

\* Email completed paperwork to [bridgetsilvamdp@gmail.com](mailto:bridgetsilvamdp@gmail.com) \*

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

**PATIENT INFORMATION:**

DATE \_\_\_\_\_ EMAIL \_\_\_\_\_

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. 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:

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**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

**For Males Only**

Enlarged Prostate  
Difficulty starting or stopping  
Urine Flow

Do you perform testes self-examination? \_\_\_\_\_

**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**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sexually Transmitted Disease  
Erectile Dysfunction  
Decreased Interest in Sex

**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? \_\_\_\_\_

Last Bone Density Scan Year \_\_\_\_\_ Where \_\_\_\_\_

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 \_\_\_\_\_ Miscarriages \_\_\_\_\_

Do you perform breast self-examinations? \_\_\_\_\_

Last Mammogram Year \_\_\_\_\_ Where \_\_\_\_\_

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)

Last Colonoscopy Year \_\_\_\_\_ Where \_\_\_\_\_

## Immunizations

## Year

Tetanus \_\_\_\_\_

Hepatitis

## Rubella

## Tuberculosis skin test

Chest x-ray for TB \_\_\_\_\_

## Flu Vaccine

## Pneumonia Vaccine

Zostavax

[illegible]

## 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, 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***  
***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.

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Signature of Patient or Guardian

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Print Patient Name

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Date

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Print Guardian Name

## ***PATIENT RESPONSIBILITIES***

Thank you for choosing us as your primary care providers. 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 they are in effect so that we can provide all of our patients with the best care 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 or insurance changes**, as they can result in a claim denial by your insurance company or being sent to collections. Co-pays, deductibles, lab fees and outstanding balances will be collected prior to your visit with the practitioner. This eliminates 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.** You will need an appointment if you have run out of refills. If you are requesting prescription for other reasons 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***

We provide you with a lab order to take with you to your contracted drawing station and input it directly into the Quest system. 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 practitioner requires you to make an appointment to go over the results.** The staff is not authorized to go over detailed results with you over the telephone. You can also set up your own portal with Quest Diagnostics to view your personal results.

### ***REFERRALS***

If your insurance requires you to obtain referrals for specialist visits, you may be required to see a practitioner here 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 is ready so that you may pick it up.

### ***FORM/ LETTER FEE***

**If you require forms to be filled out for any reason, or a letter written on your behalf, there is a \$40.00 fee to do so.** This is not billable to your insurance. An appointment is also required, so the doctor can complete them correctly and in accordance with your wishes.

### ***PRIOR AUTHORIZATIONS***

If a medication we prescribe for you requires prior authorization from your insurance company, you must have an appointment with us within 30 days prior to ensure your record is up to date. **If the authorization is denied and an appeal is needed, there is a fee of \$30.00.** This is not billable to your insurance. Please allow 7 days for the authorization to be completed before the medication is needed.

### ***SELF-PAY RATES***

If we do not take your insurance, you are responsible for the following self-pay fees:

**Appointment (in office or telemedicine): \$150.00    EKG: \$60.00**

### ***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 24 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 \$50.00 No Show Fee,** which will be collected prior to any future appointments. This is not billable to your insurance.

### ***COLLECTIONS***

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

### ***AFTER HOURS CALLS***

After-Hours calls are for **Medical Emergencies** only. For Refills, Referrals or Questions you must call the office during normal business hours. Your call will not be returned if you leave a message on the emergency line for a non-urgent issue. **You will be charged an after-hours fee of \$50.00 if you choose to have a practitioner paged, as well as your normal copay/deductible.** This is not billable to your insurance.

### ***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 payment of that service. It is Your Responsibility to know your benefits.

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Printed Name

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Patient Signature

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Date

**BRIDGET SILVA, MD, PA**

**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*