Medical Associates of Delray, PA

13590 Jog Road, Suite 4-5, Delray Beach, FL 33446
561-496-2200 (telephone) 561-495-4699 (fax)
medassocdelray.com

PATIENT INTAKE FORMS

Today's date:

PATIENT INFORMATION

Patient's Last Name: | First: | Middle: | ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms ❑ Dr. | Marital status (circle one) Single / Mar / Div / Sep / Wid

Date of Birth: / / | Age: | Sex: ❑ M ❑ F | Social Security No.: (last four digits only) X X X - X X - _ _ _ _ | Driver's License No. & State

Home Phone No: ( ) | Work Phone No: ( ) | Cell Phone No: ( ) | Email Address:

Local Street Address: | City: | State: | ZIP Code:

Out of State Address: | City: | State: | ZIP Code:

Occupation: | Employer:

Referred to practice by: | ❑ Dr. | ❑ Insurance Plan | ❑ Advertising:

❑ Family/Friend: | ❑ Other:

*** IN CASE OF EMERGENCY ***

Name of local friend or relative (not living at same address): | Relationship to patient: | Home: ( ) | Cellphone: ( )

REQUEST FOR CONFIDENTIAL COMMUNICATION

*****How would you like to receive your appointment confirmation:** ❑ Phone ❑ Email ❑ Text

I authorize the staff of Medical Associates of Delray, PA to notify me of my diagnostic or lab results, by the following method(s):

_____ Speak with only me

_____ Leave a detailed message at the number provided below:

Home ( ) Work ( ) Cell ( )

_____ I authorize the staff of Medical Associates of Delray, PA to discuss my medical conditions and treatments, including Labs and other information with the following:

Name: Relationship to patient: Cell: ( )

Patient Signature: **Date:**

AUTHORIZATION TO PAY/ FOR MEDICARE, LIFETIME AUTHORIZATION

The above information is true to the best of my knowledge. I authorize any holder of medical or other information about me to release to my insurance company, and, for Medicare/Blue Cross/Blue Shield to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of Blue Cross/Blue Shield of Florida, any information needed for this or a related insurance or claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and/or surgical insurance benefits, otherwise payable to me, to the party who accepts assignment. I understand that I am financially responsible for those charges not paid by my insurance.

Patient Signature: ____________ **Date:** ________ **Other Signature:** ____________ **Date:** ________
(if Patient Unable to Sign)

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HISTORY AND INTAKE

Name: ______________________ **Date:** ______________

Preferred language: ______________

Race:

- ☐ White
- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific island islander
- ☐ Other Race

Ethnic Group:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Preferred Pharmacy (We electronically send prescriptions to the pharmacy)

Name______________________ **Location: (cross streets)**______________

Phone Number__________________________

Past Medical History: (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

☐ Other (please specifically list) ______________________________

____

☐ None

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HISTORY AND INTAKE

Medications: (Please list all current medications)

☐ None

____
____
____
____
____
____
____
____

Allergies: (Please list all allergies to medications)

☐ None

____
____
____

Social History: (Please check all that apply)

☐ Drug use
☐ IV Drug use
☐ Alcohol consumption: None
☐ None
☐ Alcohol consumption: Less than 1 drink per day
☐ Alcohol consumption: 1-2 drinks per day
☐ Alcohol consumption: 3 or more drinks per day
☐ Other

Occupation: ____

Smoking Status: (Please check all that apply)

☐ **Current every day smoker**
☐ **Current some day smoker**
☐ **Former smoker**
☐ **Never smoked**
☐ **Smoker current status unknown**
☐ **Unknown if ever smoked**

Cautions / Alerts: (Please check all that apply)

☐ Allergy to adhesive or tape
☐ Allergy to topical antibiotic ointments
☐ Artificial heart valve
☐ Artificial joints within past two years
☐ Blood thinners
☐ Defibrillator
☐ MRSA
☐ Pacemaker
☐ Vasovagal / Fainting Spells
☐ Premedication prior to procedures
☐ Pregnancy or planning a pregnancy

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HISTORY AND INTAKE

Past Surgical History: (please check all that apply)

- ☐ Angioplasty / Stent
- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Defibrillator
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within last two years
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Pacemaker
- ☐ Prostate Removed / Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP / Prostatectomy
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ **None**

☐ Other (**please specifically list**)

____

____

Medical Associates of Delray, PA

HISTORY AND INTAKE

Family Medical History

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)?

	FATHER	MOTHER	FATHER'S		MOTHER'S		SISTER	BROTHER	SON	DAUGHTER
			FATHER	MOTHER	FATHER	MOTHER				
Heart Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
High BP	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Bleeding Issues	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

List any other important family medical condition(s) you are aware of (do not include common colds or flu). Include date of initial diagnosis if possible: Family member medical condition

____

____

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MEDICAL RECORD ACCESS
(CONFIDENTIAL INFORMATION)

Today's Date: ____________________

Patient Name: ___________________________ **Date of Birth** ___________________

Please list names of persons that may have access to your medical information:

Name:	Relationship	Phone Number

_________________________________ Patient Signature

_________________________________ Date

Care360®

Medical Associates of Delray, P.A.

13590 Jog Road, Ste 4-5
Delray Beach, Florida 33446

PHQ-9

Patient Health Questionnaire

Patient Name ______________________ DOB ______________ Date: ______________________

Over the past two weeks, how often have you been bothered by any of the following problems?	*Not at all*	*Several Days*	*More than 1/2 the days*	*Nearly every day*
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Note: If the patient has a positive response to either question, consider administering the Patient Health Questionaire-9 or asking patient more questions about possible depression. For older adults, consider the Patient Health Questionaire-9 or the 15 item Generic Depression Scale. A negative response to both questions is considered a negative result for depression.

Screening Instrument for Depression

Patient Health Questionnaire

Over the past two weeks, how often have you been bothered by any of the following problems?	*Not at all*	*Several Days*	*More than 1/2 the days*	*Nearly every day*
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless.	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3 3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better of dead, or of hurting yourself in some way.	0	1	2	3

FOR INTERNAL USE ONLY

Total ________+ ________+ ________

Interpretation:

Total Score	**Depression severity**
1 to 4	Minimal
5 to 9	Mild
10 to 14	Moderate
15 to 19	Moderately severe
20 to 27	Severe

REV 3/12

____
Physician Signature

Care360®

Medical Associates of Delray - Health Risk Assessment Form

Patient Name ______________________________ **Date:** ____________________

Please check the appropriate box

Physical Activity:

In the past 7 days, how many days did you exercise _____ days.

On days when you exercised, how long did you exercise in minutes per day________ Does Not Apply ☐

How intense was your typical exercise:

- ☐ Light (like stretching or slow walking)
- ☐ Moderate (like brisk walking)
- ☐ Heavy (like jogging or swimming)
- ☐ Very Heavy (like fast running or stair climbing)
- ☐ I am currently not exercising

Tobacco Use:

In the last 30 days, have you used tobacco?

Smoked ☐ Yes ☐ No

Used a smokeless tobacco product? ☐ Yes ☐ No

If YES to either, would you be interested in quitting tobacco use

within the next month ☐ Yes ☐ No

within the next month ☐ Yes ☐ No

Alcohol Use:

In the past 7 days, on how many days did you drink alcohol ____ days.

On days when you drank alcohol, how often did you have (4 or more) alcoholic drinks on one occasion?

- ☐ Never
- ☐ Once during the week
- ☐ 2 -3 times during the week
- ☐ More than 3 times during the week

Do you ever drive after drinking, or ride with a driver who has been drinking?

☐ yes ☐ no

Nutrition:

in the past 7 days, how many servings of fruits and vegetables did you typically eat each day?

☐ 1 cup = 1 cup of fresh vegetables
☐ 1/2 cup of cooked vegetables or
☐ 1 medium piece of fruit 1 cup = size of baseball
☐
☐ _____________ servings per day

In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day?

☐ 1 serving = 1 slice of whole wheat bread
☐ 1 cup of whole grain or high fiber cereal
☐ 1/2 cup of cooked cereal or 1/2 cup of brown rice
☐ or whole wheat pasta
☐ _____________servings per day

In the past 7 days, how many servings of fried or high fat foods did you typically eat each day? (Ex: fried chicken fried foods, cheese, mayonnaise, cream cheese, etc.

☐ _____________servings per day

In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day

☐ ____________servings per day

Depression:

In the past 2 weeks, how often have you felt down, depressed, or hopeless?

- ☐ Almost all of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Almost never

In the past 2 weeks, how often have you felt little interest or pleasure in doing things?

☐ Almost all of the time ☐ Some of the time
☐ Most of the time ☐ Almost never

Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?

- ☐ yes
- ☐ no

Anxiety:

In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

- ☐ Almost all of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Almost never

In the past 2 weeks, how often were you not able to stop your worrying or control your worrying?

- ☐ Almost all of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Almost never

Sleep:

Each night how many hours of sleep do you get? ___ hours

Do you snore or has anyone told you that you snore?

☐ yes ☐ no

General Health:

In general, would your say your health is?

☐ Excellent ☐ Fair
☐ Very Good ☐ Poor
☐ Good

Activities of Daily Living:

In the past 7 days, did you need help from others to perform every day activities: eating, getting dressed, grooming bathing walking, toileting.

☐ yes ☐ no

Instrumental Activities of Daily Living:

In the past 7 days, did you need help from others to help with laundry and housekeeping, banking shopping, using the phone food prep, transportation or taking medications

☐ yes ☐ no

Are you able to manage your own financial affairs.

☐ yes ☐ no

Patient Signature: ____________________________ **Dr. Signature:** ___________________________

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Prepare for your appointment by filling in the information below.
Health evaluations

Name: ______________________________ **Date:** ____________

Risk of falls:
- o I have had a fall
- o I have problems with balancing or walking
- o I don't have problems with balancing or falling

Bladder control:
- o I have problems with bladder control
- o I have problems with leaking
- o I don't have bladder control or urine leakage problems

Physical activity: Are you exercising?
- o Yes
- o No

How often do you exercise per week: ___________

Recommendations: ____

____

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MEDICAL RECORD ACCESS
(CONFIDENTIAL INFORMATION)

Today's Date: __________________

Patient Name: _________________________ **Date of Birth __________________**

Please list names of persons that may have access to your medical information:

Name:	Relationship	Phone Number

____
Patient Signature

____
Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT*****

I, ____________________________ have received a copy of this office's Notice of Privacy Practices.

Name: ____

Signature: ____

Date: ____

**** For office use only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgment

____ An emergency situation prevented us from obtaining acknowledgment

____ Other ______________________________

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

YOUR PERSONAL HEALTH INFORMATION RIGHTS

YOU HAVE THE RIGHT TO:

SEE OR COPY YOUR PERSONAL HEALTH INFORMATION – You have the right to see or copy treatment, payment, and other records used to make decisions about you in the course of providing care, services, or other benefits. Your request must be in writing and should be submitted to the facility where you received treatment or services. We may charge you a fee for costs associated with your request. We are not required to allow you to see or copy psychotherapy notes, or information prepared for use in legal actions or proceedings. Please contact the facility where you received treatment or services for additional information.

CORRECT INFORMATION YOU BELIEVE TO BE INCORRECT OR INCOMPLETE - If you believe that your medical information is incorrect or incomplete, you may submit a request to us asking that your information be changed. Your request must be in writing and must include the reason(s) why you believe a change should be made. We are not required to approve your request. We will notify you if we approve your request, or explain the reason(s) for our decision if we deny your request.

REQUEST A LISTING OF WHO WAS GIVEN YOUR INFORMATION AND WHY - Upon your request, we will provide you with a list that includes the date we released medical information, the name of the person or organization, a brief description, and the reason for the disclosure. The list will not include releases of information used for treatment, payment, health care operations, or disclosures that were included on listings previously supplied to you. The list will also not include disclosures made for purposes of national security, to correctional institutions, to law enforcement officials while you are in their custody, for certain health care oversight activities, authorized by you in writing, made prior to April 14, 2003, or, made more than 6 years prior to the date of your request. We will provide one list free of charge per year. Contact the facility you received service or treatment from for assistance.

REQUEST RESTRICTION(S) ON HOW WE USE OR SHARE YOUR PERSONAL HEALTH INFORMATION -
You have the right to request a restriction or limitation on how we use or release your medical information for purposes of treatment, payment or operations. We ask that you complete a request form from the treatment location site's Privacy Officer and/or designee and submit it for evaluation. We are not required to agree to your request, and will contact you if we deny your request.

REQUEST CONFIDENTIAL COMMUNICATION(S) -You may ask that we communicate with you about health matters in a certain way or at a certain location. For example, if you are an outpatient client, you could request that we contact you at your workplace or via email. We will attempt to accommodate all reasonable requests. To request an alternative method of communication, you must specify how or where you wish to be contacted.

REQUEST A PAPER COPY OF THIS NOTICE -You have the right to request a paper copy of this Notice from us at any time. Please contact the facility you received services or treatment from to request a paper copy.

HOW YOUR PERSONAL HEALTH CARE INFORMATION MAY BE USED WITHOUT YOUR WRITTEN PERMISSION

Your medical information may be used and released by us for purposes of treatment, payment for services, administrative and operational purposes, and to evaluate the quality of the services that you receive. Because we provide a wide range and variety of health care and social services to the people in Florida, not all types of uses and releases can be described in this document. We have listed some common examples of permitted uses and releases below.

FOR TREATMENT - We may share your medical information when we coordinate services you may need, such as clinical examinations, therapy, nutritional services, medications, hospitalization or follow-up care. For example, your medical information may be given to a pharmacist when you need a prescription filled.

FOR PAYMENT –We may release your medical information for billing purposes or to collect payment for service and treatment that you receive. For example, your medical information may be shared with your health plan to provide billing information for clinical exams that you have received. We may also share your medical information with government programs such as Medicare, to coordinate benefits and payment.

FOR HEALTH CARE OPERATIONS - We may use and release your medical information to ensure that the services and benefits provided to you are appropriate and high quality. For example, we may use your medical information to evaluate our treatment and service programs or to evaluate the services of other providers that use government funds to provide health care services to you. We may combine medical information about many individuals to research health trends, to determine what services and programs should be offered, or whether new treatments or services are useful.

TO OTHER GOVERNMENT AGENCIES PROVIDING BENEFITS OR SERVICES - We may release your medical information to government agencies or programs that provide similar services or benefits to you if the release is necessary to coordinate the delivery of your services or benefits, or improves our ability to administer or manage the program.

TO KEEP YOU INFORMED – We may contact you about reminders for treatment, medical care or health check-ups. We may also contact you to tell you about health-related benefits or services that may be of interest to you, and give you information about your care and treatment options.

FOR PUBLIC HEALTH - We may release your medical information to local, state or federal public health agencies, subject to the provisions of applicable state and federal law, for the following types of activities:

- To prevent or control disease, injury or disability or to keep vital statistics records such as data about births and deaths;
- To notify social service agencies that are authorized by law to receive reports of abuse, neglect or domestic violence, and;
- To report reactions to medications or problems with products to the Federal Food and Drug Administration.

FOR HEALTH OVERSIGHT – We may share your medical information with other divisions of the Department of Health and Family Services and with other agencies for oversight activities as required by law. Examples of these oversight activities include audits, inspections, investigations, and licensing activities.

LAW ENFORCEMENT – Your medical information may be disclosed to fulfill a requirement by law or law enforcement agencies. For example, medical information may be used to identify or locate a missing person.

COURT OR OTHER HEARINGS – Your medical information may be disclosed to comply with a court order.

FOR RESEARCH – We may release your medical information for research projects that have been reviewed and approved by an institutional review board or privacy board to ensure the continued privacy and protection of the medical information.

FOR LAWSUITS AND DISPUTES – If you are involved in a lawsuit or dispute, we may release your medical information about you in response to a legal order. We may also release your medical information in response to a subpoena, discovery request, or other lawful process by another party involved in the dispute, but only if they have made an effort to tell you about the request or to obtain an order protecting the medical information requested.

TO CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS – We may release your medical information to a coroner, medical examiner or funeral director, as necessary to carry out their duties as authorized by law. For example, release of medical information may be necessary to identify a deceased person.