BRIDGET SILVA, M.D.
FAMILY MEDICINE
10220 W SAMPLE ROAD
CORAL SPRINGS, FL 33065
(954) 340-1123

PATIENT INFORMATION:

DATE _____

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

PRIMARY PHONE _____SECONDARY PHONE _____

BIRTHDATE _____ AGE _____PHARMACY#_____

HOW WERE YOU REFERRED TO OUR OFFICE _____

OCCUPATION _____ WORK NUMBER_____

EMPLOYER _____

MARITAL STATUS S___ M___ D___ W___ SPOUSE NAME_____

EMERGENCY
CONTACT_____RELATIONSHIP_____

TEL# _____

PRIMARY INSURANCE _____ID#_____

PHONE # _____ GROUP # _____

PRIMARY NAME ON INSURANCE POLICY_____

PRIMARY BIRTHDATE _____ CLAIMS ADDRESS_____

_____

SECONDARY INS _____ SEC ID_____

PARTICIPATING LAB_____

(IF YOU DO NOT KNOW PLEASE CALL THE CUSTOMER SERVICE NUMBER ON YOUR CARD)

PATIENT SIGNATURE _____

Bridget Silva, M.D.
10220 West Sample Road
Suite One
Coral Springs, Florida 33065

Disclosure Form

I, _____, am not a current patient of Dr. Doris Hamawy's Practice and I have NEVER been a patient of the joint practice of Dr. Doris Hamawy, Dr. Bridget Silva and Katina Davis-Kennedy, ARNP. Currently Dr. Silva's medical practice is NOT accepting any additional new patients from the previous joint Hamawy and Silva Practice. By signing this form I acknowledge that I have read and understood the above statement.

Signature:_____

Date of Birth:_____

Date at signing:_____

Form Reviewed by staff/doctor:_____

Bridget Silva, M.D. P.A.

Patient Name _____

Today's Date _____ Age _____ Date of Birth _____

Information about your health is needed by your doctor to understand your medical problems and to get to know you a little better as a person. This information will remain confidential and will be available to our doctors only.

Hospitalizations and Surgeries

List the year, name of the hospital, and the location by city and state where you were hospitalized or had any surgical procedures done.

	Year	Hospital/City and State	Reason for hospitalization or type of surgery performed
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Medications

List any medicines that you now use. Under dosage, list how much you are taking in milligrams (mg) and number of pills per dose. Under how often, list how many times a day you take the medicine. Be sure to include vitamins, diet pills, medicines like Tylenol, aspirin, antacids, laxatives, sleeping medications, pain pills, antibiotics, anxiety medicines and birth control pills.

	Medication	Dosage	How Often
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Allergies

List any medicine, food, plants, animals, or other products that you are allergic to:

_____

_____

Past Medical History (Please circle all that apply to you)

General
Change in weight (recent)
Change in appetite (recent)
Weakness or fatigue (recent)
Anxiety or tension
Crying for no reason
Depression
Poor Memory
Suicidal Thoughts
Difficulty Sleeping

Glands
Thyroid Disease
Goiter
Diabetes

Skin
Eczema
Hives/Rashes
Acne
Skin Cancer

Head & Nervous System
Migraine or Severe Headaches
Angina
Stroke
Seizures/Epilepsy/Convulsions
Nervous or Emotional Issues
Concussions
Meningitis
Loss of Consciousness

Blood
High Cholesterol
Anemia
Bleeding Problems
Blood Transfusions
Sickle Cell Disease or Trait

Lungs
Asthma
Emphysema
Pneumonia
Pleurisy
Bronchitis
Hay Fever
Nagging Cough
Coughing up Blood

Ears
Deaf or trouble hearing
Ringing in ears
Chronic Ear Infections

Eyes
Change in Eyesight
Glaucoma
Cataracts
Blindness

Heart
High Blood Pressure
Heart Attack
Heart Failure
Rheumatic Fever
Chest Pain
Palpitations (Racing Heart)
Shortness of Breath

Contagious Infections
Chicken Pox
Mononucleosis
Shingles

Abdomen
Ulcer or Stomach bleeds
Hepatitis (yellow jaundice)
Cirrhosis
Pancreatitis
Gallstones
Bladder Infections
Polyps in Colon
Hemorrhoids
Hernias
Diverticulosis
Constipation
Black or Bloody stools

Blood Vessels
Varicose Veins
Blood clots in legs/arms

Bones and Joints
Arthritis or Rheumatism
Gout
Broken Bones
Scoliosis
Osteoporosis/Osteopenia

Kidneys
Kidney Stones
Kidney or Bladder Infections
Other Kidney Disease
Unable to Control Urination
Blood in Urine
Frequent Urination

Cancer
_____
_____
_____

For Males Only
Enlarged Prostate
Difficulty starting or stopping Urine Flow
Infection in Prostate
Painful or lumpy Testicles
Premature Ejaculation
Sexually Transmitted Disease
Erectile Dysfunction
Decreased Interest in Sex

Do you perform testes self-examination? _____

For Females Only (please fill in blank)

How old were you when your periods first started? _____
How often do you get your period? Every _____ days.
How many days do they last? _____ days.
Have you gone through Menopause? _____ What year? _____
Do you use contraception? _____ What type? _____
Date of last menstrual period? _____
Date of last Pap Smear? _____ Doctors Name _____ Results _____
Number of pregnancies _____ Number of living children _____ Abortions _____
Miscarriages _____
Do you perform breast self-examinations? _____
Do you have discharge from your nipples? _____ Lumps in breast? _____
Pain during intercourse? _____ Vaginal Bleeding? _____ Bleeding during Intercourse? _____
Decreased interest in sex? _____

Have you had any X-rays or Lab Testing done recently? (If yes, please list them)

_____

Have you had any of the following Immunizations?	Year
Tetanus	_____
Hepatitis	_____
Rubella	_____
Tuberculosis skin test	_____
Chest x-ray for TB	_____
Flu Vaccine	_____
Pneumonia Vaccine	_____
Zostavax	_____

Family Member	**Age**	**If deceased, age and cause of death**	**Cancer (Type)**	**Diabetes**	**Kidney Disease**	**Heart Disease**	**Stroke**	**High Blood Pressure**	**Arthritis**	**Gout**	**Seizures/Epilepsy**	**Bleeding Problems**	**Anemia**	**Sickle Cell Problems**	**Tuberculosis**	**Alcoholism**	**Nervous Problems**	**Mental Illness**	**Glaucoma**	**Migraines**	**Other**
Father																					
Mother																					
Brother & Sister																					
Brother & Sister																					
Other Blood Relative																					

Social/Lifestyle History

Please answer the following questions

1. Are you: Married Single Divorced Separated Widowed

2. Who lives in your house? _____

3. Are there any members in the household who are disabled in any way? Yes No
   If yes, who and in what manner? _____

4. Are there many stresses at home? Yes No At work? Yes No

5. Circle the tobacco products you have ever used regularly

   Cigarettes Pipe Cigar Chewing Tobacco Snuff None

   What is the average number of packs of cigarettes that you smoke or used to smoke per day?
   None less than ½ ½ to 1 1-2 1 or more
   Do you smoke? Yes No How many years have you smoked? _____

   If you have permanently quit, when? _____

6. Have you ever had a problem with drinking alcohol? Yes No

   Has anyone close to you ever thought you drank too much? Yes No
   Do you feel guilty about drinking? Yes No
   How often do you or did you drink?
   Never Occasionally Once a week Several times a week Daily
   How many ounces of alcohol do you consume per week? _____

7. Do you sometimes use Marijuana or other drugs socially? _____ Alone? _____

8. How many cups of coffee, tea or cola do you drink per day? _____

9. Are you on a special Diet? Yes No If yes what kind? _____

10. How often do you exercise? Never Rarely Once a week Several times a week Daily

    How many minutes do you exercise per session? _____

11. What kind of work do you do? _____

    Are you working now? Yes No
    Are you exposed to any of the following at work? Excessive Noise Air Pollution Fumes
    Poisons and Chemicals Crowded Conditions

12. Is your sex life satisfactory? Yes No Sometimes

    Is your sexual preference: Heterosexual Homosexual Bisexual Asexual
    Do you have more than one sexual partner? Yes No

13. Do you use alternative health providers/treatments, such as acupuncture, natural remedies or homeopathy? Yes No If yes please explain _____.

_____ _____

Patient Signature Date

BRIDGET SILVA, MD, PA

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Bridget Silva, MD, PA may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the above practice for their Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Bridget Silva, MD, PA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the above practice's Privacy Officer or requesting it at the office.

With my consent, Bridget Silva MD, PA may call my home or other designated locations and leave a message on a voicemail or with whomever answers my phone in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items, referrals and any call pertaining to my clinical care including lab and test results.

With my consent, Bridget Silva, MD, PA may mail to my home or other designated location any items that assist the practice in carrying out TPO.

I have the right to request that Bridget Silva, MD, PA restrict how it uses or disclosed my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form I give consent to Bridget Silva, MD, PA to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the above doctors may decline to provide treatment to me.

_____

Signature of Patient or Guardian

_____ _____

Print Patient Name Date

_____

Print Guardian Name

PATIENT RESPONSIBILITIES

Thank you for choosing us as your primary care physicians. We realize that you have a choice and we are committed to providing you with the utmost quality of care. We ask that you become familiar with our office policies and procedures, and understand that they are in effect so that we can provide all of our patients with the best service possible.

When calling our office, we have a menu of options to help expedite your call. Please listen to the message and choose the prompt you are looking for.

APPOINTMENT CHECK-IN

Please inform the front desk personnel of any address, phone, employment or insurance changes. Co-pays, deductibles, lab fees and outstanding balances will be collected prior to your visit with the doctor or lab. This will eliminate delays when checking out. We accept cash, check, or credit cards.

PRESCRIPTION REFILLS

The doctor gives you enough medication to cover you to your next appointment. If you are requesting prescription for another reason other than your normal refills, leave a message on the prescription line. Be sure to speak slowly and clearly, leave the spelling of your name, prescription name, dosage and pharmacy phone number. Please allow one week to be filled. Follow up with your pharmacy. **Note: Under no circumstances will controlled substances be refilled without an appointment.**

Some medications may require a prior authorization from your insurance company. Obtaining approval involves extensive phone calls and paperwork and may require a doctors' visit. This does not guarantee authorization, as that is up to your insurance company.

LAB

Most insurance companies require lab work to be done at a contracted drawing station. As a courtesy to our patients we may collect blood/ urine here and send it to the appropriate participating lab. This eliminates the need for you to travel to another facility for this service. There is a $20 bio-hazard disposal/convenience fee for labs drawn here the day of a doctor's visit.

We will be happy to provide you with a lab order to take with you to your contracted drawing station if you prefer. You will receive a call from us with the results approximately two weeks from the time your lab is drawn. We will inform you if the labs are normal. If there are any abnormal results, or you wish to go over normal labs in more detail, the doctors will require you to come in to go over the results. The staff is not authorized to go over results with you over the telephone.

REFERRALS

If your insurance requires you to obtain referrals for specialist visits, you will be required to see our physician prior to obtaining the referral for the reason you are visiting the specialist. Please allow 7 days for the referral to be completed. We will notify you when it has been completed so that you may pick it up.

APPOINTMENT TIMES/CANCELLATIONS

The doctors make every effort to see all patients in need of medical treatment. For this reason, if you are late for your scheduled appointment time, you may be asked to reschedule.

If you need to cancel an appointment, we ask for your consideration. Please notify us 12 hours before your scheduled appointment if you are unable to make it, so that we may give a patient in need that spot. Failure to notify us will result in you being charged a $25.00 no show fee, which will be collected prior to any future appointments.

PAYMENT FOR NON-COVERED SERVICES

Due to the high volume of insurance companies, and their agreements with varying provider networks, we cannot be responsible to track the specifics of each patient's benefits. If your insurance company does not cover a particular lab or procedure, you will be responsible for the payment of that service. It is Your responsibility to know your benefits.

In the event you do not pay your bill after 3 invoices are sent to you, you will be sent to collections. You will be responsible for all charges incurred, including the 35% collection and/or attorney's fees.

_____

Patient Printed Name

_____

Patient Signature Date

BRIDGET SILVA, M.D., PA

Authorization and General Consent

Family Medicine

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT

I hereby authorize the physician or physicians in charge of the named patient to administer any treatment, as she or they deem necessary or advisable in the diagnosis and treatment of this patient. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to results of treatments or examination. The physician is not responsible for what my insurance does or does not cover.

STATEMENT OF FINANCIAL RESPONSIBILITY

The undersigned agrees, whether he signs as Agent or as Patient, that in consideration of the Services to be rendered to the patient, he hereby individually obligates himself to pay his account in accordance with the regular rates and terms of the practice of Bridget Silva, MD, PA. If the amount owed is not fully satisfied by the due date, then **a fee of 35% of the outstanding balance** as calculated on the due date will be added to the outstanding balance and sent to our collection agency.

INSURANCE DEPARTMENT ASSIGNMENT

In the event the undersigned is entitled to professional service benefits of any type, arising out of any policy of insurance insuring patient, said benefits are hereby assigned to the appropriate physician for application on patient's bill. It is agreed that the appropriate physician may receipt for any such payment which shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment. The undersigned and the patient are responsible for all charges not covered by this assignment.

MEDICARE ASSIGNMENT OF BENEFITS

I request authorization of payment of Medicare/Medicaid benefits on my behalf for any services furnished me by the above physicians to be made to said physician. I authorize any holder of medical or other information about me to release to Medicare/Medicaid and its agents, any information needed to determine these benefits for related services.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned hereby authorizes the above physicians to release or make available for medical review or their related information to insurance companies or medical assistance programs (including their agents, representatives or assignees) through which payment of benefits in connection with hospital and/or professional services are or may be available.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ FULLY AND UNDERSTANDS THE ABOVE STATEMENTS/AUTHORIZATIONS AND EXPLANATIONS THEREIN REFERRED TO HAVE BEEN MADE; HE FURTHER CERTIFIES HE IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERM.

_____ _____

Patient Signature *Date*

_____ _____

Patient's agent or Representative *Relationship to Patient*

_____ _____

Guarantor *Relationship to Patient*

BRIDGET SILVA, MD, PA

BRIDGET SILVA, MD

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

The following individuals are authorized to receive information regarding my medical records:

Name _____ ***Relationship*** _____

Name _____ ***Relationship*** _____

Name _____ ***Relationship*** _____

I, _____ ***have read a copy of Bridget Silva, MD, PA's Notice of Privacy Practices.***

_____ _____

Signature of Patient ***Date***

BRIDGET SILVA, MD
FAMILY MEDICINE
10220 W. SAMPLE RD
CORAL SPRINGS, FL 33065
TEL. (954)340-1123 FAX (954)340-1099

MEDICAL RECORDS RELEASE

TO: _____

_____

_____

_____ _____

Telephone *Fax*

I authorize and request the disclosure of all protected information for the purpose of evaluation and treatment to:

Bridget Silva, MD
10220 W. Sample Rd
Coral Springs, FL 33065
Tel (954) 340-1123 Fax (954) 340-1099

Please include all medical documents in my record, including but not limited to office notes, history and physicals, progress notes, consultation notes from other physicians, inpatient, outpatient and emergency room treatment information, admission records, discharge summaries, all clinical charts, reports, treatment plans, and evidence of test results. This authorization includes the release of all records, including psychological, psychiatric or psychotherapeutic records, AIDS/HIV test results and records dealing with drug and alcohol treatment.
I acknowledge that I may revoke this authorization by delivering to Dr. Silva at the address above, a written notice of the revocation, but that the revocation does not apply to the extent that Dr. Silva has acted in reliance on the authorization.

a. *I acknowledge that Dr. Silva may not condition their treatment or payment upon my declination to furnish this authorization. However, I also acknowledge that Dr. Silva may determine that continuity of care cannot be adequately accomplished without access to my previous medical records and decline to accept me as a patient in the practice without information about my medical condition.*
b. *I acknowledge that Dr. Silva MD is a covered entity under HIPAA and may redisclose this information to others involved in my medical care, treatment and payment for that care without my written authorization or otherwise as permitted by law.*

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two (2) years from the date of execution at which time this authorization expires.

_____ _____

Print Patient Name *Birthdate*

_____ _____

Signature of Patient or Representative *Date*

_____

Relationship to Patient