PLEASE COMPLETE THIS SHORT FORM SO WE MAY UPDATE OUR RECORDS (PLEASE PRINT) thank you *2024*

Today's Date: ____________________

Name: ____

Date of Birth: ____________________________________

Street Address: __________________________________

Apt. / Unit Number: ______________________________

City: ____

State: ____

Zip Code: ____________ -- ______________________

How should we notify you of your appointments please circle ONE?

Text **Email** **Phone Call** **(circle one please)**

Home Phone # : ( ) ________ ---- ________________

Cell Phone #: ( ) ________ ---- ________________

Preferred Email for our Patient Portal Access:

Current Insurance Carrier: ______________________

PLEASE BE CONSIDERATE. FAILURE TO CANCEL AN APPOINTMENT WITHIN 24 HOURS OF APPOINTMENT TIME or NO SHOW WILL RESULT IN A $ 50.00 FEE.

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.

X ____

SIGNATURE OF PATIENT (authorized person if minor) DATE

2024 Updated Demographics form.docx

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

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 # ( ) _____

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 ☐ ***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**