PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION

(Please print)

Patient's Legal Name: (Last)_________________________ (First)_________________________ (MI) __________

Preferred Full Name (if different from above): ____________________________

Home Phone Number (landline):______________________ Cell:______________________ Work: ______________________

Address: ____

City, State, Zip: ____

Email Address:____ Date of Birth: __________________

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer
☐ Choose not to disclose Additional Gender Category not listed ______________________________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Choose not to disclose ☐ Other not listed ______________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Swahili ☐ Portuguese ☐ Arabic
☐ Indian: Hindi, Tamil, Gujarati etc ☐ Russian ☐ Vietnamese ☐ Haitian ☐ Albanian ☐ Burmese ☐ Cambodian
☐ Creole Bosnian/Croatian/Serbian/Serbo-Croatian ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Other not listed____________

Patient Social Security Number:______-______-_______

RESPONSIBLE PARTY INFORMATION *(If not self)*

(Information used for patient balance statements)

Responsible Party: ☐ Another Patient ☐ Guarantor ☐ Self Check here is address and telephone information is same as patient ☐

Responsible Party Name: (Last)_________________________ (First)_________________________ (MI) _______

Date of Birth: MM_____/ DD_____/ YYYY_________ Sex: ☐ Female ☐ Male

Address: ____

City, State, Zip: ____

Responsible Party Social Security Number:______-______-_______ Phone Number:____________________________

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: (Last)_________________________ (First)_________________________

Phone Number:____________________________________ Do you have a living will: ☐ Yes ☐ No

Emergency contact relationship to patient: ____ ☐ Guardian

Address: ____

City, State, Zip: ____

Home Phone:____________________________________ Work Phone:____________________________ Ext.________

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:____________________________________Date:________________

Printed name of patient or personal representative:__________________________ Relationship to patient: ________________

HCA FLORIDA FAWCETT SURGICAL SPECIALISTS

Dr. Steven Goldin P: 941-255-7007 F: 941-235-9362
Dr. Raffi Agopian P: 941-625-4270 F: 941-625-1751
21260 Olean Blvd., Suite 200, Port Charlotte, FL 33952

Dr. Maria Castilla P: 941-235-9361 F: 941-235-9362
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21260 Olean Blvd., Suite 204, Port Charlotte, FL 33952

New Patient Intake Form

Patient Name:____ DOB: ______________

CARE INFORMATION – ***please list complete name and address of physicians*** (VERY IMPORTANT)

Primary Care Physician: ____
Address: ____________________________________ City: ______________ State: _____ Zip: _________
Phone: __________________________ Fax: _______________________

Referring Physician (if different from PCP): _____________________________ Specialty: ____________
Address: ____________________________________ City: ______________ State: _____ Zip: _________
Phone: __________________________ Fax: _______________________

Other Physicians (if different from above): _____________________________ Specialty: _____________
Address: ____________________________________ City: ______________ State: _____ Zip: _________
Phone: __________________________ Fax: _______________________

Pharmacy: ____
Address: ____________________________________ City: ______________ State: _____ Zip: _________
Phone: __________________________ Fax: _______________________

PRIOR STUDIES Have you had any prior studies? Please write the most recent dates for each:

STUDY:	DATE(s):	BODY PART STUDIED:	RESULTS:
XRAY	____________	__________________________	____________________________
MRI	____________	__________________________	____________________________
CT SCAN	____________	__________________________	____________________________
EMG	____________	__________________________	____________________________
Myelogram	____________	__________________________	____________________________
Bone Density	____________	__________________________	____________________________
Other:	____________	__________________________	____________________________

PAIN ASSESSMENT

Do you experience pain as part of your daily life? ❑ Yes ❑ No
If yes, please describe the location(s), onset, duration, and characteristics of your pain:

____
____
____

If yes, on a scale of 1 to 10 (0 = no pain, 10 = the worst pain), how would you rate your pain? __________________

SURGICAL HISTORY

Please list all operations you have had: Date:

______________________________ ______________
______________________________ ______________
______________________________ ______________
______________________________ ______________
______________________________ ______________

MEDICAL HISTORY

Please list all active conditions:

____
____
____
____
____

HANDEDNESS

❑ Right Handed ❑ Left Handed

MEDICATIONS

Please list all medications you take routinely, prescribed or over-the-counter, along with the dosages.

Medication:	Dose:	Frequency:

Are you **ALLERGIC** to any medicines, latex, X-Ray dye, or iodine? ❑ Yes ❑ No

If yes, please explain: ______________________________

Are you taking any "blood thinning" medications? ❑ Yes, indicate below ❑ No

❑ Aspirin or aspirin-containing medication ❑ Anti-flammatory medication ❑ Plavix

❑ Coumadin ❑ Fish Oil ❑ Other: ______________________________

SOCIAL HISTORY

Occupation:________________ Marital Status:______________ Number of Children: __________

Do you exercise regularly? ❑ Yes ❑ No How frequently?______________________

Do you smoke cigarettes? ❑ Yes ❑ No If so, how many packs a day? ______________

Do you drink alcohol? ❑ Yes ❑ No If yes, how much daily? ________________

Do you or have you used recreational drugs? ❑ Yes ❑ No If yes, type? ______________________

Females: Are you, or could you be pregnant? ❑ Yes ❑ No Ever used Oral Contraceptives? ❑ Yes ❑ No

Ever used Hormone Replacement Therapy? ❑ Yes ❑ No

FAMILY HISTORY

Do you have a family member affected with:

Condition	Yes	No	type/affected relative	Condition	Yes	No	type/affected relative
Cancer (non brain)	❑	❑	______________	Bleeding/Clotting Problem	❑	❑	______________
Glioma	❑	❑	______________	Heart Disease	❑	❑	______________
Meningioma	❑	❑	______________	High Cholesterol	❑	❑	______________
Brain Aneurysm	❑	❑	______________	Hypertension	❑	❑	______________
Other Aneurysms	❑	❑	______________	Diabetes	❑	❑	______________
Other Conditions	❑	❑	______________				

Explain Other Conditions: ______________________________

____

Patient Name:____

REVIEW OF SYMPTOMS Do you currently, or have you had a problem with:

Constitutional	Yes	No
Fever	❑	❑
Weight loss	❑	❑
Weakness	❑	❑
Fatigue	❑	❑

Eyes	Yes	No
Blurred vision	❑	❑
Uses glasses/contacts	❑	❑
Cataracts	❑	❑
Redness	❑	❑
Infection	❑	❑

Ears, Nose, Mouth, Throat	Yes	No
Hearing loss	❑	❑
Ringing in ears	❑	❑
Dizziness	❑	❑
Nose bleeds	❑	❑
Nasal congestion	❑	❑
Sinus problems	❑	❑
Difficulty swallowing	❑	❑
Hoarseness	❑	❑

Cardiovascular	Yes	No
Chest pain	❑	❑
Palpitations	❑	❑
Edema	❑	❑
Cool extremities	❑	❑
Leg pain while walking	❑	❑

Respiratory	Yes	No
Wheezing	❑	❑
Cough	❑	❑
Shortness of breath	❑	❑
Bloody mucous	❑	❑

Psychiatry	Yes	No
Anxiety	❑	❑
Depression	❑	❑

Integumentary	Yes	No
Rashes	❑	❑
Lesions	❑	❑
Lumps	❑	❑
Hair loss	❑	❑

Endocrine	Yes	No
Heat/cold intolerance	❑	❑
Increased thirst	❑	❑
Night sweats	❑	❑
Hot flashes	❑	❑

Gastrointestinal	Yes	No
Poor appetite	❑	❑
Nausea	❑	❑
Vomiting	❑	❑
Rectal bleeding	❑	❑
Change in bowel habits	❑	❑
Diarrhea	❑	❑
Constipation	❑	❑
Indigestion	❑	❑
Hemorrhoids	❑	❑
Yellowing of skin/eyes	❑	❑
Abdominal pain	❑	❑

Genitourinary	Yes	No
Frequency	❑	❑
Urgency	❑	❑
Painful urination	❑	❑
Blood in urine	❑	❑
Incontinence	❑	❑
Urinary infections	❑	❑

Musculoskeletal	Yes	No
Joint pain	❑	❑
Joint stiffness	❑	❑
Backache	❑	❑
Muscle pain/cramps	❑	❑
Swelling joints	❑	❑
Difficulty walking	❑	❑

Neurological	Yes	No
Fainting	❑	❑
Blackouts	❑	❑
Numbness or tingling	❑	❑
Loss of sensation	❑	❑
Paralysis	❑	❑
Tremors	❑	❑
Memory loss	❑	❑
Balance issues	❑	❑
Headaches	❑	❑
Weakness	❑	❑

Hematological/Lymphatic	Yes	No
Easy bruising	❑	❑
Swollen glands	❑	❑
Bleeding problems	❑	❑

Allergic/Immunologic	Yes	No
Seasonal allergies	❑	❑
Food/medication allergies	❑	❑

Provider Signature:____________________________________ Date:______________

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Authorization to Release Medical Records

❑ REQUEST INFORMATION

I Hereby Authorize HCA Florida Fawcett Surgical Specialists__________________(Select from above) **to REQUEST information**

FROM: Doctor/Facility Name and Address:____

Phone #:____ Fax #: ______________________________________

❑ RELEASE INFORMATION

I Hereby Authorize HCA Florida Fawcett Surgical Specialists__________________(Select from above) **to REQUEST information**

TO: Doctor/Facility Name and Address:____

Phone #:____ Fax #: ______________________________________

REGARDING THE FOLLOWING PATIENT:

Name:____Phone #: ___________________

Address:____Date of Birth: ___________________

Records to be Released:

Date(s) treatment was received:____

❑ Consultative Report ❑ History and Physical ❑ Laboratory Report
❑ Operative Report ❑ Pathology Report ❑ Progress Notes
❑ X-Ray Film ❑ X-Ray ❑ Report Photographs, Videos Digital or Other Images
❑ Entire Record ❑ Certified Copy ❑ Other______________________________________

I authorize the release of information relating to:
❑ HIV/AIDS Testing/Treatment ❑ Psychiatric Evaluation/Treatment ❑ Alcohol/Drug Abuse Evaluation/Treatment

Purpose of Release:
❑ Continuing care for ongoing treatment ❑ Transfer of Care ❑ Other____

This authorization expires on the following date, event or condition:____.
If I do not specify any expiration date, event or condition, this authorization will expire in one year.

Statement of Authorization:

- I understand that, except for research-related treatment, HCA Florida Fawcett Surgical Specialists will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to HCA Florida Fawcett Surgical Specialists (Medical Records). A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

____ ______________________________
Signature of Patient/Legally Authorized Representative Date

____ ____
Relationship to Patient Reason Patient Unable to Sign

Patient name: ______________________________

Date of birth: _______________________________

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, WEST FLORIDA PHYSICIAN NETWORK, LLC may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge WEST FLORIDA PHYSICIAN NETWORK, LLC may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to WEST FLORIDA PHYSICIAN NETWORK, LLC any insurance or other third-party benefits available for health care services provided to me. I understand WEST FLORIDA PHYSICIAN NETWORK, LLC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to WEST FLORIDA PHYSICIAN NETWORK, LLC, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to WEST FLORIDA PHYSICIAN NETWORK, LLC by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for WEST FLORIDA PHYSICIAN NETWORK, LLC or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that WEST FLORIDA PHYSICIAN NETWORK, LLC or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or WEST FLORIDA PHYSICIAN NETWORK, LLC or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _______________________________ Date: _________________

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse
Parent
Legal Guardian

Guarantor
Healthcare Power of Attorney
Other (please specify) _______________________________