PINNACLE
HEALTHCARE SYSTEM

PATIENT INFORMATION SHEET

PATIENT INFO: LAST NAME_____**FIRST**_____ **MI**____

SEX M F D.O.B. _____/_____/_____ **SS#** _____/_____/_____ **CIVIL STATUS** MARR DIV SING W SEP

ADDRESS_____**CITY**_____**ST**_____**ZIP**_____
PHONE
HOME_____**WORK**_____**CELL**_____

PREFERRED PHONE METHOD _____ **EMAIL** _____

Can we leave a voice message regarding upcoming appointments on your home or cell phone? _____YES ____NO

Would you like to receive communication regarding your appointments via text message _____YES ____NO

Or Email _____YES ____NO

Race:
_____ **American Indian or Alaska Native**
_____ **Asian**
_____ **Native Hawaiian or Other Pacific Islander**
_____ **White**
_____ **Black or African American**
_____ **Hispanic**
_____ **Other Pacific Islander**
_____ **Other Race**
_____ **Prefer Not To Answer**

Ethnicity : _____**Hispanic or Latin** _____ **Not Hispanic or Latin** _____ **Prefer Not To Answer**

Preferred Language: _____ **English** _____ **Spanish** _____ **Other** _____

EMPLOYER_____**ADDRESS**_____

WHO IS YOUR PRIMARY CARE PHYSICIAN_____**PHONE** _____

PREFERRED PHARMACY_____ **ADDRESS**_____

PHARMACY PHONE_____

IN CASE OF EMERGENCY, WHOM SHOULD WE CONTACT? (*YOU MUST FILL THIS OUT*)

NAME_____ **RELATIONSHIP** _____

ADDRESS_____**CITY**_____**ST**_____**ZIP**_____
PHONE
HOME_____**WORK**_____**CELL**_____

<u>GUARANTOR INFO: (WHO IS RESPONSIBLE FOR THE BILL?)</u>

LAST NAME_____ **FIRST**_____ **MI**_____

SEX M F D.O.B. _____/_____/_____ **SS#** _____/_____/_____ **CIVIL STATUS** MARR DIV SING W SEP

ADDRESS_____**CITY**_____**ST**_____**ZIP**_____
PHONE
HOME_____**WORK**_____**CELL**_____

PRIMARY INSURANCE INFORMATION

INS. CO. NAME_____

INS ADDRESS_____

INS PHONE NO. _____

SECONDARY INSURANCE INFORMATION

INS. CO. NAME_____

INS ADDRESS_____

INS PHONE NO. _____

GROUP NO. _____ID _____ **GROUP NO. _____ID _____**

NAME OF INSURED_____ **NAME OF INSURED_____**

INSURED'S SOCIAL _____-_____--_____ **INSURED'S SOCIAL _____-_____--_____**

WOULD YOU LIKE TO FILL OUT A LIVING WILL OR NAME A PROXY IN CASE OF EMERGENCY? YES NO

If there is someone that you would like to authorize to receive medical information about you, please fill out below:

I hereby authorize Pinnacle Healthcare System to release medical information about me to:

NAME _____RELATIONSHIP_____

ASSIGNMENT OF BENEFITS

I hereby assign payment directly to Pinnacle Healthcare System (PHS) accepting assignment of medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to PHS for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay. It is further agreed that any credit balance resulting from payment of insurance or other sources may be applied to any other accounts owed to PHS by the insured.

RELEASE OF INFORMATION

PHS may disclose all or part of the patients record to any person or corporation which is or may be liable under a contract to the physician or to the patient or to a family member or employer of the patient for all or part of PHS charges, including, but not limited to, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

HMO DISCLAIMER

I certify that I _____ am ____ am not presently enrolled in any Health Maintenance Organization (HMO). Subsequent rejection of a claim as a result of this procedure due to current enrollment in a HMO Plan will constitute responsibility for payment of claim on my part.

MEDICARE AND MEDICAID PATIENT CERTIFICATION - PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS

I certify that the information given by me in applying for payment under Title XVIII and /or Title XIX, of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to PHS. I understand that I am responsible for any health insurance deductible and coinsurance.

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she individually obligates himself/herself to pay the account in accordance with the regular rates and terms. Should the account be referred to a collection agency and/or an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

I am responsible for payment myself because: ___Procedure/Visit not covered by insurance ___I do not have health insurance

_____ _____

Name Of Patient (please print) Name Of Witness (please print)

_____ _____

Signature of Patient Signature of Witness

_____ _____

Patients Agent or Representative Date

Patient was unable to sign due to: _____

_____ _____

Signature of Witness Policy Holders Signature (If other than patient)

PINNACLE
HEALTHCARE SYSTEM

I understand and agree that if my check is dishonored or returned for any reason, check plus will electronically debit my account for the amount of the check plus a processing fee of $25.

_____ _____
Signature Date

I understand I will be charged and agree to pay a fee of $25 if I do not cancel my appointment 24 hours prior to the appointment.

_____ _____
Signature Date

I understand and agree that all copayments are to be paid prior to seeing the doctor, and if I failed to pay my copayment at my appointment maybe reschedule to another date.

_____ _____
Signature Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of Pinnacle Healthcare systems notice of privacy practices.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Patient's Name Name and Relationship of Personal Representative

PATIENT'S SIGNAURE RELEASE AUTHORIZATION AND STATEMENT OF FINANCIAL RESPONSIBILITY

I authorize use of this form on all my insurance submissions. I understand that I am financially responsible for the charge is not covered by the assignment or for any and all charges which the insurance carrier declines to pay. I authorize payment directly to Pinnacle Healthcare System.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Patient's Name Name and Relationship of Personal Representative

PATIENT'S RELEASE TO VIEW MEDICATION HISTORY

One of the features of electronic prescribing systems is that it allows us to view medications that have been electronically prescribed to you by other physicians. This improve patient safety by helping us avoid prescribing medication that might interfere with what you were already taking. By signing below, you authorize us to review your medication history.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Patient's Name Name and Relationship of Personal Representative

PINNACLE
HEALTHCARE SYSTEM

HIPAA 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 notice 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 with this restriction, but if we do, we shall honor this agreement. The HIPAA (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:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO:_____

I hereby authorize you to release copies of my medical records and any information including the diagnosis and records of any treatment or examinations:

Related to or from the period of:_____

_____

_____

Please release the records to: (circle one)

PINNACLE HEALTHCARE SYSTEM

Hollywood Office
3700 Washington St, Ste 500
Hollywood, FL 33021
954-989-4700
Fax: 954-989-4754

Pembroke Pines
2213 N University Dr, Ste A
Pembroke Pines, FL 33024
954-963-2151
Fax: 954-966-6629

DISCLAIMER: I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN COPIES OF INFORMATION RECEIVED FROM ANOTHER HEALTH CARE FACILITY OR DOCTOR AND ALSO AUTHORIZE THE RELEASE OF THIS INFORMATION TO THE INDIVIDUAL SPECIFIED ABOVE. I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN REFERRENCE TO OR THE RESULTS OF: HIV ANTIBODY (AIDS) TESTING, TESTING OR TREATMENT FOR COMMUNICABLE DISEASE, TREATMENT FOR MENTAL HEALTH PROBLEMS, TESTING FOR OR TREATMENT OF DRUG OR ALCOHOL ABUSE, AND I AUTHORIZE THIS INFORMATION.

_____
Patient Name (Please Print)

_____
Patient SS#

_____
Signature of Patient

_____
Patient Date of Birth

_____
Relationship to Patient

_____
Date

PINNACLE
HEALTHCARE SYSTEM

PATIENT PERSONAL HISTORY DATE_____

LAST NAME	FIRST	MIDDLE	BIRTH DATE:	BIRTH PLACE
ADDRESS	CITY	STATE ZIP	PHONE:	WORK PHONE:
OCCUPATION:	INSURANCE:	MALE FEMALE	MARITAL STATUS	RELIGION

IN CASE OF EMERGENCY WHO SHOULD WE NOTIFY?

_____RELATIONSHIP TO YOU_____

ADDRESS_____PHONE_____

DATE OF LAST PHYSICAL EXAM_____DOCTOR_____

PRIMARY OR REFERRING DOCTOR_____ADDRESS_____

FAMILY HISTORY	**SEX**	**AGE**	**IF LIVING: HEALTH**	**Age at Death**	**IF DECEASED: CAUSE**
MOTHER	XXX				
FATHER	YYYY				
M-GRANDMOTHER	XXX				
M-GRANDFATHER	YYY				
P-GRANDMOTHER	XXX				
P-GRANDFATHER	YYY				
SIBLINGS:					
	M/F				
	M/F				
	M /F				
	M/F				
	M/F				

DO YOU HAVE ANY RELATIVE WHO HAS OR HAS HAD ANY OF THE FOLLOWING: (please circle and give relationship to you)

STROKE _____ EPILEPSY_____ HEART ATTACK_____ NERVOUS BREAKDOWN_____
CANCER_____ SUICIDE_____ STOMACH ULCER_____ RHEUMATIC HEART_____
MIGRAINE_____ KIDNEY DISEASE_____ HAY FEVER_____ HIGH BLOOD PRESSURE_____
TUBERCULOSIS_____ ARTHRITIS_____ LEUKEMIA_____ GOITER_____ COLITITS_____
CONGENITAL HEART DISEASE_____ DIABETES_____ INSANITY_____ ASTHMA_____ BLEEDING_____

PERSONAL HISTORY

Yes No Do you regularly smoke? ◊ Cigarettes ◊ Pipe ◊ Cigars _____per day, for _____ years
Yes No Do you drink coffee? How many cups per day? _____
Yes No Do you regularly drink alcohol? ◊ 1oz per day ◊ 2 oz. per day ◊ 4 oz per day ◊ over 6oz per day
BEER ◊ 1 bottle per day ◊ 2 bottles per day ◊ over 4 bottles per day
Yes No Do you have trouble falling asleep?
Yes No Do you awaken early in the morning without apparent cause?

MEDICATIONS: Are you presently taking any of the following medications?

Yes	No	Aspirin, Bufferin, Anacin	Yes	No	Blood pressure pills	Yes	No	Cortisone
Yes	No	Cough Medicine	Yes	No	Digitalis	Yes	No	Hormones
Yes	No	Insulin or diabetic pills	Yes	No	Iron or poor blood medications	Yes	No	Laxatives
Yes	No	Sleeping pills	Yes	No	Thyroid Medicine	Yes	No	Tranquilizers
Yes	No	Weight reducing/diet pills	Yes	No	Blood thinning pills	Yes	No	Dilantin
Yes	No	Shots	Yes	No	Water pills	Yes	No	Antibiotics
Yes	No	Barbiturates	Yes	No	Birth Control pills	Yes	No	Phenobarbital

Please list the names and dosages of all your medications below:

NAME OF MEDICATION	HOW MANY MGS OR UNITS	HOW OFTEN	FOR WHAT CONDITION

*****PLEASE LIST ANY MEDICATIONS THAT YOU ARE ALLERGIC TO:** **WHAT TYPE OF REACTION DOES IT CAUSE YOU?**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list any time you have been hospitalized:

NAME OF HOSPITAL	ADDRESS, CITY & STATE	DATES	FOR WHAT

List any surgery that you have had:

Surgery for:	Date	Hospital

List any illnesses that you have had that did NOT require hospitalization:

_____

_____

_____

_____

_____

List any accidents or injuries:

_____

_____

_____

_____

_____

TO BE ANSWERED BY WOMEN ONLY:

Yes No Are you still having regular menstrual periods? Date of your last period_____

Yes No Have you ever had bleeding between your periods? If so when?_____

Yes No Do you have very heavy bleeding with your period?

Yes No Do you feel bloated and irritable before your period?

Yes No Are you now or have you ever taken birth control pills? When?_____

Yes No Have you ever had a miscarriage? When?_____

Yes No Have you ever had discharge from the nipple of your breast? When?_____

Yes No Do you regularly have cancer screening of the cervix (Pap Smear)? Date of last Pap Smear_____

How many times have you been pregnant?_____ How many children were born alive?_____

How many were stillbirths?_____ How many were miscarriages?_____

How many cesarean sections?_____ How many were premature births?_____

Did you have any complications during pregnancy if so what was it?_____

TO BE ANSWERED BY MEN ONLY:

Yes No Have you ever had a prostate exam? Date of last exam _____

Yes No Have you had loss of sexual activity? For how long? _____

Yes No Have you been treated for genital warts? Yes No Have you had discharge from penis?

Yes No Have you had a hernia? When?_____ Yes No Have you had Prostate trouble?

TO BE ANSWERED BY BOTH MEN AND WOMEN:

Yes No Do you suffer from headaches? If so how often?_____ How severe?_____

Yes No Do they cause visual trouble? Yes No Do they occur on one side of the head?

Yes No Do they awaken you from sleep? Yes No Do they feel like a tight head band?

Yes No Does it hurt most in the back of the head and neck? Yes No Does Aspirin relieve them?

_____

Yes No Have you ever fainted? Yes No Have you ever had a seizure or convulsion?

Yes No Do you ever have dizzy spells? Yes No Do you ever have double vision?

Yes No Do you ever have weakness of arms or legs? Yes No Do you ever have pain in your ears?

Yes No Do you ever have ringing in your ears? Yes No Do you ever have nosebleeds?

_____

Yes No Do you frequently have bleeding gums? Yes No Do you frequently have a sore tongue?

Yes No Do you frequently have trouble swallowing? Yes No Do you often have nausea or vomiting?

Yes No Do you frequently have hoarseness?

_____

Have you ever had shortness of breath? Yes No If so continue to answer the following:

Yes No Do you get it doing your usual work? Yes No Do you have a chronic cough?

Yes No While climbing a flight of stairs? Yes No Accompanied by wheezing?

Yes No Which awakens you at night? Yes No Have you ever coughed up blood?

Yes No Do you cough up much sputum? Yes No Does it cause you a dry cough?

_____

Have you ever had chest pain or tightness in the chest? Yes No If so, does it begin with any of the following?

Yes No When exerting yourself. Yes No Does it radiate to the arm?

Yes No When walking against the wind. Yes No Does it disappear at rest?

Yes No When walking up a hill? Yes No Occur only at rest?

Yes No After a heavy meal? Yes No When walking fast.

Yes No When upset or excited? Yes No When walking in cold weather?

Describe the chest pain or tightness _____

Yes No Do you get palpitations? Yes No Do you sleep on more than one pillow?

_____

Yes No Have you had pain in the stomach? If so, does it:

Yes	No	Occur 1-2 hours after a meal?	Yes	No	Is brought on by eating fried or greasy foods
Yes	No	Awakens you at night?	Yes	No	Is relieved by antacid medications.
Yes	No	Is relieved with milk or eating?	Yes	No	Occurs while eating or immediately after
Yes	No	Is relieved by a bowel movement.	Yes	No	Loss of appetite.

If you have had a change in bowel habit recently please answer the following:

Yes	No	Do you get a crampy pain in the abdomen?	When?_____
Yes	No	Alternating diarrhea and constipation?	When?_____
Yes	No	Pain during or after bowel movement?	When?_____
Yes	No	Mucous in the stool?	When?_____
Yes	No	Blood in the stool?	When?_____
Yes	No	Ribbon-like stools?	When?_____
Yes	No	Black Stools?	When?_____
Yes	No	Require use of strong laxatives or enemas?	When?_____

_____

HAVE YOU HAD:

Yes	No	Burning when urinating?	When?_____
Yes	No	Loss of control of bladder?	When?_____
Yes	No	Blood in the urine?	When?_____
Yes	No	Dark colored urine?	When?_____
Yes	No	Trouble starting to urinate?	When?_____
Yes	No	Trouble holding urine?	When?_____
Yes	No	Getting up frequently at night?	When?_____
Yes	No	Passed a kidney stone?	When?_____

_____

HAVE YOU RECENTLY HAD:

Yes	No	Pain in calves or legs when walking?	When?_____
Yes	No	Cramps in legs at night?	When?_____
Yes	No	Pain in the big toe?	When?_____
Yes	No	Varicose Veins?	When?_____
Yes	No	Phlebitis or inflamed leg veins?	When?_____
Yes	No	Swelling in the ankles?	When?_____

_____

BRIEFLY DESCRIBE YOUR PRESENT SYMPTOMS:

_____

_____

_____

_____

_____

_____

_____

_____

_____