



**REGISTRATION FORM**

Date: \_\_\_\_\_ Chart # \_\_\_\_\_

**(PLEASE PRINT) PATIENT INFORMATION**

<b>Last Name:</b>		<b>Birth date:</b>	<b>Age:</b>	<b>Sex:</b>	<b>Ethnicity:</b> Refuse to report
<b>First:</b>	<b>Middle:</b>	/ /		M F	Latino Non Latino
<b>Race:</b> American Indian or Alaska Native Asian Native Hawaiian or other pacific Islander White Black or African American Hispanic Other Race		<b>Marital status</b> (circle one) Single / Mar / Div / Sep / Widow		<b>Email:</b>	
<b>Street address:</b>		<b>P.O. box:</b>	<b>City:</b>	<b>State:</b>	<b>ZIP Code:</b> <b>Primary Language:</b> English Spanish Other
<b>Home phone:</b> ( ) ( )	<b>Cell phone:</b> ( ) ( )	<b>Occupation:</b>	<b>Employer:</b>		<b>Employer phone no.:</b> ( ) ( )
<b>Chose clinic because/Referred to clinic by:</b> Dr. Insurance Plan Hospital Family Friend Yellow Pages Other					

**INSURANCE INFORMATION**

(Please give your insurance card to the receptionist.)

**Please indicate primary insurance** MEDICARE MEDICAID BCBS UHC CIGNA AETNA HUMANA POLK PLAN SELFPAY

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			\$

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

**IN CASE OF EMERGENCY**

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( ) ( )	( ) ( )

**RELEASE OF MEDICAL INFORMATION CONSENT**

I do not wish that any information regarding my health or results of any kind be released to anyone other than myself or my legal personal representative.

I give permission to Advanced Internal Medicine Care, P.A. to release medical information to the person listed below to regard to appointments, lab results, diagnostic test results, etc. The only exception to this permission is results pertaining to sexually transmitted diseases or HIV as this requires my additional consent.

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

**Authorization to treat/Medication acknowledgment/Pay benefits to physician/Release information/Release medical records**

By signing below, I give full authorization to Dario Cardona, MD, his staff and professional association (Advanced Internal Medicine Care) to treat me for the condition/illness

I also consent all laboratory exams and office procedures they may consider necessary for my treatment. I also agree to read any and all package inserts of any medication prescribed to me and ask all the questions before taking such medications. If any samples are provided to me, I further agree to ask all questions risks and benefits and ask for the package insert and to read in detail before taking these samples. I also agree to comply with the medical recommendations and follow up appointments given to me; failure to do so may affect seriously my health and my life. I also agree if I missed two appointments in a consecutive basis I may be dismissed from the practice for failure to follow up.

I authorize payments directly to Advanced Internal Medicine Care of the medical benefits, if any, otherwise payable to me for their services as described, realizing I am responsible to pay non-covered services and co-payments as required by my insurance. I understand that my co-pay/co-insurance/deductible must be collected before services are rendered.

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

I hereby also authorize Dario Cardona, MD to release any information acquired in the course of my treatment necessary to process insurance claims and to any consulting physician I may be referred to. If my insurance is an HMO or PPO, it is my responsibility to ensure Dario Cardona, MD is listed as my primary care physician.

I permit a copy of this authorization to be used in place of the original. The authorization is in force until it is either canceled or changed by me and so noted in writing. **By signing below, I agree that I have read carefully the above statements and agree with all provisions and authorizations set forth in said statement.**

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

## PATIENT QUESTIONNAIRE

**Pateint's Name:** \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

Do you need help with: Grooming **Y/N** Dressing **Y/N** Toilet Use **Y/N** Housework **Y/N** Shopping **Y/N**  
Prepare meals **Y/N** Feeding **Y/N** Walking **Y/N** Bathing **Y/N** Transferring (in and out of chairs) **Y/N**

Do you need help to walk? **Y/N** If yes, please circle one: Another person; Cane; Walker; Wheel Chair or scooter;  
Prosthetics \_\_\_\_\_

Do you have any hearing impairment? **Y/N** If yes, any hearing aids or device \_\_\_\_\_

Do you have any visual impairment? **Y/N** If yes, please circle: Glasses; Contacts; Cataract; Glaucoma; Macular  
Degeneration; Diabetic Retinopathy; Other \_\_\_\_\_

**Date of last eye exam:** \_\_\_\_\_ **Done By** \_\_\_\_\_

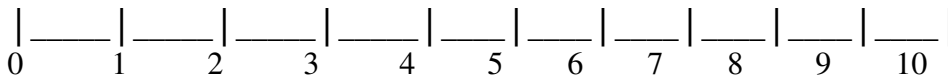
Do you try to stay active on a daily basis? **Y/N**

Do you have chronic pain on a daily basis? **Y/N** If yes, please describe below:

**Location:** \_\_\_\_\_

### CHOOSE A NUMBER FROM 0 TO 10 THAT BEST DESCRIBES YOUR PAIN

**No pain** **Distressing pain** **Unbearable pain**



### CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



<b>0</b>	<b>2</b>	<b>4</b>	<b>6</b>	<b>8</b>	<b>10</b>
NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST

Have you have any falls within the last year? **Y/N** If yes, how many \_\_\_\_\_

Do you have any problems controlling your bladder? **Y/N** If yes, please discuss symptoms with the doctor

Do you have Advanced Directives: Living will **Y/N** Surrogate Decision Letter **Y/N**

If you don't have any advance directives please discuss your options with the doctor

I you are 50 years or older, have you had a colonoscopy done? **Y/N**

If yes, date test done \_\_\_\_\_ Done By \_\_\_\_\_ Result Normal \_\_\_\_ Abnormal \_\_\_\_

I you are a female 40 years or older, have you had a mammogram done? **Y/N**

If yes, date test done \_\_\_\_\_ Done By \_\_\_\_\_ Result Normal \_\_\_\_ Abnormal \_\_\_\_

I you are a female, have you had a pap smear done? **Y/N**

If yes, date test done \_\_\_\_\_ Done By \_\_\_\_\_ Result Normal \_\_\_\_ Abnormal \_\_\_\_

*Advanced Internal Medicine Care*  
**HEALTH HISTORY QUESTIONNAIRE**

All questions contained in this questionnaire are strictly confidential  
 and will become part of your medical record.

Date \_\_\_\_\_

Chart #: \_\_\_\_\_

Name (Last, First, M.I.): _____	<input type="checkbox"/> M <input type="checkbox"/> F	DOB: _____
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**PERSONAL HEALTH HISTORY**

<b>Immunizations and dates:</b> <input type="checkbox"/> Tetanus <input type="checkbox"/> Pneumonia <input type="checkbox"/> Hepatitis <input type="checkbox"/> Influenza	<b>Hospitalization or Surgeries:</b>  	<b>Medical problems that other doctors have diagnosed</b>  
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**PHARMACY**

Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

<b>List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers</b>  	<b>Allergies to medications Please write the name and reaction you had</b>  
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**HEALTH HABITS AND PERSONAL SAFETY**

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Occasional <input type="checkbox"/> Regular		
<b>Caffeine</b>	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day? _____		
<b>Alcohol</b>	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	How many drinks per week? _____		
<b>Tobacco</b>	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Cigarettes – pks./day <input type="checkbox"/> Chew - #/day <input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day		
	<input type="checkbox"/> # of years <input type="checkbox"/> Or year quit		
<b>Drugs</b>	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Personal Safety</b>	Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No    If No, whom do you live with? _____		
	Do you have an Advance Directive or Living Will?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Would you like information on the preparation of these?		<input type="checkbox"/> Yes <input type="checkbox"/> No

**FAMILY HEALTH HISTORY**

	Father	Mother	Grandmother	Grandfather	Sibling	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Diabetes						
Other						

**WOMEN ONLY**

Date of last menstruation: _____ Period every _____ days	Date of last mammogram ____/____/____    Normal Abnormal
Are you pregnant or breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No    No. of pregnancies ____ No. of live births ____	Date of last pap and rectal exam ____/____/____    Normal Abnormal

**MEN ONLY**

Do you usually get up to urinate during the night? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, # of times _____		
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

# *Advanced Internal Medicine Care, P.A.*

## OFFICE POLICIES

Our office verifies all insurances prior to your first appointment. The information obtained from your insurance carrier is not a guarantee of payment. It is only a review of the patient benefits.

### **PAYMENT POLICIES**

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable co-insurance and co-payments. Our office accepts cash, checks, Visa, and MasterCard. There is a service charge for returned checks of \$25.00.

Co-payments are collected at the time of registration. Patient who are unable to pay their copayment will need to reschedule.

Patients with deductibles will be required to pay a deposit of \$120.00 for a first time visit and \$90.00 for each follow up visit until deductible has been met. Payment must be done at check in. Patient credits will be applied to the next visit or refunded if no other appointment is necessary.

Patients with an outstanding balance, please communicate with our billing and collection staff so that they may assist you to create a financial plan. After the second attempt to collect payment your account will be reported to a collection agency.

### **REFILL OF MEDICATIONS**

Medications must be refilled during your doctor's visit. If you call to request a refill of medications please allow us 48 hours to process your request. No refills will be authorized if patient has not been seen by the doctor for more than 3 months. I have been advised, understand and agree that Advanced Internal Medicine Care has the right to do a medication history check from the pharmacies.

### **MEDICAL RECORDS**

Patients requesting copies of their medical records must first sign a release form. The charge is \$1.00 per page for the first 25 pages and \$0.50 cents for each additional page thereafter. Records can be picked up with a photo ID; they cannot be mailed. This is to ensure patient confidentiality.

### **MEDICARE SUPPLEMENT INSURANCE**

We are a participating provider with the Medicare Part B program; and as such we are obligated to write off the difference between what Medicare pays us for the services rendered to you (the "allowed amount") and our usual and customary charge. Medicare pays 80% of the "allowed amount" to us directly. The remaining 20% co-pay and your annual deductibles are the patient's responsibility by federal law.

### **NO-SHOW**

Patients failing to cancel or reschedule an appointment without a 24-hour notice, will be subject to a \$15.00 "FAILED APPOINTMENT FEE"

### **TRAVELERS INSURANCE FOR INTERNATIONAL PATIENTS**

Any international patient who have Canadian health care insurance or traveler's insurance, automatically become self pay patients. It is the patient's responsibility to file their claim with the insurance company.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**A COPY WILL BE KEEP IN YOUR MEDICAL RECORDS**

# Advanced Internal Medicine Care

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

To release healthcare information of the patient named above to:

**Advanced Internal Medicine Care P.A.**  
**5245 US 98 NORTH**  
**LAKELAND FL 33809**  
**Phone (863)644-3585**  
**Fax (863) 644-3171**

### This request and authorization applies to:

Last 3 months consult , Last Labs , Radiology reports , Last Mammogram , Last Papsmear , Last colonoscopy and FOBT

Other healthcare information

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes  No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.**