Elizabeth Daquila M.D., LLC

851 Dunlawton Ave. Suite 102 Port Orange, FL 32127 Office: (386) 236-9328 ▪ Fax: (386) 492-2586
Website: daquilamd.com

Patient Name: _____Date: _____

PATIENT INFORMATION:

Dr. Lic #: _____ Date of Birth: _____ Referred By: _____

Social Security Number: _____-_____-_____ Marital Status: ____Email Address: _____

Mailing Address: _____ Apt. # _____ Circle: Male or Female

City/State/Zip:_____

Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____

Leave a Message: _____ (Yes or No) Education/Degrees_____

Advance Directive/ Living Will: Y/ N

Insurance Information

Primary Insurance Name: _____ Phone Number: (___)_____

Insurance Address: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

Secondary Insurance Name: _____ ID#_____

Employer Information

Employer Name: _____ Phone Number: (___)_____

Address: _____

Work Status:□ Full time □ Part-time □ Disability □ Retired □ Other Occupation_____

Emergency Contact Name: _____ Phone Number: (___)_____

Please list individual(s) we are authorized to speak with regarding your care/account:

Name:_____ Name:_____

Pharmacy Name & Location: _____ Phone Number: (___)_____

Please list any and all **Allergies**: ( ) No Known Drug Allergies

_____

_____

Elizabeth Daquila MD, LLC requires all patients needing to cancel a scheduled appointment to call 24 hours prior to your appointment. A $25.00 cancellation fee will apply if cancelled less than 24hrs. Any patient that no shows for their scheduled appointment will be charged a $25.00 No Show Fee.

I acknowledge prior receipt of Notice of Privacy Practices and that no warranty or guarantee has been made to me as to result or cure. I certify that I understand this statement.

Signature_____ **Date**_____

PAYMENT IN FULL IS REQUIRED AT THE TIME OF YOUR VISIT

Patient Personal History & Health Assessment

Name: _____ **D.O.B**____/_____/_____ Age: _____

Do you take any prescription medications?

□ No

□ Yes - Please list names / dosages / frequency

_____

_____

_____

_____

_____

_____

Do you take daily vitamins / supplements?

□ No

□ Yes

_____

_____

Exercise:

□ Yes - _____ times per week

□ No exercise

Caffeine Use: □ No caffeine □ Yes - Check all that apply

□ Coffee Soda □ Tea □ Energy Drinks

How many servings per day? _____

Tobacco Use: □ Never smoked

□Previous smoker - Quit _____ years ago.

□ Currently smoke - For _____ years.

How many cigarettes per day? _____

Smokeless tobacco? □Yes □ No

Alcohol Use: □ No alcohol

Social - How many drinks per week? _____

Daily - How many drinks per day? _____

Recovering alcoholic - Sober for _____ years.

Drug Use: □ No history of drug use

□ Yes, have used drugs in the past – □ Marijuana □ Heroin □ Cocaine □ Other

□ Yes, currently use _____

Have you ever abused prescription drugs? □ Yes □ No

Name: _____ **D.O.B**____/_____/_____

Past Medical History (Personal): Please check all that apply

□ Alcohol Overuse _____

□ Allergies Environmental / Seasonal _____

□ Anemia _____

□ Anxiety _____

□ Arthritis _____

□ Asthma _____

□ Cancer _____

□ Colitis _____

□ COPD _____

□ Colon Polyps _____

□ Diabetes _____

□ Depression _____

□ Gout _____

□ Heart Disease _____

□ Hepatitis _____

□ Hypertension (High Blood Pressure)_____

□ High Cholesterol _____

□ Insomnia / Trouble Sleeping _____

□ Kidney Problems _____

□ Prostate Problems _____

□ Sleep Apnea _____

□ Stroke _____

□ Thyroid Disease _____

□ Osteoporosis / Osteopenia _____

Other: _____

_____

_____

_____

_____

Name: _____ **D.O.B**____/_____/_____

Past Surgeries:

_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____

Hospitalizations / Serious Injuries:

_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____

Family History:

Mother □ Living Age _____

Medical problems: _____

_____

□ Deceased Age _____ Cause _____

Father □ Living Age _____

Medical problems: _____

_____

□ Deceased Age _____ Cause _____

Brothers _____

_____

Sisters _____

_____

Maternal Side: Aunts / Uncles _____

_____

Grandparents _____

_____

Paternal Side: Aunts / Uncles _____

_____

Grandparents _____

_____

Other _____

_____

Name: _____ **D.O.B**____/_____/_____

MALES Preventative Screenings:

Last colonoscopy _____

Last routine labs _____

Last routine physical _____

Last PSA (prostate blood test) _____

Last chest x-ray _____

Last rectal exam / prostate check _____

Last cardiac stress test _____

Last eye exam _____

Last tetanus vaccine _____

Last shingles vaccine _____

Last pneumococcal vaccine _____

DIABETICS

Are you diabetic? □ Yes □ No

Last diabetic foot exam _____

Last diabetic eye exam _____

Last HbA1C _____

FEMALES

OB /GYN History:

How many pregnancies have you had? _____

How many live births? _____

Vaginal or C/Section

How many miscarriages / abortions? _____

Any complications during any pregnancies?

_____

_____

Menstrual History:

Age you started menses _____

Are you still menstruating? _____

If yes, are your periods regular / irregular

Last menstrual period _____

If no, when did you stop menstruating? _____

FEMALES Preventative Screenings:

Last mammogram _____

Last DEXA scan _____

Last pap / well woman exam _____

Last colonoscopy _____

Last routine labs _____

Last routine physical _____

Last chest x-ray _____

Last cardiac stress test _____

Last eye exam _____

Last tetanus vaccine _____

Last shingles vaccine _____

Last pneumococcal vaccine _____

Have you had HPV vaccine? _____

Patients Name:_____ **D.O.B**____/_____/_____

REVIEW OF SYSTEMS: Check (√) any symptoms you have had in the LAST MONTH

General:
□ Fever □ Chills □ Sweats □ Loss of Appetite □ Fatigue □ Weakness □ Malaise □ Weight Loss □ Sleep Disorder

Ear/Nose/Throat
□ Earache □ Ear Discharge □ Decrease Hearing □ Nasal Congestion □ Nosebleeds □ Sore Throat □ Hoarseness
□ Difficulty Swallowing

Eyes:
□ Blurring □ Double Vision □ Irritation □ Discharge □ Vision Loss □ Eye Pain □ Eye Pain In Light

Cardiovascular:
□ Chest Pain □ Fainting □ Shortness of Breath Walking □ Shortness of Breath Laying Flat □ Shortness of Breath at Night
□ Leg Swelling

Respiratory:
□ Cough □ Shortness of Breath □ Excessive Sputum □ Coughing up Blood □ Wheezing □ Pleurisy

Gastrointestinal:
□ Nausea □ Vomiting □ Diarrhea □ Constipation □ Change in bowel habits □ Abdominal Pain □ Black Stool □ Bloody Stool
□ Jaundice □ Gas/Bloating □ Indigestion/ Heartburn □ Pain with Swallowing

Musculoskeletal:
□ Back Pain □ Joint Pain □ Joint Swelling □ Muscle Cramps □ Muscle Weakness □ Stiffness □ Arthritis □ Sciatica
□ Restless Legs □ Leg Pain at Night □ Leg Pain with Exercise

Skin:
□ Rash □ Itching □ Dryness □ Suspicious Lesions

Neurological:
□ Paralysis □ Numbness □ Seizures □ Tremors □ Vertigo □ Loss of Vision □ Frequent Falls □ Frequent Headaches
□ Difficulty Walking □ Weakness □ Fainting □ Headache

Mental:
□ Depression □ Anxiety □ Memory Loss □ Suicidal Thoughts □ Hallucinations □ Paranoia □ Phobia □ Confusion

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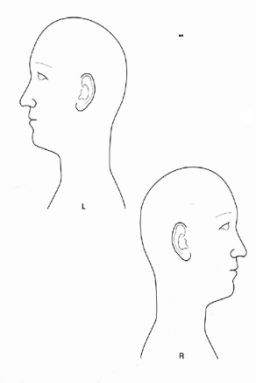
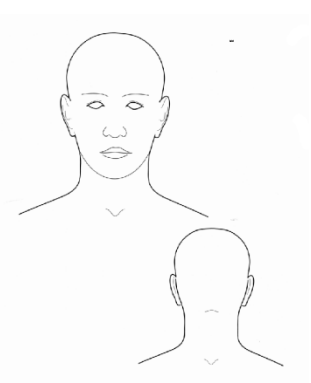
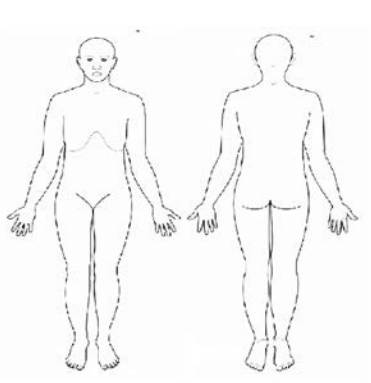
If being seen for:

Weight Loss – What is your greatest area of concern on physical appearance?
Facial Aesthetics – Mark the greatest area of concern on the chart below.
Pain - Shade the areas where you have pain. If it travels, mark with an 'X' where it starts and draw an arrow to where it spreads.

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to my under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers(e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosure of protected health information and my right under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of_____20_____.

Print Patient Name_____

Signature_____

Relationship to Patient_____

Pregnancy Disclosure

To the best of my knowledge, **I AM NOT PREGNANT**.

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

All of the above possible side effects of medication(s) have been fully explained to me and I understand that, at the present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioid(s)/narcotics to assure complete safety to my unborn child (ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/fetus/baby.

_____ _____ _____ _____

Patient Signature Date Witness Date

Bio-Identical Hormone Replacement Disclaimer

I, _____, have been advised to have a yearly gynecological exam as well as a mammogram (if age appropriate). It is my responsibility to provide these records to Dr. Daquila.

I understand if I fail to provide Dr. Daquila with records of these important studies, Elizabeth Daquila MD, LLC cannot be held liable for any missed diagnosis these procedures would indicate.

_____ _____ _____ _____

Patient Signature Date Witness Date

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Financial Policy

The doctor and staff at Elizabeth Daquila MD, LLC would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visit as convenient as possible.

By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current-accordingly, all self-pay or insurance co-payments, co-insurance and deductibles will be collected at the time of service. Payable by cash, debit card, and credit card only.
- If you do not have your payment(s), your appointment WILL BE RESCHEDULED.
- You may be asked to schedule another appointment for issues other than the reason for your original appointment.

If you have health insurance coverage:

We will submit your claims, however **we must emphasize that as medical providers, our relationship is with you, not your insurance company.** Although we attempt to verify your healthcare benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

By signing below you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- Not all services are covered benefits with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You're responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the dates of service that is rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information please do not hesitate to ask us. We are here to help you.

General Consent to Treat

I voluntarily consent to medical care of a routine/emergency nature from the authorized professional staff of Elizabeth Daquila M.D., LLC for myself or the above-mentioned minor for whom I am the parent/guardian. I authorize the release of any and all medical records and information obtained through my medical evaluation to those individuals that my doctor feels appropriate for my continued medical care. I understand that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available. It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

Medicare Agreement

The information provided by me in applying for payment of Social Security benefits is true and correct. I also authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf. I request that the payment of benefits be made for me. The benefits due to me for services provided by my physician shall be paid directly to Bay Harbor Family Medicine. In the event the physician does not receive such payment, I authorize such physician to submit a claim to Medicare on my behalf. If my current policy prohibits direct payment to Elizabeth Daquila M.D., LLC , I hereby direct the check made out to me and mailed to: Elizabeth Daquila M.D., LLC 851 Dunlawton Ave. Suite 102, Port Orange, Florida 32127

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____	X_____	_____
Patient Name (please print)	Patient Signature	Date
_____	X_____	_____
Guarantors Name (please print)	Guarantor s Signature	Date