OVIEDO PRIMARY CARE

HEALTH QUESTIONNAIRE

Patient Name: ____________________ Age: _______ Date of birth: ____________ Today's date: ____________

Reason for visit: ____

____

Concerns: ____

____

Are you allergic to any medications? ___________________________________

PLEASE LIST CURRENT MEDICATIONS

Medication name	Strength (mg,mcg,units,etc)	How often a day

SURGICAL HISTORY

Year	Illness/Surgery	Year	Illness/Surgery

MEDICAL HISTORY

__Ringing in ear
__Dizzy Spells
__Glaucoma
__Double vision
__Nose bleeds
__Hay fever
__Pneumonia
__Asthma
__Shortness of breath
__Chest pain
__High blood pressure
__Painful urination
__Heart Murmur
__Irregular pulse
__Swollen ankles
__Ulcerative colitis
__Leg pain when walking
__Varicose veins
__Loss of appetite
__Indigestion
__Persistent nausea/vomiting
__Ulcers
__Diverticulosis/Diverticulitis
__Prolonged hoarseness
__Blood in stool
__Hemorrhoids
__Gallbladder trouble
__Urinary Infections-Freq.
__Decreased force of urination
__Trouble hearing
__Jaundice/Hepatitis
__Poor circulation
__Chronic Fatigue syndrome
__Recent weight loss
__Anemia
__Diabetes
__Convulsions/seizures
__Tremors/hand shaking
__Arthritis
__Joint injury
__Bone fracture
__Hernia
__Psoriasis
__Blood in urine
__Kidney stones
__Wear Glasses
__Cohn's Disease
__Gout
__Herpes
__HIV/AIDS
__Bruise easily
__Thyroid Disorder
__Rheumatic fever
__Headache-Freq.
__Venereal Disease
__Recurrent Back pain
__Anxiety Disorder
__Fainting spells
__Depression
__Palpitations
__Sleeping Difficulty
__Mental Illness
__Phobias
__Drug use

FAMILY HISTORY

	Living /Deceased	Cause of death	Age	Chronic health problems
Mother				
Father				
Brother				
Sister				

SOCIAL HISTORY

Vaping: [] Yes [] No Chewing Tobacco: [] Yes [] No

Smoking: [] Yes [] No If yes, a) Cigs/per day ___ b) Number of yr.(s)____ Drink Alcohol: [] Rarely [] Occasionally [] Daily [] Never

WOMEN'S HEALTH

Last Pap: ____ yr.(s) ago Last Mammogram: _____ yr.(s)ago Mark, if apply: [] Menopausal [] Hysterectomy

Birth control method: [] Pill [] IUD [] Norplant [] Depo Provera []Diaphragm []Condoms [] Tubal Ligation []No Birth Control

Menstrual History: [] Pain with flow [] Regular []Irregular Age of Onset:____

Mark, if apply: a) N° of pregnancies ___ b) N° of Live Births ___ c) N° of Premature Births d) N° of Miscarriages ___

PATIENT INFORMATION DATA

LAST NAME: ______________ FIRST NAME: __________________ MIDDLE: ____________ AGE: ______

D.L.#: __________________ DATE OF BIRTH: ____________ (MM/DD/YYYY) SEX: F M WEIGHT: ____ HEIGHT: ____

ADDRESS: (STREET)____
CITY:_________________________ STATE:_____________________ ZIP CODE: ________

DO YOU HAVE A DIFFERENT MAILING ADDRESS? [] Yes [] No IF SO, PLEASE PRINT HERE:
ADDRESS: (STREET)____
CITY:_________________________ STATE:_____________________ ZIP CODE: ________

EMAIL ADDRESS: ____
TELEPHONE#: (HOME)_________________ (WORK)_________________ (CELL)_________________

MARITAL STATUS: []MARRIED []SINGLE []WIDOWED []SEPARATED []DIVORCED
[]OTHER:__________________
Work Status: []EMPLOYED []FULL/TIME STUDENT []PART/TIME STUDENT []OTHER:_______________

EMPLOYER:____________________________POSITION:________________TELEPHONE#:_______________

ADDRESS:____

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU: ______________________________________

RELATIONSHIP: ___________________________ TELEPHONE#: ______________________________

SPOUSE/ PARENT NAME: ______________ D.L.#: ____________________DATE OF BIRTH: ______________ (MM/DD/YYYY)

EMPLOYER:____________________________POSITION:________________TELEPHONE#:_______________

ADDRESS: (STREET)____

CITY: _________________________ STATE: _____________________ ZIP CODE: ________

DO YOU HAVE ANY IMMEDIATE FAMILY MEMBERS WHO ARE PATIENTS OF THIS PRACTICE? []YES []NO

PLEASE MENTION WHO: ____

REFERRING SOURCE: []RECOMMENED BY FAMILY MEMBER (NAME:___________________) []RECOMMENDED BY A FRIEND (NAME:___________________) []OFFICE CONVENIENTLY LOCATED []INSURANCE HEALTH PLAN/MANAGED CARE DIRECTORY []YELLOW PAGE AD []FLORIDA HOSPITAL "CENTRAL CARE" []OTHER (SPECIFY)__________________________

INSURANCE INFORMATION

1st INSURANCE CO.____
INSURED NAME____________________ Sex []M []F DATE OF BIRTH: ____________
MM/DD/YYYY
INSURED EMPLOYER: ____________________ WORK#__________

CLAIM ADDRESS______________________________CLAIM PHONE# ____________
POLICY# ________________GROUP#__________ RELATION OF INSURED TO PATIENT: []SELF []SPOUSE []CHILD
[]OTHER (SPECIFY):______________________

....

2nd INSURANCE CO.____
INSURED NAME____________________ Sex []M []F DATE OF BIRTH: ____________
MM/DD/YYYY
INSURED EMPLOYER: ____________________ WORK#__________

CLAIM ADDRESS______________________________CLAIM PHONE# ____________
POLICY# ________________GROUP#__________ RELATION OF INSURED TO PATIENT: []SELF []SPOUSE []CHILD
[]OTHER (SPECIFY):______________________

INSURANCE ASSIGNMENT

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DR. SYED A HASSAN. I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED.

______________________________ ______________
SIGNATURE OF PATIENT DATE

RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL, PSYCHIATRIC, ALCOHOL, HIV TESTING AND/OR DRUG ABUSE INFORMATION FOR INSURANCE CARRIERS OR FOR CONTINUING PATIENT CARE.

______________________________ ______________
SIGNATURE OF PATIENT DATE

______________________________ ______________
SIGNATURE OF PARENT, GUARDIAN, AND/OR RESPONSIBLE PARTY DATE

FOR MEDICARE PATIENT'S ONLY / MEDICARE PART B SIGNATURE AUTHORIZATION -LIFETIME

I certify that the information given by me in applying for payment under Title XVIII 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 intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

______________________________ ______________________________
PATIENT NAME PATIENT SIGNATURE

______________________________ ______________________________
MEDICARE B NUMBER DATE

*****PLEASE, GIVE ALL INSURANCE CARDS AND DRIVER'S LICENSE TO RECEPTIONIST FOR COPYING*****

OVIEDO PRIMARY CARE

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At OVIEDO PRIMARY CARE we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The Law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters, or other information. We may also want to call and remind you about your appointment. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any use or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, DC 20201. you will not be retaliated against for filing a complaint.

I have received a copy of the Oviedo Primary Care Notice of Privacy Practices.

Signature: ____

Print Name: ____

Date: ____________

If signing as a parent or guardian, please note the name of the patient____

Advance Directive

An advance directive is a written or oral statement which is made and witnessed in advance of serious illness or injury, about how you want medical decisions made. Three forms of advance directives are: 1. a Living Will, 2. Health Care Surrogate Designation. 3. Durable power of attorney.

An advance directive allows you to state your choices about health care or to name someone to make those choices for you, if you become unable to make decisions about your future medical treatment.

Advanced Directive
(For compliance with the patient self determination act)

Have you executed and advanced directive? Yes______ No______
If yes, is this directive in the form of:

______ a living will
______ a durable power of attorney
______ a health care surrogate

If you have executed and advanced directive in any of the above formats, have you provided this office with a copy for your medical records? Yes____ No____

____________________________ ________________
Signature Date

Patient Financial Responsibility Form

Dear Patient:

This office will be filing a claim to your insurance as a courtesy to you for your office visit(s). We have no written or verbal agreement with your insurance that guarantees payment, therefore, you will be responsible for any unpaid balance on this account. You will receive a statement **if** your insurance company has not paid and at that time you may want to call your insurance company to ensure your claim is being processed. After 60 days from when the claim was filed, this account will become your financial responsibility. We will expect full payment of the balance at that time. * If we may assist you with any billing questions you may have please contact this office. Thank you for choosing Dr. Syed Hassan and Oviedo Primary Care for your health needs.

____

Signature of Patient/Guardian

____

Date

*Past due accounts are subject to a service charge of 1.5% per month (18% annual rate- APR). There will be a charge of $20 added to your account if it is turned over for collection. In the event of default of payment, recipient of services agrees to pay attorney fees, reasonable costs, and late charges by Florida State Law.

Patient Health Questionnaire (PHQ-9)

Name: ______________________________ Date: ____________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: Total Score ______ = ______ + ______ + ______

Total Score ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult