PARADISE FAMILY HEALTHCARE

Kevin Miller, MD
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PATIENT INFORMATION (please print)

Patient's last name: _____ First: _____ Middle: _____ Mr. Mrs. Ms. Miss Single / Married/ Divorced/ Widowed

Legal name (if different): _____ Former name: _____

Date of birth: ____/_____/_____ Age: _____ Sex: Male / Female / Other

Street address: _____ Social security #: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Cell phone: _____

E-mail address: _____ May we use your e-mail for appointment reminders? Yes / No

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address) _____

Relationship to patient: _____ Home phone: _____ Cell phone: _____

INSURANCE AUTHORIZATION

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Paradise Family Healthcare or insurance company to release any information required to process my claims.

Patient / guardian signature: _____ Date: ____/_____/_____

YOU MUST PROVIDE PICTURE IDENTIFICATION AND INSURANCE CARD UPON ARRIVAL.

1101 Tamiami Trail S, Ste 108, Venice FL 34285
www.paradisefamilyhealthcare.net
Phone: (941) 488-2332
Fax: (941) 894-6230

Additional or Northern Address:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____ Date of birth: ____/_____/_____

Previous or referring doctor: _____

Date of last physical exam: ____/_____/_____

Childhood illnesses: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken pox ☐ Rheumatic fever ☐ Polio

Immunizations:

☐ Tetanus	____/_____/_____	☐ Pneumonia	____/_____/_____
☐ Hepatitis B	____/_____/_____	☐ Influenza	____/_____/_____
☐ MMR	____/_____/_____	☐ Shingles	____/_____/_____

List any problems other doctors have diagnosed: (high blood pressure, diabetes, etc.): _____

_____

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes / No

List any medications you are currently taking, including both prescribed and vitamins:

Name of drug	Strength	Frequency taken

Allergies to medications:

Medication	Reaction

HEALTH HABITS AND PERSONAL SAFETY

Exercise
- ☐ Sedentary (no exercise)
- ☐ Mild exercise (i.e. climb stairs, walk 3 blocks, golf)
- ☐ Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 min.)
- ☐ Regular vigorous exercise (i.e. work or recreation, 4x/week or more for 30 min.)

Diet

Are you dieting?	Yes / No
If yes, are you on a physician prescribed medical diet?	Yes / No
Number of meals you eat on an average day?	_____
Rank salt intake:	High / Medium / Low
Rank fat intake:	High / Medium / Low

Caffeine ☐ None ☐ Tea _____ ☐ Soda _____ ☐ Coffee _____

Alcohol

Do you drink alcohol?	Yes / No
If yes, what kind?	_____
How many drinks per week?	_____
Are you concerned about the amount you drink?	Yes / No
Have you considered stopping?	Yes / No
Have you ever experienced blackouts?	Yes / No
Are you prone to "binge" drinking?	Yes / No
Do you drive after drinking?	Yes / No

Tobacco

Do you use tobacco?	Yes / No
What type of tobacco (cigarettes, chew, pipe, cigars, vape)?	_____
Number of years?	_____

What year did you start? _____ What year did you quit? _____

Drugs

Do you currently use recreational or street drugs?	Yes / No
Have you ever given yourself street drugs with a needle?	Yes / No

Sex

Are you sexually active?	Yes / No
If yes, are you trying for a pregnancy?	Yes / No
If not trying for a pregnancy, list contraceptive method:	_____
Any discomfort with intercourse?	Yes / No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would like to discuss this issue with your provider? Yes / No

Personal Safety

Do you live alone?	Yes / No
Do you have frequent falls?	Yes / No
Do you have vision or hearing loss?	Yes / No
Do you have an Advanced Directive?	Yes / No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? Yes / No

FAMILY HEALTH HISTORY

	MOTHER	FATHER	SIBLINGS
Thyroid disorder			
Heart disease			
Diabetes			
Stroke			
Cancer			
Liver disease			
Other _____			

MENTAL HEALTH

Is stress a major problem for you?	Yes / No
Do you feel depressed?	Yes / No
Do you panic when stressed?	Yes / No
Do you have problems with your appetite?	Yes / No
Do you cry frequently?	Yes / No
Have you ever attempted suicide?	Yes / No
Have you ever thought about hurting yourself?	Yes / No
Have you ever been to a counselor?	Yes / No
Do you have trouble sleeping?	Yes / No

OTHER PROBLEMS

Do you, or have you had any symptoms in the following areas to a significant degree and briefly explain:

Skin	Throat	Intestinal	Changes in weight
Head / Neck	Lungs	Bladder	Changes in energy level
Ears	Chest / Heart	Bowel	Changes in sleep
Nose	Back	Circulation	Other:

_____

_____

_____

_____

_____

WOMEN ONLY

Age at onset of menstruation: _____

Date of last menstruation: ___/___/____ Period every _____ days

Heavy periods, irregularity, spotting, pain, or discharge? Yes / No

Number of pregnancies? _____Number of live births? _____

Are you pregnant or breastfeeding? Yes / No

Have you had a D&C, hysterectomy, or Caesarean? Yes / No

Any urinary tract, bladder, or kidney infections within the last year? Yes / No

Any blood in your urine? Yes / No

Any problems with control of urination? Yes / No

Do you have problems emptying your bladder completely? Yes / No

Do you usually get up to urinate during the night? Yes / No

if yes, number of times: _____

Any hot flashes or sweating at night? Yes / No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around your period? Yes / No

Do you have any breast tenderness, lumps, or nipple discharge? Yes / No

Date of last pap and rectal exam? ___/___/_____

MEN ONLY

Do you usually get up to urinate during the night? Yes / No

if yes, number of times: _____

Do you feel pain or burning with urination? Yes / No

Any blood in your urine? Yes / No

Do you feel burning or discharge from your penis? Yes / No

Has the force of your urination decreased? Yes / No

Have you/ had any kidney, bladder, or prostate infections within the last 12 months? Yes / No

Do you have problems emptying your bladder completely? Yes / No

Any difficulty with erection or ejaculation? Yes / No

Any testicle pain or swelling? Yes / No

Date of last prostate and rectal exam? ___/___/_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Paradise Family Healthcare to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Paradise Family Healthcare describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. A current Notice of Privacy Practices is posted in the waiting room of the clinic. Paradise Family Healthcare 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

Paradise Family Healthcare, Inc.
1101 South Tamiami Trail, Ste. 108
Venice, FL 34285

With this consent, Paradise Family Healthcare may call my home or other alternative location and leave a message on voice mail 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 test results, among others.

With this consent, Paradise Family Healthcare may mail 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 as long as they are marked "Personal and Confidential."

With this consent, Paradise Family Healthcare may e-mail 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 Paradise Family Healthcare restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, Paradise Family Healthcare may receive notices of admissions and discharges at hospitals and rehabilitation facilities in the Florida Health Information Exchange. This includes information about admissions and discharges for psychiatric illnesses or substance abuse disorders.

By signing this form, I am consenting to allow Paradise Family Healthcare to use and disclose 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, Paradise Family Healthcare may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Patient's Name

FINANCIAL RESPONSIBILITY FORM

At Paradise Family Healthcare, we strive to give you the best possible care. To serve this purpose, it is important that you understand the mechanisms of reimbursement. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability.

INSURANCE COVERAGE
It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions, and limitations as well as authorization requirements. This information is obtained by contacting your insurance carrier. We attempt to verify that your coverage is valid at the time of the visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for payment is yours. If you have had any changes in your insurance coverage – even if there is only a small change in the co-payment amount or a change in the expiration date of the policy – you must notify us. Even a small discrepancy on the claim form can lead to a claim denial.

CO-PAYMENTS, CO-INSURANCES AND DEDUCTIBLES
Co-payments and co-insurances are your responsibility. Your insurance company expects us to collect them from you at the time of service. Understand that you will be expected to pay your co-payment for each date of service. You are also responsible for your deductibles. The deductible is determined by your individual contract with your insurance carrier. We do not have information about each person's deductible amount, and how much of that has been met.

INSURANCE PAYMENTS SENT TO YOU
If insurance payments are sent to you erroneously, you are responsible for forwarding them to our office.

NON-COVERED SERVICES
All patients are responsible if their insurance carrier denies payment for services rendered because they were "non-covered services." These non-covered services may include certain treatment types, blood work, supplies or equipment, etc. To avoid this, please check with your insurance carrier prior to receiving any treatment.

COLLECTION CHARGES
Payment is due at the time of service. From time to time we may let you carry a balance or send a statement for the balance due. If you do not pay your balance in a timely manner, then we may send it to a collection agency and you will be liable for both the balance due and the fee that the collection agency charges us to collect your balance. This fee may add up to 50% of your balance.

Bad checks – If a check bounces you will be liable for $25.00 in addition to the fees that the bank charges against Paradise Family Healthcare.

I have read and fully understand this Financial Responsibility Form. I acknowledge my personal financial responsibility and I consent to continue with treatment.

_____ _____

Patient or Guardian Signature Date

ADVANCED DIRECTIVES

I, _____ _____, ask that my family, my doctors, other healthcare providers, my friends, and all other, follow my wishes as communicated by my Health Care Agent, or as otherwise expressed in this form. This form becomes valid when I am unable to make decisions or speak for myself. I revoke any healthcare advanced directives I have made previously.

HEALTH CARE AGENT

If I am no longer able to make my own health care decisions, this form names the person I choose to make those decisions for me. This person will be my Health Care Agent (or other term used by my state, such as proxy, representative, health care power of attorney, or surrogate). This person will make my health care choices if both of these things happen:

- My attending or treating physician finds that I am no longer able to make health care choices, AND
- Another health care provider agrees that this is true.

If my state has a different way of finding that I am not ableto make health care choices, then my state's method should be followed.

The Person I choose as my Health Care Agent Is:

Name: _____ Phone: _____

Address:

_____

If this person is unable or unwilling to make these choices for me, OR is divorced or legally separated from me, OR this person has died, then these people are my next choices:

Second choice name: _____ Phone: _____

Address: _____

Third choice name: _____ Phone: _____

Address: _____

THE KIND OF MEDICAL TREATMENT I WANT OR DON'T WANT

Life Support treatment means any medical procedure, device, or medication to keep me alive. Life support treatment includes: medical devices to help me breath; food and water supplied by medical devices (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive.

HERE IS THE KIND OF MEDICAL TREATMENT THAT I WANT OR DON'T WANT IN FOUR SITUATIONS:

Close to Death: If my doctor and another health care provider both agree that I am likely to die within a short period of time, and life support treatment would only delay the moment of my death, (choose one of the following):

☐ I want to have life support treatment.
☐ I do not want life support treatment. If it has been started, I want it stopped.
☐ I want to have life support treatment if my doctor believes it could help, but I want my doctor to stop giving me life support treatment if it is not helping my health condition or symptoms.

In a Coma and not Expected to wake up or recover: If my doctor and another health care professional both agree that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life support treatment would only delay the moment of my death (choose one of the following):

☐ I want to have life support treatment.
☐ I do not want life support treatment. If it has been started, I want it stopped.
☐ I want to have life support treatment if my doctor believes it could help, but I want my doctor to stop giving me life support treatment if it is not helping my health condition or symptoms.

Permanent and severe brain damage and not expected to recover: If my doctor and another health care professional both agree that I have permanent and severe brain damage and I am not expected to get better, and life support treatment would only delay the moment of my death (choose one of the following):

☐ I want to have life support treatment.
☐ I do not want life support treatment. If it has been started, I want it stopped.
☐ I want to have life support treatment if my doctor believes it could help, but I want my doctor to stop giving me life support treatment if it is not helping my health condition or symptoms.

End Stage Condition: If my doctor and another health care professional agree that my health condition has worsened, and I am no longer able to care for myself (choose one of the following):

☐ I want to have life support treatment.

☐ I do not want life support treatment. If it has been started, I want it stopped.

☐ I want to have life support treatment if my doctor believes it could help, but I want my doctor to stop giving me life support treatment if it is not helping my health condition or symptoms.

Printed name: _____

Signature: _____

Phone: _____ Date: ___/____/_____

Witness Statement (Two Witnesses Needed)
I, the witness, declare that the person who signed or acknowledged this form, is personally known to me, that he/she signed or acknowledged this Health Care Agent and/or Living Will form in my presence, and that he/she appears to be of sound mind, under no duress, fraud or undue influence.

Signature of Witness #1_____

Printed Name of Witness: _____
Address: 1101 S. Tamiami Trail, Suite 108, Venice FL 34285
Phone: 941-488-2332 Date: ___/____/_____

Signature of Witness #2_____

Printed Name of Witness: _____
Address: 1101 S. Tamiami Trail, Suite 108, Venice FL 34285
Phone: 941-488-2332 Date: ___/____/_____

IMPORTANT NOTICE TO MEDICAL PERSONEL:
I have completed my ADVANCED DIRECTIVES:

_____
Signature
Please consult this document and/or my Health Care Agent in an emergency. My Agent is:
Name: _____
Address: _____
Phone: _____

My Primary Care Physician Is:
_____
1101 S Tamiami Trail, Suite 108
Venice, FL 34285
(941) 488-2332
My Advanced Directives document is located:
_____
_____
_____

PARADISE FAMILY HEALTHCARE
1101 S. Tamiami Trail, Ste 108
Venice, FL 34285
Ph: (941) 488-2332 Fax: (941) 894-6230

PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient: _____

Date of Birth: _____

SSN: _____

Paradise Family Healthcare is authorized to receive medical records from:

Medical facility or provider: _____

Phone: _____

Fax number: _____

I authorize the release of the following medical records **[AT LEAST ONE BOX MUST BE CHECKED OR THIS FORM IS VOID]:**

☐ I give permission to release all my medical records including information and records, or copies of records relating to the history, diagnosis, treatment, or services rendered to me in connection with any condition or disease. This includes permission to release potentially sensitive information which may include information concerning mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers, and/or psychotherapists/psychologists, if any.

☐ I give permission to release ALL records in the past two years, or if unavailable, the most recent office visit, labs, and procedures (including spirometry, radiology, EKGs, etc.).

☐ I give permission to release only the records described below:

_____

_____

I release Paradise Family Healthcare and the medical facility or provider listed above, and any of their providers and staff from ail responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Paradise Family Healthcare, provided that I do so in writing. This authorization will remain in effect for 1 year from the date of signing.

Patient signature: _____ Date: ___/___/_____