



**ASSOCIATED  
FAMILY  
PHYSICIANS**  
OF BOCA RATON, P.L.

MARILYN B. CABRAL  
Administrator

**MEDICAL STAFF**

LYNDA ALTMAN, M.D., F.A.A.F.P.  
Board Certified in Family Medicine

OWEN A. BARRUW, M.D., F.A.C.P.  
Board Certified in Internal Medicine

DUSHYANT J. UTAMSINGH, M.D., PA.  
Board Certified in Internal Medicine

RADHIKA PHADKE, M.D., Ph.D.  
Board Certified in Endocrinology

Date: \_\_\_\_\_

Patient's Name : \_\_\_\_\_ Marital Status : \_\_\_\_\_

Address : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_ Age : \_\_\_\_\_ Sex : M F

State: \_\_\_\_\_ Zip Code : \_\_\_\_\_ -- \_\_\_\_\_

**Race:**  Caucasian  Black  Hispanic  Asian  Native American  Asian Pacific American  
 Pacific Islander  Subcontinent Asian American  American Indian or Alaskan Native  
 Native Hawaiian  Black Non-Hispanic  White Non-Hispanic  
 Other Race or Ethnicity

**Ethnicity:**  Latino / Hispanic  Other  Not Reported / Refused

Home Phone : ( ) \_\_\_\_\_ -- \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ -- \_\_\_\_\_

Referred By : \_\_\_\_\_ Employed : Y / N Student : Y / N Retired: Y / N

Drivers License \_\_\_\_\_ Employer: \_\_\_\_\_  
(Please give drivers license to receptionist)

Address: \_\_\_\_\_

Other Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
(if applicable)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ -- \_\_\_\_\_

**PRIMARY INSURANCE**

INSURANCE COMPANY NAME: \_\_\_\_\_

Please Present Card To Receptionist

Below information is relating to **subscriber** (insured, not necessarily patient):

CHECK BOX IF SAME AS ABOVE

Relationship to subscriber: \_\_\_\_\_ self \_\_\_\_\_ spouse \_\_\_\_\_ child \_\_\_\_\_ other (pls. explain)

NAME OF SUBSCRIBER: \_\_\_\_\_

DATE OF BIRTH : \_\_\_\_\_

SUBSCRIBER'S ADDRESS: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

SUBSCRIBER'S EMPLOYER : \_\_\_\_\_

EMPLOYER'S ADDRESS: CHECK BOX IF SAME AS ABOVE

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_



**ASSOCIATED  
FAMILY  
PHYSICIANS**  
OF BOCA RATON, P.L.

MARILYN B. CABRAL  
Administrator

MEDICAL STAFF

LYNDA ALTMAN, M.D., F.A.A.F.P.  
Board Certified in Family Medicine

OWEN A. BARRUW, M.D., F.A.C.P.  
Board Certified in Internal Medicine

DUSHYANT J. UTAMSINGH, M.D., PA.  
Board Certified in Internal Medicine

RADHIKA PHADKE, M.D., Ph.D.  
Board Certified in Endocrinology

Patient's Name : \_\_\_\_\_

**SECONDARY INSURANCE (if applicable)**

INSURANCE COMPANY NAME: \_\_\_\_\_

Please Present Card To Receptionist

Below information is relating to **subscriber** (insured, not necessarily patient):

CHECK BOX IF SAME AS ABOVE

Relationship to subscriber: \_\_\_\_\_ self \_\_\_\_\_ spouse \_\_\_\_\_ child \_\_\_\_\_ other (pls. explain)

NAME OF SUBSCRIBER: \_\_\_\_\_

HOME # ( ) \_\_\_\_\_ -- \_\_\_\_\_ DATE OF BIRTH : \_\_\_\_\_

SUBSCRIBER'S ADDRESS : \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

SUBSCRIBER'S EMPLOYER: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**PLEASE BE CONSIDERATE. FAILURE TO CANCEL AN APPOINTMENT WITHIN 24 HOURS OF APPOINTMENT TIME WILL RESULT IN A \$ 25.00 FEE.**

Do you have a Health Care Surrogate? Y / N If yes please furnish a copy for your medical record.

Do you have a living will? Y / N If yes, please furnish a copy for your medical record. If you would like literature on Advance Directives please ask your Health Care Provider.

Primary Language Spoken: ( ) English ( ) Spanish ( ) French ( ) Other \_\_\_\_\_

Name of an emergency contact: \_\_\_\_\_

Phone number ( ) \_\_\_\_\_ -- \_\_\_\_\_

Relationship \_\_\_\_\_

Payment is required at the time services are rendered.

**LIFETIME AUTHORIZATION**

I, authorize the healthcare providers and staff of Associated Family Physicians of Boca Raton, P.L. to render medical care to me or my minor child that they deem necessary. I guarantee payment of any and all charges for services provided.

SIGNATURE OF PATIENT (authorized person if minor) \_\_\_\_\_ DATE \_\_\_\_\_

Relationship if Minor: \_\_\_\_\_

**VISIT OUR WEBSITE: [www.afpdocs.org](http://www.afpdocs.org)**

Patient Demographic Form master file

9910 SANDALFOOT BLVD., SUITE 1, BOCA RATON, FLORIDA 33428-6692

TELEPHONE (561) 883-3030 • FACSIMILE (561) 852-7611

[www.afpdocs.org](http://www.afpdocs.org)



**ASSOCIATED  
FAMILY  
PHYSICIANS**  
OF BOCA RATON, P.L.

# 2022

Today's date \_\_\_\_\_

**PLEASE LET US KNOW HOW YOU WOULD LIKE CONFIDENTIAL MEDICAL INFORMATION CONVEYED TO YOU?**

MARILYN B. CABRAL  
Administrator

Call home phone (        ) \_\_\_\_\_  
Can we leave medical information on your answering machine /  
voicemail? Yes or NO

**MEDICAL STAFF**

LYNDA ALTMAN, M.D., F.A.A.F.P.  
Board Certified in Family Medicine

Call cell phone (        ) \_\_\_\_\_  
Can we leave medical information on your answering machine /  
voicemail? Yes or NO

OWEN A. BARRUW, M.D., F.A.C.P.  
Board Certified in Internal Medicine

Can we leave medical information with a designated person? Yes or NO  
If yes, please give us the individual's complete name, date of birth and  
relationship:

DUSHYANT J. UTAMSINGH, M.D., PA.  
Board Certified in Internal Medicine

RADHIKA PHADKE, M.D., Ph.D.  
Board Certified in Endocrinology

Name	date of birth	Relationship
------	---------------	--------------

By signing, below I understand this authorization form to release confidential information will remain in effect until I revoke the authorization in writing.

\_\_\_\_\_  
Patient's Name (Guardian if minor)

\_\_\_\_\_  
Patient's Signature (Guardian if minor)                      Date

**LOCAL PHARMACY**

NAME: \_\_\_\_\_ PHONE # (    ) \_\_\_\_\_

**MAIL ORDER PHARMACY**

NAME: \_\_\_\_\_ PHONE # (    ) \_\_\_\_\_

Confidential medical information form.docx



**ASSOCIATED  
FAMILY  
PHYSICIANS**  
OF BOCA RATON, P.L.

**ASSOCIATED FAMILY PHYSICIANS OF BOCA RATON, P.L.**

**Only complete if you are on Medicare or Medicare Advantage**

To Our Valued Patients:

Healthcare fraud and abuse have been identified as a national problem costing taxpayers literally billions of dollars each year. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding Medicare. We strive to achieve the very highest standards of ethics and integrity in performing services for our Medicare patients.

It is our policy to properly determine accurate compensation for our services in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper Medicare expenditures. As a part of this plan, we have implemented a Compliance Program that we believe will help us prevent any Medicare service or billing errors.

Our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. We welcome your input regarding any billing or service problem so that we may remedy the situation promptly.

**MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION  
(SIGNATURE ON FILE)**

\_\_\_\_\_  
NAME OF BENEFICIARY (PATIENT)

\_\_\_\_\_  
MEDICARE NUMBER

"I request that payment of Medicare benefits be paid on my behalf to the Provider of medical services, for services provided to me. I authorize the release of medical information about me to the Health Care Financing Administration and its agents, any information needed to determine benefits payable for these services.

I understand my signature requests that payment be made directly to the Provider of medical services. I authorize the release of medical information necessary to pay the claim. In Medicare assignment cases, I understand that I am responsible for my annual deductible, Co-insurance (20% of the approved amount), and any non-covered services provided to me. All other charges will be adjusted off. I understand the amount of payment I'm responsible for is due at the time services are rendered."

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE

MARILYN B. CABRAL  
Administrator

MEDICAL STAFF

LYNDA ALTMAN, M.D., F.A.A.F.P.  
Board Certified in Family Medicine

OWEN A. BARRUW, M.D., F.A.C.P.  
Board Certified in Internal Medicine

DUSHYANT J. UTAMSINGH, M.D., PA.  
Board Certified in Internal Medicine

RADHIKA PHADKE, M.D., Ph.D.  
Board Certified in Endocrinology



**ASSOCIATED  
FAMILY  
PHYSICIANS**  
OF BOCA RATON, P.L.

**ASSOCIATED FAMILY PHYSICIANS OF BOCA RATON, P.L.**

**LIFETIME AUTHORIZATION**

MARILYN B. CABRAL  
Administrator

**MEDICAL STAFF**

LYNDA ALTMAN, M.D., F.A.A.F.P.  
Board Certified in Family Medicine

OWEN A. BARRUW, M.D., F.A.C.P.  
Board Certified in Internal Medicine

DUSHYANT J. UTAMSINGH, M.D., PA.  
Board Certified in Internal Medicine

RADHIKA PHADKE, M.D., Ph.D.  
Board Certified in Endocrinology

“ I authorize the release of any medical information necessary to process a claim or any insurance related claim made on my behalf. I assign the benefits payable for services to the healthcare provider furnishing the services. I authorize such healthcare provider to submit a claim to my insurance company on my behalf.” I authorize the healthcare provider and staff of Associated Family Physicians of Boca Raton, P.L. to render medical care to me or my minor child that they deem necessary.

A photocopy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
PATIENT'S NAME

X \_\_\_\_\_

PATIENT'S SIGNATURE (authorized person if minor)      DATE

Authorization forms

# ALLERGY PROFILE

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Please check all symptoms that you experience occasionally or more than once a day:

- |   |  |   |   |                                   |
|---|--|---|---|-----------------------------------|
| <input type="checkbox"/> Sneezing         | <input type="checkbox"/> Runny Nose          | <input type="checkbox"/> Postnasal Drip | <input type="checkbox"/> Hives/Rash                       | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Itchy/Watery eyes   | <input type="checkbox"/> Wheezing       | <input type="checkbox"/> Cough                            | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Itching        | <input type="checkbox"/> Swollen lips, tongue, face, etc. |                                   |

Have you tried over the counter allergy medication(s)? (Antihistamines, Decongestants):

Yes  No Which medications have you tried? \_\_\_\_\_

Have you ever been allergy tested?  Yes Date: \_\_\_\_\_  No

## PHYSICIAN USE ONLY

Physician Recommendations:  Allergy Testing  No recommendation

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Allergic Rhinitis Unspecified J30.9 | <input type="checkbox"/> Allergic Conjunctivitis H10.45 | <input type="checkbox"/> Asthma Mild Persistent J45.30     |
| <input type="checkbox"/> Chronic Rhinitis J31.0              | <input type="checkbox"/> Rash R21                       | <input type="checkbox"/> Asthma Mild Intermittent J45.20   |
| <input type="checkbox"/> Urticaria - Idiopathic L50.1        | <input type="checkbox"/> Atopic Dermatitis L20.81       | <input type="checkbox"/> Asthma Moderate Persistent J45.40 |
| <input type="checkbox"/> Urticaria - Allergic L50.0          | <input type="checkbox"/> Angioedema T78.3 A 0 S         | <input type="checkbox"/> Asthma Other J45.998              |
| <input type="checkbox"/> Sinusitis Chronic (NOS) J32.9       | <input type="checkbox"/> Allergic Gastro K52.2          |  |

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Lynda Altman, M.D., F.A.A.F.P. | <input type="checkbox"/> Debra A. Costantino, ANP-BC | <input type="checkbox"/> Gabriela Lopez Botero, PA |
| <input type="checkbox"/> Owen A. Barrow, M.D., F.A.C.P. | <input type="checkbox"/> Tabitha M. Dugal, FNP-C     | <input type="checkbox"/> Other: _____              |
| <input type="checkbox"/> Dushyant J. Utamsingh M.D.     |  |  |
| <input type="checkbox"/> Radhika Phadke, MD             |  |  |

X \_\_\_\_\_

X \_\_\_\_\_

Provider Signature

Documented in Chart