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 :_____

Age : _____ Sex : M F Date of Birth: _____

Address : _____

Apartment / Suite #: _____

City: _____ State: _____ Zip Code : _____-- _____

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native ☐ not reported Refusal ☐ not reported don't know ☐ not reported not ascertained

Ethnicity: ☐ Latino / Hispanic ☐ Non-Hispanic or Latino ☐ 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)

Other Address (if applicable) : _____

Apartment / Suite #: _____

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: Address : _____

Apartment / Suite #: _____

City: _____ State: _____ Zip Code : _____-- _____

SUBSCRIBER'S EMPLOYER _____

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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: _____

==========

PLEASE BE CONSIDERATE. FAILURE TO CANCEL AN APPOINTMENT WITHIN 24 HOURS OF APPOINTMENT TIME or NO SHOW WILL RESULT IN A $ 50.00 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. If your account is sent to outside collections there will be a 35% collection fee added to your account.

_____
SIGNATURE OF PATIENT (authorized person if minor) DATE

Relationship if Minor: _____

VISIT OUR WEBSITE: www.afpdocs.org
2024 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

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Board Certified in Endocrinology

Today's date _____

2024

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 # ( ) _____

2024 Confidential medical information form.docx

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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 t hat 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 it's 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

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LIFETIME AUTHORIZATION

" 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

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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 ☐ **Allergic Conjunctivitis** H10.45 ☐ **Asthma Mild Persistent** J45.30
☐ **Chronic Rhinitis** J31.0 ☐ **Rash** R21 ☐ **Asthma Mild Intermittent** J45.20
☐ **Urticaria – Idiopathic** L50.1 ☐ **Atopic Dermatitis** L20.81 ☐ **Asthma Moderate Persistent** J45.40
☐ **Urticaria – Allergic** L50.0 ☐ **Angioedema** T78.3 A D S ☐ **Asthma Other** J45.998
☐ **Sinusitis Chronic (NOS)** J32.9 ☐ **Allergic Gastro** K52.2

☐ Lynda Altman, M.D., F.A.A.F.P ☐ Gabriela Lopez Botero, PA ☐ Other: _____
☐ Owen A. Barruw, M.D., F.A.C.P ☐ Samantha L. Burstell, FNP-BC
☐ Dushyant J. Utamsingh M.D. ☐ Sherlyne A. Jean Baptiste, FNP-BC
☐ Radhika Phadke, MD

X_____ X_____

Provider Signature **Documented in Chart**