SFH

FAMILY PRACTICE SPECIALIZING IN GERIATRICS

Patient: _____

Date : _____

PATIENT DEMOGRAPHICS

First Name: _____ Last Name: _____

MI: _____ DOB: _____ SSN: _____ Gender: ◯ Male ◯ Female

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Employer: _____ Occupation: _____

Address: _____ City/St/Zip: _____

Spouse/Parent's Name: (If patient is a minor) _____

Referred by whom: _____

Emergency Contact: _____

Relation to Patient: _____ Phone: ( ) _____

INSURANCE INFORMATION

Please Provide Insurance Card(s) and Photo ID to the Receptionist

◯ No Insurance

◯ Primary Insurance

Policy Holder Name: (If different than patient) _____

Name of Insurance Company: _____ Group: _____

Member ID: _____

◯ Secondary Insurance

Name of Insurance Company: _____ Group: _____

Member ID:

Relationship to policy holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other_____

I certify the above information is correct. I authorize Antonio A. Flores M.D., P.A. to release or request medical information necessary to process health insurance claims. I authorize assignment of benefits on my medical insurance claims to Antonio A. Flores M.D., P.A. I understand that I will be responsible for payment at the time of services are rendered. I will be responsible for any deductible and/or coinsurance or copays due. Antonio A. Flores M.D., P.A. can provide itemized receipts upon request.

Patient Signature: _____ Date: _____

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Acknowledgement of Receipt of the Notice of Privacy Practice

Your name and signature on this document indicate that you have been given the opportunity to review and request a copy of the Notice of Privacy Practices for The Medical Office of Antonio A. Flores, M.D. P.A. on the date indicated. Additionally, you consent to the use and disclosure of your medical information as set forth in the Notice of Privacy Practice except as expressly stated below. If you have any questions regarding our medical office's Notice of Privacy Practices, please do not

May we release your health information to family member(s) or any other individual or care giver(s)?

( ) Yes **( ) No**

If yes, please list name and relationship below:

Name:	Relationship:
_____	_____
_____	_____
_____	_____

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____ _____

Patient Name Patient's Date of Birth

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient

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MEDICAL INFORMATION

Is this a Work-Related Injury ( ) Yes ( ) No

Is this related to an auto accident? ( ) Yes ( ) No

If Yes, see the receptionist BEFORE your appointment

What are you being seen for today?

_____

MEDICAL HISTORY

PLEASE COMPLETE TO THE BEST OF YOUR ABILITY

Patient Name: _____ DOB: _____

CONFIDENTIAL RECORD: Information contained here will not be released except when you have authorized us to do so.

Please state briefly the problems that have brought you to the doctor's office today:

_____

PERSONAL INFORMATION

Marital Status: ( ) Married ( ) Single ( ) Widowed ( ) Divorced

Children: ( ) Yes ( ) No If yes, how many? _____

Any problems with their health and if so, who and what?

_____

Smoking: ( ) Yes ( ) No If yes, how many packs per day? _____ For how long?_____

Alcohol: ( ) Yes ( ) No If yes, how much? _____ How frequently?_____

Illicit or Frequent Drug Use: ( ) Yes ( ) No If yes, ( ) Ongoing ( ) Past Use

Which Substance(s): _____

Do you have any of these conditions or any other problems that you want the doctor to know about?

( ) Problems with Vision
( ) Problems w/ chewing or swallowing
( ) Short of breath; asthma/emphysema
( ) Swelling of feet or hands
( ) Mitral Valve
( ) Problems with hearing
( ) Heart Murmur
( ) Urinating at night
( ) Heart beating fast
( ) Elevated Cholesterol
( ) Hemorrhoids
( ) Chest Pains
( ) Heart skipping beats
( ) Pain when Urinating
( ) Migraines

( ) Other: _____

Patient Name: _____ DOB:_____

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Patient's Surgical History

Surgeries:	*Date:*
( ) Tonsils	_____
( ) Hernia	_____
( ) Adenoids	_____
( ) Knee Replacement	_____
( ) Vein Stripping	_____
( ) Hip Replacement	_____
( ) Urinary Bladder	_____
( ) Lungs	_____
( ) Stomach or Intestines	_____
( ) Hemorrhoids	_____
( ) Heart	_____
( ) Broken Bones	_____
( ) Gallbladder	_____
( ) Hysterectomy	_____
( ) C-Section	_____
( ) Ovaries	_____
( ) Tubal Ligation	_____
( ) Colonoscopy	_____
( ) Appendix	_____

Past Medical

(Have you had any of the following? If so, please include the date)

( ) Pneumonia	_____	( ) Lung Disease	_____	( ) Hypertension	_____
( ) Chest Pain	_____	( ) Acid Reflux	_____	( ) Diabetes	_____
( ) Stroke	_____	( ) Hyperthyroidism	_____	( ) Kidney Disease	_____
( ) Cancer	_____	( ) Gout	_____	( ) Migraines	_____
( ) Peptic Ulcer	_____	( ) Liver Disease	_____	( ) Hepatitis	_____
( ) Jaundice	_____	( ) Diverticulitis	_____	( ) Irritable Bowel Syndrome	_____
( ) Colon Polyps	_____	( ) Hypothyroidism	_____	( ) Inflammatory Bowel Disease	_____

Family History

(Please check those that apply and identify date & which family member)

(F) Father, (M) Mother, (B) Brother, (S) Sister, (MAT GF) Maternal Grandfather, (PAT GF) Paternal Grandfather, (MAT GM) Maternal Grandmother, (PAT GM) Paternal Grandmother

( ) Hypertension	_____	( ) Leukemia	_____	( ) Diabetes	_____
( ) Renal Disease	_____	( ) Heart Attack	_____	( ) Arthritis	_____
( ) Cancer	_____	( ) Goiter	_____	( ) Lung Disease	_____
( ) Heart Disease	_____	( ) Hepatitis	_____	( ) Gallstones	_____
( ) Thyroid Disease	_____	( ) Stroke	_____	( ) Liver Disease	_____

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FAMILY PRACTICE SPECIALIZING IN GERIATRICS

continued...

( ) Tuberculosis
( ) Epilepsy
( ) Colon Polyps
( ) Migraines
( ) Emphysema
( ) Ulcerative Colitis
( ) Peptic Ulcer Disease
( ) Inflammatory Bowel
( ) Irritable Bowel Syndrome
( ) Gout
( ) Chrons Disease
( ) Other:
_____
_____

Patient Name: _____ DOB: _____

Current Immunizations

( ) TD/Tdap _____
( ) HEP B _____
( ) HEP A _____
( ) MMR _____
( ) HPV _____
( ) Meningitis _____
( ) Pneumonia _____
( ) Chicken Pox _____
( ) Flu _____
( ) Shingles _____
( ) RSV _____
( ) Covid _____

Medications

(List all medications you are currently taking, including over the counter and prescriptions and dosage)

_____

_____

_____

Allergies

Are you allergic to any medications? ( ) YES ( ) NO

If yes, please list: _____

Other non-medication allergies? ( ) YES ( ) NO

If yes, please list: _____

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FAMILY PRACTICE SPECIALIZING IN GERIATRICS

Patient Office Policy Acknowledgement Form

I have read and understand the Patient Office Policies of Antonio A. Flores, M.D., P.A. By signing below I acknowledge receipt and communication of these policies with me and have been made aware that failure to comply with the Patient Office Policies may result in my termination as a patient for Antonio A. Flores, M.D. P.A. and associated medical providers. I understand that Antonio A. Flores, M.D. P.A. reserves the right to modify the Patient Office Policies as necessary and I reserve the right to request a printed copy of the Patient Office Policies.

_____ _____

Patient/Legal Guardian Name (Print) Patient's Date of Birth

_____ _____

Patient/Legal Guardian Signature Date

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FAMILY PRACTICE SPECIALIZING IN GERIATRICS

Physician Assistant / Nurse Practitioner Consent for Treatment

This facility has a physician assistant (Dennis Krueger, Jr.) on staff and three Nurse Practitioners (Bobbi Thomas, Celia Rosales, and Kirsten Adams) to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

“Supervision” does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical service provided.

A physician assistant may provide medical services that are within his/her education, training, and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation of a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting with surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above and understand that, from time to time, I may be asked to see a physician assistant but will not be required to do so. I understand that, at any time, I can refuse to see the physician assistant and request to see a physician. However, I understand that if I elect NOT to see a physician assistant, I will not be able to schedule my appointment until the physician is available.

_____ _____

Patient Name (Print): Date:

_____ _____

Patient Signature: Witness: (If applicable)

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FAMILY PRACTICE SPECIALIZING IN GERIATRICS

Medication Agreement & Refill Policy

In the course of your treatment you may be prescribed medication by our medical providers. Medications allow our providers to improve your health, but serious side effects may arise if certain of these medications are not managed properly. Our first priority is your health and safety. To this end, our medical providers have established guidelines and policies for your safety. **Our medical providers reserve the right to contact your other treating physicians and pharmacies regarding your healthcare, including medication. Below are the aforementioned policies and guidelines:**

1. I understand that medication refills will only be available during regular office hours. Prescription refills require a 48 hour notice, so we ask that you do not wit until you have run out of your medication before you contact our office.
2. I understand that medication refills WILL NOT be made after hours, on the weekends, or on holidays.
3. I understand that my medical providers have the right to refill or NOT refill medications prescribed to me by another medical provider.
4. I agree to provide detailed information about my medication when I request medication refills (I.E. medication name, dosage, name of pharmacy, etc.)
5. I understand that I may not be prescribed narcotic or habit forming medication at my first visit.
6. I agree to follow the dosing schedule as prescribed to me by my medical provider.
7. I agree to NEVER share medications prescribed to me as a patient with any other person.
8. I agree to NEVER sell, exchange or trade my medications for any reason.
9. I understand that the safeguard and safekeeping of my medications is my responsibility. My medical provider will not be obligated or required to replace LOST OR STOLEN prescriptions or medications.
10. I agree to contact my medical provider if I experience any adverse effects or dosage problems with my prescription medications.
11. I agree and understand that I will not be allowed to receive narcotic or controlled medication prescriptions from my medical provider if I am also receiving similar medication prescriptions from another medical provider. Only after the express consent or consultation of my medical provider will this be authorized.
12. I understand narcotic or controlled medication prescriptions will NEVER be filled early.
13. I understand and agree to use only one pharmacy for my narcotic or controlled medication prescriptions.
14. I agree to keep on all scheduled appointments and I understand that if I am 15 minutes late or later for my scheduled appointment time, I may have to reschedule.
15. I agree that NO medication will be given for cancelled or no-show appointments.
16. I agree to bring all my prescribed medications or provide an accurate list of current prescribed medications at each office visit.
17. I understand that I should not drive or operate heavy machinery while taking medications that may cause drowsiness or impaired cognitive function.
18. I agree and understand that abusive behavior or harassment toward the staff of Antonio A. Flores, MD PA will not be tolerated or acceptable.
19. I understand that if I forge, copy, or falsify prescriptions I will immediately be fired as a patient from Antonio A. Flores, MD PA.
20. I understand that I will be dismissed as a patient if I violate the policies of this agreement.
21. I understand that Antonio A. Flores, MD PA reserved the right to REQUEST A DRUG SCREEN BY URINE IF I AM PRESCRIBED CONTROLLED SUBSTANCES. If my drug screening tests show positive for un-prescribed substances or negative for medications I have been prescribed, I understand I will be dismissed as a patient from Antonio A. Flores, MD PA.

_____

Patient Signature and Date

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FAMILY PRACTICE SPECIALIZING IN GERIATRICS

Chronic Pain & Narcotics

1. I understand that patients requiring long term pain management, over six (6) months, will require a referral to a pain management specialist. Certain diagnoses may be exempt for this requirement on a case by case basis.
2. I understand that if I am unwilling to see a pain management specialist when referred by my medical provider, I will only be prescribed non-narcotic pain medication.
3. I understand that all patients with chronic pain must undergo testing to determine the source of the pain. Chronic pain without objective findings (positive tests) will not be prescribed narcotics.
4. I understand controlled, scheduled, and triplicate medications do not have refills and all patients who require prescription refills for these medications must be seen by a medical provider for evaluation and documentation of their pain every three (3) months.
5. I understand that I will be required to present photo identification and sign before my triplicate prescriptions will be release to me. Triplicate prescriptions will only be released to the patient with the exception of nursing home residents.
6. I understand that Fibromyalgia will not be treated with narcotic pain medications.
7. I understand patients may be prescribed pain medications for short-term acute injuries (I.E. back sprain.) The prescribed medication will be for temporary use and will NOT be refilled.
8. I understand that scheduled and controlled medications can become highly addictive if abused, misused, or not taken as directed by my medical provider.
9. I understand that all patients currently receiving pain medication and who refuse to comply with this agreement and its policies will be weaned off narcotic pain medications.

_____

Patient Signature and Date

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FAMILY PRACTICE SPECIALIZING IN GERIATRICS

Acknowledge of Receipt of the Medication Agreement and Refill Policy

By signing this acknowledgement, I confirm that I have read, understood, and accepted all of the policies and sections in the Medication Agreement and Refill Policy. I agree to comply with the policies of this agreement and understand that failure to comply with this agreement may result in my dismissal as a patient of Antonio A. Flores, M.D. P.A.

Please note that medication will not be prescribed without the acceptance of this agreement.

_____ _____

Patient Name: (Print) Date:

_____ _____

Patient Signature: Guardian: (If applicable)

Authorization to Access Historical Prescription Information

I hereby authorize the medical providers of Antonio A. Flores, M.D. P.A. to access my historical prescription drug information.

_____ _____

Patient Signature: Date:

_____

Guardian Signature: (If applicable)