this claim and authorize Hamptons Medical Associates apply for benefits on my behalf for all covered services rendered and/or ordered by them. I also request that payment from my insurance company be made directly to Hamptons Medical Associates. I certify that the insurance information I have provided is current and correct and permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or my insurance company at any time if in writing. I also authorize Hamptons Medical Associates to have access to all of my prescription history.

_____ _____
Patient Signature **Date**

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HIPAA Form

Date: _____

I _____, authorize Hamptons Medical Associates to contact me at

Home: (_____) _____
Cell: (_____) _____
Work: (_____) _____

Hamptons Medical Associates **may** _____ **may not** _____ leave voicemails disclosing my medical information.

◯ Hamptons Medical Associates may disclose and may leave messages regarding my personal medical information to the following

Name: _____

Name: _____

Name: _____

◯ Hamptons Medical Associates **may not** disclose my personal medical information to anyone other than myself.

By signing this document, you are aware that Hamptons Medical Associates has permission to access your prescription history, as provided through your insurance company.

_____ **Patient Signature**

_____ **Witness Signature**

Emergency contact: _____ Tel # _____
Relationship: _____

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Consent for Purposes of Treatment

I consent to the use of disclosure of any protected health information by Hamptons Medical Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditional upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected healthcare information is used or disclosed to carry out treatment and payment of healthcare operations of the practice. Hamptons Medical Associates is not required to agree to the restrictions that I may request. However, if they agree to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Hamptons Medical Associates has taken action in reliance to this consent.

My "protected health information" means health information, including any demographic information collected from me and collected or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearing house. This protected information relates to my past, present or future physical or mental health or condition that identifies me, or there is a reasonable basis to believe this information may identify me.

I understand I have a right to review Hamptons Medical Associates Notice of Privacy Practices prior to signing this document. A copy of the Notice of Privacy Practices will be made available to me to read should I desire. The Note of Privacy Practices describes the types of uses and disclosure of my protected healthcare information that will occur in my treatment, payment of my bills or in the performance of healthcare operation of Hamptons Medical Associates.

Hamptons Medical Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

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Office Policies

____ (Initials) I will arrive on time for my appointments and understand that if I am more than 15 minutes late, my appointment may be rescheduled.

____ (Initials) I understand that refills will be made only during business hours Monday – Friday and that it is my responsibility to request refills early enough to allow at least two business days for medication refills to be called in for me, should they be approved.

____ (Initials) I am responsible for knowing what my insurance does and does not cover.

____ (Initials) I may pay by cash, personal check, Visa or Mastercard. Each time I make a payment to Hamptons Medical Associates. The office will give you a receipt. Should your account be sent to a Collection Agency, you will be responsible for all costs of collections and/or attorney's fees.

____ (Initials) I understand that full payment of my insurance co-payment is to be paid at the time the services are rendered.

____ (Initials) I am responsible for payment of any and all charges not paid or covered by my insurance company unless specifically prohibited by my insurance company.

____ (Initials) If you are unable to keep any scheduled appointments, kindly give us 24 hours notice, otherwise we will have to charge $35.00 "no show" fee.

____ (Initials) I do hereby authorize Hamptons Medical Associates to furnish copies of my medical records, I ncluding information regarding HIV/AIDS related problems, psychiatric and alcohol related problems to my insurance company.

____ (Initials) I agree to complete, sign and execute forms necessary to ensure payment by my insurance company to Hamptons Medical Associates. This includes forms sent to my home for other insurance coverage or student status. I understand that my failure to cooperate in that regard could jeopardize my insurance coverage and I will be personally responsible for payment of all medical and professional services.

To verify we accept your insurance, Dr. Steven Caridi should be listed as your Primary Care Physician. Inquire at our front reception desk if we accept your insurance.
Please acknowledge your acceptance of this responsibility by signing and entering today's date below. If the patient is a minor or otherwise unable to sign, the patient's parent or guardian is responsible for payment and must sign for the patient.

Patient Signature _____Date: _____

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Laboratory and Vaccination Fees Notice

____ (Initials) I understand that some of the laboratory tests or immunization vaccines that may be ordered by our office may not be covered by your medical insurance.

Insurance coverage for laboratory tests and vaccination coverage differs between insurance company and among the plans they offer. It is not possible for us to know the details of your coverage.

While we will continue to be conscious of the cost and order only those tests or vaccines we feel to be essential, we are unwilling to compromise the care we provide by restricting services that we deem to be medically necessary to your health and welfare.

____ (Initials) I understand that I will be held responsible for payment of all laboratory fees and costs incurred. Regardless of the coverage provided by my individual insurance plan, I may elect to call my insurance company to see what they will cover and schedule the tests for a later date.

_____ _____
Patient Signature Date

_____
Patient's Name

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Current Medication List:

1. _____

2. _____

3. _____

4. _____

5._____

6. _____

7. _____

8. _____

Please provide your preferred Pharmacy information:

Name: _____

Phone Number: _____

Fax Number: _____

Address: _____

City: _____ **State:** _____

Name: _____

Phone Number: _____

Fax Number: _____

Address: _____

City: _____ **State:** _____

Are you allergic to any medications?

Yes / No

If yes, please list below

1. _____

2. _____

3. _____

4. _____

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Past Medical History

Cardiovascular
☐ Abnormal Heart Rhythm
☐ Arterial Clot
☐ Carotid Artery Disease
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Deep Vein Thrombosis
☐ High Cholesterol
☐ Hypertension
☐ Heart Attack
☐ Peripheral Vascular Disease
☐ Superficial Vein Clot
☐ Phlebitis
☐ Heart Valve Disease

Pulmonary
☐ Asthma
☐ Bronchietasis
☐ Chronic Bronchitis
☐ COPD
☐ Croup
☐ Cystic Fibrosis
☐ Pneumonia
☐ Pulmonary Embolism
☐ Pulmonary Hypertension
☐ Respiratory Syncytial Virus
☐ Sarcoidosis
☐ Sleep Apnea
☐ TB

Gastrointestinal
☐ Gall Stones
☐ Cirrhosis
☐ Colon Polyps
☐ Crohn's Disease
☐ Incontinence of Feces
☐ GERD
☐ Hepatitis
☐ Irritable Bowel Syndrome
☐ Pancreatitis
☐ Peptic Ulcer Disease
☐ Rotavirus
☐ Ulcerative Colitis

Renal
☐ Acute Renal Failure
☐ Benign Prostatic Hypertrophy
☐ Chronic Renal Failure
☐ Endometriosis
☐ Bed Wetting
☐ Erectile Dysfunction(Impotence)
☐ Glomerulonephritis
☐ Infertility
☐ Polycystic Kidney Disease
☐ Kidney Stones
☐ Multiple Sexual Partners
☐ Homosexual Partners
☐ Urinary Incontinance
☐ Frequent Bladder Infections
☐ Vesicoureteral Reflux

Musculoskeletal/Connective tissue
☐ Chondromalacia Patellae
☐ Chronic Pain
☐ Fibromyalgia
☐ Fractures
☐ Gout
☐ Juvenile Rheumatoid Arthritis
☐ Legg-Calve-Perthes Disease
☐ Osgood-Schlatter Disease
☐ Osteoarthritis
☐ Osteoporosis
☐ Paget's Disease
☐ Polymyalgia Rheumatica
☐ Rheumatoid Arthritis
☐ Sjogren's Disease
☐ Slipped Capital Femoral Epiphysis
☐ Systemic Lupus Erythematosis

Endocrine
☐ Addison's Disease
☐ Carcinoid Syndrome
☐ Cushing's Disease
☐ Diabetes
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Osteoporosis
☐ Panhypopituitarism

Neurological
☐ Alzheimer's Disease
☐ ADD/ADHD
☐ Autism
☐ Cerebral Palsy
☐ Stroke
☐ Dementia
☐ Degenerative Disc Disease
☐ Headaches
☐ Huntington's Disease
☐ Meningitis
☐ Mental Retardation
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Myasthenia Gravis
☐ Parkinson's Disease
☐ Sensory Neuropathy
☐ Pervasive Developmental Delay
☐ Seizures
☐ TIAs

Hematologic
☐ Hemolytic Anemia
☐ Iron Deficiency Anemia
☐ Myelofibrosis
☐ Pernicious Anemia
☐ Sickle Cell Disease
☐ Thallasemia

Allergy/Immune/Skin
☐ Allergies
☐ Angioedema
☐ Chicken Pox
☐ Eczema
☐ Giardiasis
☐ Immune Deficiency
☐ Ear Infections (frequent)
☐ Psoriasis
☐ Sinusitis (frequent)

Cancers
☐ Bone
☐ Brain
☐ Breast
☐ Colon
☐ Hepatic/Liver
☐ Leukemia
☐ Lung
☐ Lymphoma
☐ Melanoma
☐ Pancreatic
☐ Prostate
☐ Renal/Kidney
☐ Skin
☐Testicular
☐ Thyroid

Other
☐ Cataract
☐ Glaucoma
☐ Over Weight

Psychiatric
☐ Anxiety
☐ Anorexia Nervosa
☐ Bipolar Disorder
☐ Bulimia
☐ Depression
☐ Obsessive Compulsive
☐ Schizophrenia
☐Insomnia

Do You See Any Specialists? If **Yes** (Indicate below)

_____
_____
_____
_____
_____
_____
_____

Surgical History - Adult

Cosmetic
- ☐ Blepharoplasty
- ☐ Facelift
- ☐ Liposuction
- ☐ Rhinoplasty
- ☐ Varicose Vein Stripping

Organ Removal/Resection
- ☐ Appendix
- ☐ Gall Bladder
- ☐ Colon
- ☐ Larynx
- ☐ Lung
- ☐ Parathyroid
- ☐ Prostate
- ☐ Sinus

Organ Removal/Resection (cont)
- ☐ Small Bowel
- ☐ Spleen
- ☐ Thyroid
- ☐ Tonsils
- ☐ Uvula

Other Surgeries
- ☐ Abortion
- ☐ Aortic Aneurysm
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Coronary Artery Bypass
- ☐ Cardiac Valve
- ☐ Carotid Endarterectomy
- ☐ Cataract Removal

Other Surgeries (cont)
- ☐ Coronary Artery Stent
- ☐ C-Section
- ☐ Dilation & Curettage
- ☐ Fracture repair
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Ovaries Removed
- ☐ Joint replacement
- ☐ Laminectomy
- ☐ Laparotomy (exploratory)
- ☐ Nissen Fundoplasty
- ☐ Pacemaker
- ☐ Coronary Angioplasty
- ☐ Tubal Ligation
- ☐ TURP
- ☐ Vasectomy

Other Procedures
- ☐ Circumcision
- ☐ Lasik
- ☐ Lumbar Puncture
- ☐ PRK
- ☐ Bone Marrow Biopsy
- ☐ Liver Biopsy
- ☐ Prostate Biopsy
- ☐ Renal Biopsy
- ☐ Skin Biopsy
- ☐ Vasectomy

☐ Other _____
☐ Other _____

Family History

Relation	Medical Problems	Age at Death	Cause of Death
Father			
Mother			
Brothers #			
Sisters #			
Sons #			
Daughters			
Paternal GF			
Paternal GM			
Maternal GF			
Maternal GM			

Pregnancy/Gynecological History

Pregnancies # _____
Children # _____
Abortions # _____
Miscarriages # _____

☐ Pregnancies Problems
☐ Menstrual Problems

Current Birth control _____
Age Periods Started _____
Age at Menopause _____

Last Pap Smear _____
Last Mammogram _____

Social History - Adult

Occupation _____
Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Number of Children _____
Hobbies _____
Exercise (type): _____
- ☐ Daily
- ☐ Rarely
- ☐ Never

Caffeine: _____ drinks/day
Smoking:
- ☐ Never
- ☐ Now
- ☐ In past

Tobacco:
- ☐ Cigarettes
- ☐ Cigar
- ☐ Smokeless

Alcohol:
- ☐ None
- ☐ Current alcoholic
- ☐ Past alcoholism

How often do you use alcohol?
- ☐ None
- ☐ Rare
- ☐ Experimented with
- ☐ Social
- ☐ Regular
- ☐ Occasional Binge
- ☐ In past

Illicit Drugs:
- ☐ Yes
- ☐ No
- ☐ In past

Are you taking any herbals or supplements?
- ☐ Yes
- ☐ No

Are you currently dieting?
- ☐ Yes
- ☐ No