2022

QUICK UPDATE FORMS

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

TABITHA M. DUGAL, FNP-C
Nurse Practitioner

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 # ( ) _____

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

Name_____ Date_____

Do I Need a Test For PAD?

'eripheral Artery Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain and kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, blood pressure that is difficult to control, or symptoms of stroke. People with PAD are at significantly higher risk of stroke and heart attack. Answers to these questions will help determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Check All Applicable Boxes

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? ☐
2. Do you have a history of cardiovascular disease or diabetes and experience any pain or swelling at rest in your lower legs or feet? ☐
3. Do you have a history of cardiovascular disease or diabetes and experience any leg, foot, or toe pain that often disturbs your sleep? ☐
4. Do you have an ulcer on your thigh, calf, ankle, foot or toe that is slow to heal? ☐
5. Do you have diabetes and unusual hair loss or skin discoloration in your legs? ☐
6. Do your fingers or toes feel numb or cold in response to temperature changes or stress? ☐
7. Have you suffered a severe injury to your leg(s) or feet? ☐
8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? ☐
9. Have you had blockages in your coronary or heart arteries? ☐

Other Comments or Notes: _____

_____

_____

Patient Signature:_____ Date:_____

Note: *Providers are advised that insurance carriers have policies regarding when diagnostic services are considered medically necessary. These policies may vary between carriers and are subject to change at any time. Providers should check coverage requirements with specific insurance plans before testing.*

ASSOCIATED
FAMILY
PHYSICIANS
OF BOCA RATON, P.L.

SPECIMEN DROP OFF

TODAY'S DATE: _____

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT'S PHONE NUMBER: ( ) _____

PLEASE CIRCLE BELOW: PATIENT'S HEALTHCARE PROVIDER:

DR. ALTMAN DR. BARRUW DR. UTAMSINGH DR. PHADKE

TABITHA M. DUGAL, FNP-C GABRIELA LOPEZ BOTERO, PA-C

DID HEALTH CARE PROVIDER ORDER SPECIMEN? YES NO
If no you need to schedule an appointment
PLEASE CIRCLE BELOW

TYPE OF SPECIMEN: URINE STOOL CARDS STOOL SPECIMEN OTHER
(specify) _____

_____

DATE		**STOOL SLIDE # 1**	**NEGATIVE**	**POSITIVE**
DATE		**STOOL SLIDE # 2**	**NEGATIVE**	**POSITIVE**
DATE		**STOOL SLIDE # 3**	**NEGATIVE**	**POSITIVE**

DATE	**URINE**	COLOR	BLOOD	BILIRUBIN	UROBILINOGEN	KETONES
PROTEIN	NITRITE	GLUCOSE	PH	SPECIFIC GRAVITY	LEUKOCYTES	

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**