DEMOGRAPHICS FORM

Today's date:	Name of Previous Doctor:				
PATIENT INFORMATION					
Patient's last name: First: Middle:			☐ Mr. ❑ Mrs.	☐ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Email Address:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:	Home phone no.: ( )		
Cell Phone No:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer phone no.: ( )			
Chose this Office because it was referred by:	❑ Dr.	❑ Newspaper	❑ Insurance Plan ☐ Hospital		
❑ Family	❑ Friend	❑ Drove By (Sign)	❑ Church Ad	❑ Web Search ☐ Billboard	❑ Newsletter ❑ Mail-Out
Name of Person who referred you:		Other family members seen here:			
INSURANCE INFORMATION					
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Is this person a patient here? ☐ Yes ☐ No					
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ☐ Yes ❑ No					
Please indicate **primary** insurance	❑ Medicare	❑ CarePlus	❑ Freedom	❑ Simply	❑ Optimum
❑ Amerigroup	❑ Wellcare	☐ BetterHealth	☐ BCBS ☐ Aetna ☐ UHC ☐UHC	☐ Other	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	Self	❑ Spouse	❑ Child	❑ Other	
Name of **secondary** insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	☐ Other	
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )		

I AUTHORIZE **D4A MEDICAL GROUP** TO PROVIDE ANY MEDICAL CARE DEEMED NECESSARY ACCORDING TO THEIR PROFESSIONAL OPINIONS. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO **D4A MEDICAL GROUP.** I AUTHORIZE THE RELEASE OF ANY INFORMATION BY. TO MY INSURANCE CARRIER PERTINENT TO MY HEALTH INSURANCE CLAIM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

I UNDERSTAND THAT SERVICES RENDERED TO ME MAY NOT BE ELIGIBLE FOR BENEFITS UNDER MEDICARE, MEDICAID OR OTHER INSURANCES OR PAYORS. SERVICES NOT ELIGIBLE FOR BENEFITS MAY INCLUDE TESTS AND PROCEDURES THAT ARE NOT COVERED, OR THOSE DELIVERED BY HEALTH CARE PROVIDERS WHO DO NOT PARTIOPATE WITH MY INSURANCE PLAN. NON-COVERED SERVICES MAY ALSO INCLUDE THOSE MY PHYSICIAN DETERMINES MEDICALLY NECESSARY, BUT ARE LATER DETERMINED UNNECESSARY BY MY INSURANCE PLAN. I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT OF ANY NON-COVERED SERVICE.

Patient/Guardian signature *Date*

HEALTHY HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.)* ☐ M ☐ F	DOB:
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced	
Previous or referring Doctor:	

PREFERRED PHARMACY TO SEND YOUR PRESCRIPTIONS TO

Pharmacy	Name:	
	Address:	
	Phone:	

Allergies to Medications	
Name of Drug	Reaction You Had

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Consent to Obtain External Prescription History

I, _____, authorize IMA Medical Group and Its Affiliated Providers to view my external prescription history via the RxHub service.

I understand that my prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by the providers and staff of IMA Medical Group, and it may include prior prescriptions from previous years.

_____ _____

Signature Date

PERSONAL HEALTH HISTORY

PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

PERSONAL HEALTH HISTORY

Problems

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

	Current	Past		Current	Past		Current	Past		Current	Past
Allergic rhinitis	☐	☐	Cancer, Melanoma	☐	☐	Epilepsy (seizures)	☐	☐	Kidney Stones	☐	☐
Alzheimer	☐	☐	Cancer, Ovarian	☐	☐	Erectile Dysfunction	☐	☐	Low back pain	☐	☐
Anemia	☐	☐	Cancer, Prostate	☐	☐	Fibromyalgia	☐	☐	Lupus	☐	☐
Anesthesia issues	☐	☐	Cancer, Skin (exc Melanoma)	☐	☐	Gallstones	☐	☐	Lymphoma	☐	☐
Aneurysm	☐	☐	Cardiomegaly	☐	☐	Gastritis	☐	☐	Macular degeneration	☐	☐
Angina	☐	☐	Cardiomyopathy	☐	☐	Glaucoma	☐	☐	Menorrhagia	☐	☐
Anxiety	☐	☐	Carotid artery stenosis	☐	☐	GERD	☐	☐	Migraines	☐	☐
Aortic stenosis	☐	☐	Cataract	☐	☐	Gout	☐	☐	Myocardial Infarction	☐	☐
Arterial thrombosis	☐	☐	Chronic Kidney Disease	☐	☐	Heart Attack	☐	☐	Osteoporosis	☐	☐
Arthritis (Osteo)	☐	☐	Colon Polyp	☐	☐	Hematuria (Blood in Urine)	☐	☐	Peripheral Arterial Disease	☐	☐
Arthritis (Rheuma)	☐	☐	Cong. Heart Fail(CHF)	☐	☐	Hemorrhoids	☐	☐	Overactive Bladder	☐	☐
Atrial Fibrillation	☐	☐	Constipation	☐	☐	Hepatitis A, B, C (circle type)	☐	☐	Pancreatitis	☐	☐
B12 deficiency	☐	☐	Coronary Artery Disease	☐	☐	High Cholesterol	☐	☐	Rectal Bleeding	☐	☐
Back Pain	☐	☐	Depression	☐	☐	High Blood Pressure	☐	☐	Stent, Leg	☐	☐
Cancer, Breast	☐	☐	Diabetes Type 1	☐	☐	Hyperthyroidism	☐	☐	Stent, Heart	☐	☐
Cancer, Colon	☐	☐	Diabetes Type 2	☐	☐	Hypothyroidism	☐	☐	Tuberculosis	☐	☐
Cancer, Lung	☐	☐	Eczema	☐	☐	Irritable Bowel Syndrome	☐	☐	Other	☐	☐

Any Other Health problems not listed above

Hospitalization

Year	Reason	Hospital

Surgeries

Year	Reason	Hospital

IMA Medical Group

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father ☐ Alive ☐ Dead		☐ Hypertension ☐ Diabetes 1 ☐ Diabetes 2 ☐ CAD ☐ Prostate Cancer	Children	☐ M ☐ F	
Mother ☐ Alive ☐ Dead		☐ Hypertension ☐ Diabetes 1 ☐ Diabetes 2 ☐ CAD ☐ Breast Cancer ☐ Ovarian Cancer		☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*	☐ Alive ☐ Dead	
	☐ M ☐ F		**Grandfather** *Maternal*	☐ Alive ☐ Dead	
	☐ M ☐ F		**Grandmother** *Paternal*	☐ Alive ☐ Dead	
	☐ M ☐ F		**Grandfather** *Paternal*	☐ Alive ☐ Dead	

HEALTH MAINTENANCE

			DATE OF LAST
Have you ever had an EKG?	☐ Yes	☐ No	
Have you ever had a Colonoscopy	☐ Yes	☐ No	
Have you ever had a blood transfusion?	☐ Yes	☐ No	
Have you ever had a Prostate Exam? (Man Only)	☐ Yes	☐ No	
Have you ever had Mammogram? (Woman Only)	☐ Yes	☐ No	
Have you ever had a Dexa Exam? (Woman Only)	☐ Yes	☐ No	
Have you ever had a Pap? (Woman Only)	☐ Yes	☐ No	
Have you ever had a Blood Work?	☐ Yes	☐ No	

Patient Signature: _____ Date: _____

LIVING WILL/DESIGNATION OF HEALTHCARE

Declaration made this _____ day of _____, _____

I, _____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the Circumstances set forth below, and I do hereby declare that:

If at any time I am incapacitated and;

_____ I have a terminal condition, or

_____ I have an end-stage condition, or

_____ I am in a persistent vegetative state

And if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying and that I am permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. In the event that I have been determined to be unable to provide or express and inform consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate my surrogate to carry out the provisions of this declaration.

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law, and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility. I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to my surrogate, so they may know to carry out the provisions of this declaration:

Name:_____

Address:_____

_____

Phone:_____

Patient Signature:_____

<u>Witness 1:</u>

Signed:_____

Name:_____

IMA Medical Group

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

Declaration made this _____ day of _____, _____,
(day) (month) (year)
I,_____, give permission to
IMA Medical Group to discuss any of my medical information with the following individuals:

Name: _____
Address:_____
_____ Zip Code: _____
Phone: _____

Name: _____
Address:_____
_____ Zip Code: _____
Phone: _____

Name: _____
Address:_____
_____ Zip Code: _____
Phone: _____

Name: _____
Address:_____
_____ Zip Code: _____
Phone: _____

Signed: _____

Witness 1: Signed: _____

Name: _____

Witness 2:

Signed: _____

Name: _____

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMTION FROM OTHER HEALTHCARE FACILITIES

Patient Name:_____ SS#_____

Telephone: _____ DOB: _____/_____/_____

Address: _____ City:_____ State:_____

Name of Healthcare Facility from which Records are Requested:

_____ Ph:_____ Fax:_____

(Please Print)

Address:_____ City:_____ State:_____ Zip:_____

Dates of Treatment Requested:_____ Reason for Disclosure:_____

MAIL INFORMATION TO: **IMA MEDICAL GROUP**
6675 Westwood Blvd, Suite 475, Orlando, FL, 32821

Or FAX TO: **866-914-1818**

I hereby authorize **IMA MEDICAL GROUP** to obtain the health information indicated below that is contained in my patient records to the recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, genetic testing information, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

Check a Box ☐

	Complete Record				Radiology Reports
	Laboratory Reports				Pathology Reports
	Other (Specify)				Physical Therapy

SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ Drug/ Alcohol Abuse or Treatment ☐ HIV/ AIDS Test Results or diagnoses ☐ Genetic Testing Information

☐ Psychotherapy Notes (The release of Psychotherapy Notes required a separate authorization)

This consent is subject to revocation at any time except to the extent the action has been taken thereon. **This authorization and consent will expire one year from the date of authorization written below.**

Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, re-disclosure of your health care information by the Recipient may no longer be protected by law.

_____ _____

Signature of Patient or Legal Representative Date Signed

Printed Name:_____ Relationship if not Patient:_____

**If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.

**For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.

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 IMA Medical Group, 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 or your primary doctor.
- 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 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 appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an 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 uses 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 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 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, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact one of the staff members at IMA MEDICAL GROUP at (407) 845-0330.

This notice goes into effect as of April 14, 2003.

Acknowledgement

I have received a copy of IMA MEDICAL GROUP Notice of Privacy Practices.

Print Name:_____ Date:_____

Signature: _____

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

_____

NO SHOW POLICY

In an effort to better serve our patients, we require a 24-HOUR ADVANCE NOTICE, if you are not able to keep your appointment. Same-day Cancellations will be treated as **NO SHOW**.

I_____,
understand the importance of keeping my appointment and agree to notify the office at least 24 hours in advance, if I am unable to keep it.

I also understand that if I do not give the required advance notice, I will be charged a $20.00 No-Show fee.

_____ _____
Patient Date

_____ _____
Witness Date