NGUYEN MEDICAL GROUP

THOMAS B. NGUYEN, M.D.

BOARD CERTIFIED INTERNAL MEDICINE

New Patient Information

Referred by: ☐ Friend / Relative (Print Name) _____

☐ Doctor _____

☐ Other _____

PERSONAL INFORMATION

First Name: _____ Last Name: _____ MI: _____

Date of Birth: ____ / ____ / ____ Sex: Male / Female Social Security: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home (_____) _____ - _____ Work (_____) _____ - _____ Cell (_____) _____ - _____

Occupation: _____ Employer: _____ Phone: (_____) _____ - _____

Address: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorce ☐ Other _____

INSURANCE INFORMATION

☐ Medicare # _____ ☐ Medicaid # _____

☐ Other Primary Insurance: _____ ID Number: _____

☐ Secondary Insurance: _____ ID Number: _____

Are you responsible for this account? ☐ Yes ☐ No If not, please name person responsible for this account:

Name: _____ Relationship: _____ DOB: ____ / _____ / _____

Who to notify in emergency (nearest relative or friend)?

Name: _____ Relationship: _____

Address: _____

Phone: Home (_____) _____ - _____ Work (_____) _____ - _____ Cell (_____) _____ - _____

WOOLBRIGHT PROFESSIONAL PLAZA
2309 WEST WOOLBRIGHT ROAD SUITE#1, BOYNTON BEACH, FLORIDA, 33426
TELEPHONE (561) 364-7800 FAX (561) 364-0587

Patient Name: _____

NGUYEN MEDICAL GROUP

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BOARD CERTIFIED INTERNAL MEDICINE

Patient Medical History

Have you been in hospital recently? ☐ Yes ☐ No

If yes, which hospital and reason: _____

Do you have diabetes: ☐ Yes ☐ No

If yes, what type of medicine are you taking: _____

Did you ever have a stroke: ☐ Yes ☐ No

If yes, please specify the date: _____

Do you have cancer: ☐ Yes ☐ No

If yes, what type of cancer: _____

If yes, what kind of treatments: Chemo ☐ Radiation ☐ Surgery ☐

Did you have heart surgery: ☐ Yes ☐ No

If yes, what type of surgery:

☐ CABG ☐ Heart valve repair ☐ Pacemaker ☐ Other: _____

Please check if you have or have had:

☐ Arthritis	☐ Asthma	☐ Bleeding Disorder	☐ Depression	☐ Emphysema
☐ Gout	☐ Hepatitis	☐ High blood pressure	☐ High Cholesterol	☐ HIV
☐ Heart Disease	☐ Insomnia	☐ Kidney Disease/stones	☐ Migraines	☐ Seizure
☐ Osteoporosis	☐ STD	☐ Stroke	☐ TB	☐ UTI
☐ Thyroid disease	☐ Dialysis	☐ Macular Degeneration		

☐ Other: _____

PAST SURGICAL HISTORY

Surgery	Date	Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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ALLERGIES

☐ None

☐ Yes, please list Allergies and Reactions:

_____

_____

PRESCRIPTION : please list medication name, dosage, and how often you take per day

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10._____
11._____ 12. _____
13. _____ 14. _____

Please list your preferred pharmacy:

Name: _____ Phone Number: _____

REVIEW OF SYSTEMS : please check off any of the following you are currently experiencing.

☐ Fatigue	☐ Weight gain	☐ Weight loss	☐ Fever	☐ Blurred Vision	☐ Eye Pain
☐ Dizziness	☐ Hearing problems	☐ Sore throat	☐ Chest Pain	☐ Feet swelling	☐ Cough
☐ Palpitation	☐ Hoarseness	☐ Short of breath	☐ Diarrhea	☐ Abdominal pain	☐ Nausea
☐ Vomiting	☐ Constipation	☐ Blood in stool	☐ Back pain	☐ Painful urination	☐ Itching
☐ Rash	☐ Blood in urine	☐ Incontinence	☐ Flank pain	☐ Frequent urine	☐ Joint pain
☐ Headache	☐ Muscle pain	☐ Breast Mass	☐ Numbness	☐ Memory loss	☐ Hair loss
☐ Impotence	☐ Easy bruising	☐ Excess thirst	☐ ED	☐ Insomnia	☐ Stress
☐ Anxiety	☐ Excess thirst	☐ Runny nose	☐ Other:_____		

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PREVENTION CARE

Have you ever had mammogram: ☐ No ☐ Yes If yes, date of last mammogram: _____

Any abnormalities noted? ☐ No ☐ Yes, _____

Have you ever had pap smear? ☐ No ☐ Yes If yes, date of last pap smear: _____

Any abnormalities noted? ☐ No ☐ Yes, _____

Have you ever had colonoscopy: ☐ No ☐ Yes If yes, date of last colonoscopy: _____

Any abnormalities noted? ☐ No ☐ Yes, _____

Have you ever had bone density: ☐ No ☐ Yes If yes, date of last bone density: _____

Any abnormalities noted? ☐ No ☐ Yes, _____

Have you ever had an eye exam: ☐ No ☐ Yes If yes, date of last eye exam: _____

Any abnormalities noted? ☐ No ☐ Yes, _____

Have you ever had a dental exam? ☐ No ☐ Yes If yes, date of last dental exam: _____

Any abnormalities noted? ☐ No ☐ Yes, _____

IMMUNIZATION : If you have had the following vaccines, please indicate the date of when you received it.

Flu vaccine: _____ Prevnar 13: _____

Pneumovax 23: _____ Shingles: _____

Other: _____

FAMILY HISTORY

Mother: ☐ Alive ☐ Deceased, what age: _____ Cause of death: _____

Father: ☐ Alive ☐ Deceased, what age: _____ Cause of death: _____

Brother: ☐ Alive ☐ Deceased, what age: _____ Cause of death: _____

Brother: ☐ Alive ☐ Deceased, what age: _____ Cause of death: _____

Sister: ☐ Alive ☐ Deceased, what age: _____ Cause of death: _____

Sister: ☐ Alive ☐ Deceased, what age: _____ Cause of death: _____

Indicate any significant family illness: _____

_____

Patient Name: _____

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SOCIAL HISTORY

☐ Occupation: _____ ☐ Retired, since when (year): _____

Exercise: ☐ None ☐ 1-2 times a week ☐ 3-4 times a week ☐ 5-7 times a week

Type of exercise: _____

Are you currently on a special diet: ☐ No ☐ Yes, what kind? _____

Have you smoked before?

☐ Never

☐ Previously smoked, quit date: _____ Past # Packs/Day: _____

☐ Current smoker: ☐ every day smoker ☐ intermittent smoker

Cigarettes/Cigars per day: _____

☐ Vaping, how often: _____

How often do you consume alcohol?

☐ Never ☐ Rare ☐ Social ☐ Regularly ☐ Binges

Number of drinks per day: _____ Number of drinks per week: _____

Do you consume caffeine?

☐ Never ☐ Soda ☐ Tea ☐ Coffee

Number servings per day: _____

Do you partake in illicit drug use:

Current use ☐ No ☐ Yes, type of drug:_____

Prior use ☐ No ☐ Yes, type of drug: _____

Quit date: _____

Do you use CBD oil:

Current use ☐ No ☐ Yes, how often: _____

Prior use ☐ No ☐ Yes, how often: _____

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THOMAS B. NGUYEN, M.D.
BOARD CERTIFIED INTERNAL MEDICINE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Hien B. Nguyen, M.D., P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Hien B. Nguyen, M.D., P.A.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.) I have the right to review the Notice of Privacy Practices prior to signing this consent.

Hien B. Nguyen, M.D., P.A. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Hien B. Nguyen, M.D., P.A., Privacy officer at 2309 West Woolbright Road, Suite 1, Boynton Beach, FL 33426.

With this consent, Hien B. Nguyen, M.D., P.A. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Hien B. Nguyen, M.D., P.A. may mail to my home or other alternatives location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements as long as they are marked Personal and Confidential.

With this consent, Hien B. Nguyen, M.D., P.A. may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Hien B. Nguyen, M.D., P.A. restrict how it uses or disclose my HPI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Hien B. Nguyen, M.D., P.A.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Hien B. Nguyen, M.D., P.A. may decline to provide treatment to me.

_____ _____
Print Name Date of Birth

_____ _____
Patient/Responsibility Party/Guardian Signature Date

NGUYEN MEDICAL GROUP

THOMAS B. NGUYEN, M.D.

BOARD CERTIFIED INTERNAL MEDICINE

Authorization to Release Medical Records

Patient Name: _____

Address: _____
Street City State Zip Code

Date of Birth: _____ /_____ /_____ Preferred Phone Number: _____

My medical records to be released **FROM**:

Name: _____

Address: _____
Street City State Zip Code

Phone Number: _____ Fax Number: _____

My medical records to be released **TO**:

Name: Thomas B. Nguyen M.D.

Address: 2309 West Woolbright Road Suite #1 Boynton Beach FL 33426
Street City State Zip Code

Phone Number: (561) 364-7800 Fax Number: (561) 634-7265

☐ I authorize the release of **All** my medical records.

☐ I authorize the release of my medical records from _____ to _____ only.

I understand the following:

- I authorize and request you to provide a copy of my medical records to Dr. Nguyen's office.
- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- This information released in response to this authorization may be re-disclosed to other parties.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment.
- Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until 90 days from the date of execution at which time this authorization expired.

_____ _____

Patient's Signature Date Witness Signature Date

NGUYEN MEDICAL GROUP

THOMAS B. NGUYEN, M.D.
BOARD CERTIFIED INTERNAL MEDICINE

Authorization for Release of Information to Family Member/Friend

Patient Name _____ Date of Birth _____

Under the requirements of HIPAA we are not allowed to provide medical or billing information to anyone without the patient's consent. If you wish to have your medical and billing information released to family members/friend you must sign this form. Signing this form will only allow family members/friend listed below access to your medical or billing information.
I authorize Dr. Nguyen to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Circle either A or B:

A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing)
B. Disclose my health record, as above, **BUT do not disclose** the following:
   (Circle as appropriate)
   a. Mental Health Records
   b. Communicable diseases (including HIV and AIDS)
   c. Alcohol/drug abuse treatment
   d. Other (please specify): _____

I understand I have the right to revoke this authorization at any time by notifying my health care provider through writing.
I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

Patient Signature _____ Date _____

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BOARD CERTIFIED INTERNAL MEDICINE

PREVENTIVE HEALTH INSTRUCTIONS

Promotion of healthy lifestyles and the early identification of potential health risks will benefit you and are important to us. In accordance with the current United States Preventive Services Task Force (USPSTF) guidelines, we have put together the following information for your guidance. Please read this preventative education sheet and feel free to discuss any of the topics with your physician. Only you can take appropriate actions to maintain your health and wellbeing.

- Diet and exercise:
  A healthy diet and regular exercise are the most effective ways to maintain good health, longevity, and increase your quality of life. Choose a diet low in saturated fat, cholesterol, sugar, and salt; eat plenty of vegetables, fruits, grains which provides vitamins, minerals, and fibers; lean meats, pastas, and etc. Twenty minutes of exercise, three times a week (i.e., walking, swimming, etc.) will help keep your heart and bones healthy.

- Substance Abuse:
  Use of tobacco is known to cause heart disease, strokes, and lung cancer as well as other cancers. Excessive alcohol intake is associated with many illnesses, including cancer, liver disease, and impaired judgement (as in driving or operating machine). Illicit drug use has many risks such as AIDS, hepatitis, heart problems, and mental and social disorders.

- Sexual Behavior
  Certain sexual practices (i.e., promiscuity, unprotected sex) can expose you to potentially fatal diseases such as AIDS, sexually transmitted diseases, and other common infections.

- Excessive Sun Exposure
  Causes sun cancer, always wear sunscreen when exposed to the sun. The higher the SPF you use, the higher the protection level against the ultraviolet rays.

- Injury Prevention
  Take advantage of the many safety products that are important in preventing serious injury. These includes seat belts, bicycle helmets, and other protective gears, sage work habits (lifting, bending, and etc.), smoke detectors, firearm safety, water safety practices for adults and children, CPR training for household members, poison prevention, and etc.

- Dental Health
  Brush and flush regularly, see your dentist for your routine visits every six months.

_____ _____
Print Name Date of Birth

_____ _____
Patient/Responsibility Party/Guardian Signature Date

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Financial Assignment Agreement

Thank you for choosing Hien B. Nguyen, M.D., P.A. as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive.

You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, coinsurance amounts or any other patient responsibility indicated by your insurance carrier, which are not otherwise covered by supplemental insurance.

You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: your health plan determines that the services you received at our office are not medically necessary and/or not covered by your insurance plan; your health plan coverage has lapsed or expired at the time you receive services; or you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be re-scheduled.

We may verify your insurance benefits or submit your claim to your insurance carrier as a courtesy to you. You agree to facilitate payment of claims by contacting your insurance carrier when necessary. Without waiving any obligation to pay, you assign to Hien B. Nguyen, M.D., P.A., for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize our office to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to your treatment (including itemization of any charges and payments on my account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. Hien B. Nguyen, M.D., P.A. does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to our office until your patient account is paid in full. If you make a

NGUYEN MEDICAL GROUP

THOMAS B. NGUYEN, M.D.

BOARD CERTIFIED INTERNAL MEDICINE

payment that results in a surplus on your account, you authorize us to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a Financial Responsibility Party, and any remaining balance will be returned to the payor.

All managed care co-payment amounts are due at the time of service. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by the plan.

Hien B. Nguyen, M.D., P.A. is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare. We may submit a claim to any supplemental plan as a courtesy to you, so long as you provide all necessary policy information.

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to Hien B. Nguyen, M.D., P.A. for the below Patient's care and treatment, including copayments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report. I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

_____ _____

Print Name Date of Birth

_____ _____

Patient/Responsibility Party/Guardian Signature Date

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NGUYEN MEDICAL GROUP

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CONSENT FOR EMAIL COMMUNICATION

Patient name: _____

Patient email address: _____

I. Risk of using email
   a. Your personal information can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b. Email senders can easily misaddress an email
   c. Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
   d. Email can be intercepted, altered, forwarded, or used without authorization or detection.
   e. Email can be used to introduce viruses into computer systems
   f. Email can be used as evidence in court
   g. Email may not be secure and therefore it is possible that the confidentiality of such communication may be breached by a third party

II. Conditions for the use of email – Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by provider's intentional misconduct. Patient must acknowledge and consent to the following conditions.
   a. Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email will be read and responded to within any particular period of time
   b. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email
   c. All email will usually be printed and filed in the patient's medical record.
   d. Provider will not forward patient identifiable emails outside of our providers without the patient's written consent except as authorized or required by law
   e. The patient should not use email for communication regarding sensitive medical information
   f. Provider is not liable for breaches of confidentiality caused by the patient or any third party
   g. It is patient's responsibility to follow up and schedule an appointment if warranted

III. Instructions – to communicate by email, the patient shall:
   a. Put the patient's name in the body of the email
   b. Put in the topic (ex: medical question, complaint, billing question) in the subject line
   c. Inform Provider of changes in his/her email
   d. Acknowledge any email received from the Provider

IV. Patient Acknowledgement and Agreement
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions the Provider may impose to communicate with patient by email.

Patient signature:

_____

Date: _____

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