SURGICAL CONSULTANTS OF CENTRAL FLORIDA

PATIENT REGISTRATION

Today's Date: ________________

Name: ______________________ __________________ ____ Sex: Male ☐ Female ☐
Last First M.I.

Mailing Address:
Street: __________________________________ City: ________________ State: ____ Zip: ________

Phone: Home: _________________ Cell: _________________ Work: _________________
Please circle the preferred number to reach you during our working hours.

Email: ____

Age: _____ Birth Date: ________________ Social Security Number: __________________

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐

Occupation: ____________________________ Employer: ____________________________

Health Insurance Company: __________________ Identification #: _______________________

Insured's Name (If different from patient): _________________________ Relationship: ___________

Referring Physician: ______________________ **Primary Care Physician:** _____________________

Is there anyone else we may speak to concerning appointments and medical information other than your doctor?

☐ No ☐ Yes If yes please list: ____

____
Patient's Signature

Pharmacy: Name: ______________________________ Phone: __________________________

RACE:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Hispanic
- ☐ Other Race
- ☐ Unreported / Refused to report

ETHNICITY:
- ☐ Hispanic or Latin
- ☐ Not Hispanic or Latin
- ☐ Refused to Report

LANGUAGE:
- ☐ English
- ☐ Other
- ☐ Indian (includes Hindi & Tamil)
- ☐ Spanish
- ☐ Russian

REFERRAL INFORMATION

How did you hear about Surgical Consultants of Central Florida?
☐ Dr. Referral ☐ Friend ☐ Magazine Advertisement ☐ Yellow Pages
☐ Website / Internet ☐ Other (specify) ____

PATIENT'S NAME: ______________________________

WHAT PROBLEM(S) ARE YOU SEEKING CARE FOR?

1. ______________________________ 2. ______________________________

MEDICAL HISTORY

DO YOU TAKE ANY OF THESE MEDICATIONS?

Coumadin / warfarin: Yes ☐ No ☐ **Pradaxa:** Yes ☐ No ☐ **Plavix:** Yes ☐ No ☐
Aspirin: Yes ☐ No ☐ **Vitamin E** Yes ☐ No ☐

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (Including over the counter and vitamins)

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

HAVE YOU EVER BE DIAGNOSED WITH:

Condition			Condition		
High blood pressure	Yes ☐	No ☐	Anemia	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
DVT (Blood Clot in Vein)	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Bleeding/Clotting Disorder	Yes ☐	No ☐	Kidney Failure	Yes ☐	No ☐
Rheumatic Heart Disease	Yes ☐	No ☐	Emphysema	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	C.O.P.D.	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
Heart Trouble	Yes ☐	No ☐	Mental Illness	Yes ☐	No ☐
Liver Disease	Yes ☐	No ☐	Heart Attack	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐	HIV / AIDS	Yes ☐	No ☐
Mitral Valve Prolapse	Yes ☐	No ☐	Seizures	Yes ☐	No ☐
Cancer	Yes ☐	No ☐			

If yes what type(s): ____

OTHER SERIOUS PAST ILLNESSES:

______________________ ______________________ ______________________
______________________ ______________________ ______________________

ALLERGIES:

Adhesive Tape: Yes ☐ No ☐
Latex: Yes ☐ No ☐
Medicines: Yes ☐ No ☐ If yes please list: ______________________________
____

PATIENT'S NAME: ____________________________

PREVIOUS SURGICAL OPERATIONS (Give type, approximate date and hospital):

__________________________ __________________________ __________________________
__________________________ __________________________ __________________________
__________________________ __________________________ __________________________

FAMILY HISTORY

Has any blood relative been diagnosed with any of the following (Write Relationship):

- ☐ AIDS _____________ ☐ Diabetes _____________ ☐ Heart Attack ____________
- ☐ Colon Cancer ___________ ☐ Lung Cancer ___________ ☐ Breast Cancer ___________
- ☐ Other Cancers (Type: _______________) ______________ ☐ Other ______________

Are there any hereditary diseases in your family? ____

PERSONAL HISTORY

Are you a:

- ☐ Current Smoker How many packs a day? ___________________ For how long? ___________
- ☐ Former Smoker How long ago did you quit? __________________
- ☐ Nonsmoker

Do you drink alcohol?

Yes ☐ No ☐ How many drinks per week of: Beer ______ Wine ______ Whiskey ______

What is your present weight? _______ What is your height? _______

Date of last Colonoscopy: _______________ ☐ Never had one

If Female: Are you pregnant? Yes ☐ No ☐ Date of last menstrual period: _____________

Date of last Mammogram: _____________ Date of last PAP smear: _____________

REVIEW OF SYMPTOMS:

Check any symptoms you have experienced in the past year:

- ☐ Frequent or severe headaches
- ☐ Fainting or unconscious spells
- ☐ Seizures
- ☐ Blurred vision / visual changes
- ☐ Persistent hoarseness
- ☐ Difficulty swallowing
- ☐ Chest pain or angina
- ☐ Palpitations or fluttering heart
- ☐ Bloody sputum / coughed up blood
- ☐ Frequent shortness of breath
- ☐ Heartburn
- ☐ Recent frequent vomiting
- ☐ Vomited blood
- ☐ Blood in stools
- ☐ Frequent diarrhea
- ☐ Frequent constipation
- ☐ Difficulty starting urination
- ☐ Pain on urinating
- ☐ Getting up frequently at night to urinate
- ☐ Joint pains
- ☐ Joint swelling
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Stroke

Surgical Consultants of Central Florida, PA
1830 SW 18th Ave., Suite 3
Ocala, FL 34471
Phone: 352-690-6000 Fax: 352-690-6643

ATTENTION ALL PATIENTS

Please take note, that if your insurance requires a referral and/or authorization from your primary care physician to see Dr. Oraedu this has to be obtained **before** the time of your appointment.

Please check with your primary care physician to be sure all the necessary forms have been submitted to your insurance company in order for you visit to be covered.

All charges for visits and/or procedures **will be the responsibility of the patient** if the referral/authorization is not done, or not done correctly by your primary care physician and the insurance company rejects your claim for lack of or improper referral.

____ _______________

Patient Signature Date

SURGICAL CONSULTANTS OF CENTRAL FLORIDA, P.A.
Deerwood II, 1830 SE 18th Ave., Suite 3, Ocala FL 34471
Phone: 352-690-6000 Fax: 352-690-6643

FINANCIAL POLICY

Surgical Consultants of Central Florida, P.A. is committed to providing you with the best possible care and we are please to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

RELEASE OF INFORMATION: I, the below named patient do hereby authorize Surgical Consultants of Central Florida, P.A. to release to any third or third party provider (such as Insurance Company, government agency, physicians or hospitals) any medical information and records concerning diagnosis and treatment for services rendered for its us in connection with determining a claim for payment for such treatment and or diagnosis or when required by a third party provider in the assessment planning and/or implementation of my care.

MEDICARE/MEDICAID: Patients certification authorization to release information and payment request: I certify that the information given by me in applying payment under Title XVIII/IX of the Social Security Act is correct. I authorize any holder of medical information about me to release the Social Security Administration/Division of Family Services or its intermediaries or carriers, any information needed for this related Medicare/Medicaid claim, I understand that I am responsible for any health insurance deductibles and co-insurance; I hereby certify that all Medicare/Medicaid benefits shall be assigned to Surgical Consultants of Central Florida, P.A. It is the policy of the practice "NOT" to accept Medicaid as a secondary payer, except those cases where Medicare is the primary payer. Surgical Consultants of Central Florida, P.A. dose adhere to the Florida Medicaid Agreement and Title 42 Code of the Federal Regulation 447.20 and Civil Rights Act of 1964.

COLLECTIONS: In the event my account is turned over to a collection agency or attorney for collection, I will be responsible for any and all costs incurred.

WORKERS' COMPENSATION: We will call to authorize your visit prior to your appointment. We will file with your company's insurance. In the event you fail to prosecute the claim for Workers' Compensation for this illness/condition or it is determined by the Workers' Compensation case you agree to pay the usual and customary fees for services rendered to you in this case.

AUTHORIZATION FOR SERVICES: I understand that my insurance company may require an authorization for service. If for any reason my insurance company does not give authorization for services incurred by me I will responsible for any and all charges.

FEES FOR SERVICES: I understand that all fees and or charges explained to me by this office is only an estimate of charges and will be considered as such. Fees may consist of several items for various separate procedures and tests. An actual charge can only be determined after services have been performed.

CHECKS: All checks presented must have a current address printed on the check. Checks can only be accepted with valid state identification i.e. driver's license. We are unable to accept postdated checks or to hold checks. A service fee will be applied to all returned checks.

CHILDREN OF DIVORCED PARENTS: The Guardian accompanying the minor child at the time services are rendered will be responsible for payment no matter who is said to be the responsible party by order of the divorce decree.

AGREEMENT: I will be responsible for the entire amount due for services rendered if the expense is not covered under my policy. Surgical Consultants of Central Florida, P.A. will not become involved in disputes between you and your insurance company regarding deductibles, co-payments covered charges or usual and customary charges other than to supply factual information as necessary.

The undersigned will pay all costs and expenses including a reasonable attorney's fee incurred or paid by Surgical Consultants of Central Florida, P.A. in the collection of this obligation by suit or otherwise. The entire amount is due and payable upon billing.

Patient Name: ______________________________ Date of Birth: ______________________________
(Print Name)

Guarantor Signature ______________________________ Date: ______________ Phone: ______________
(Legal Signature)

Guarantor Social Security # ______________________________ Address: ______________________________

Surgical Consultants of Central Florida

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

____
Please Print 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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