PLEASE COMPLETE THIS SHORT FORM SO WE MAY UPDATE OUR RECORDS (PLEASE PRINT) thank you ***2022***

Today's Date: _____

Name: _____

Date of Birth: _____

Street Address: _____

Apt. / Unit Number: _____

City: _____

State: _____

Zip Code: _____ -- _____

Preferred Phone #: ( ) _____ ---- _____

Home Phone # : ( ) _____ ---- _____

Cell Phone #: ( ) _____ ---- _____

How would you like to be notified of your appointment please circle?

Text Email Phone Call (circle all that apply)

Email for our New Portal Access: _____

_____

Current Insurance Carrier: _____

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.

X _____

SIGNATURE OF PATIENT (authorized person if minor) DATE

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

Today's date _____ **2022**

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

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

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

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:

_____
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

9910 SANDALFOOT BLVD., SUITE 1, BOCA RATON, FLORIDA 33428-6692
TELEPHONE (561) 883-3030 • FACSIMILE (561) 852-7611
www.afpdocs.org

ALLERGY PROFILE

Name: _____ Phone: _____ DOB: _____ Date: _____

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

☐Sneezing ☐Runny Nose ☐Postnasal Drip ☐Hives/Rash ☐Vomiting
☐Headaches ☐ Itchy/Watery eyes ☐ Wheezing ☐ Cough ☐Diarrhea
☐Nasal Congestion ☐Shortness of Breath ☐ Itching ☐ Swollen lips, tongue, face, etc.

Have you tired 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

☐ **Allergic Rhinitis Unspecified** j30.9
☐ **Chronic Rhinitis** j31.0
☐ **Urticaria – Idiopathic** L50.1
☐ **Urticaria – Allergic** L50.0
☐ **Sinusitis Chronic (NOS)** J32.9
☐ **Allergic Conjunctivitis** H10.45
☐ **Rash** R21
☐ **Atopic Dermatitis** L20.81
☐ **Angioedema** T78.3 A D S
☐ **Allergic Gastro** K52.2
☐ **Asthma Mild Persistent** J45.30
☐ **Asthma Mild Intermittent** J45.20
☐ **Asthma Moderate Persistent** J45.40
☐ **Asthma Other** J45.998

☐ Lynda Altman, M.D., F.A.A.F.P
☐ Owen A. Barruw, M.D., F.A.C.P
☐ Dushyant J. Utamsingh M.D.
☐ Radhika Phadke, MD
☐ Debra A. Costantino, ANP-BC
☐ Tabitha M. Dugal, FNP-C
☐ Gabriela Lopez Botero, PA
☐ Other: _____

X _____ X _____

Provider Signature **Documented in Chart**