ANDREW J. SCOMA, M.D., F.A.C.E., P.A.
1925 MIZELL AVE., SUITE 201
WINTER PARK, FLORIDA, 32789

NEW PATIENT INFORMATION SHEET

NAME_____ AGE_____ BIRTHDATE_____

SOCIAL SECURITY NUMBER_____ PHONE(_____)_____

ADDRESS_____CITY_____STATE_____ZIP_____

NAME OF SPOUSE _____

YOUR EMPLOYMENT_____PHONE_____

EMPLOYMENT OF SPOUSE_____PHONE_____

EMERGENCY CONTACT_____ PHONE_____

REFERRED BY_____

PRIMARY CARE DOCTOR:_____

PRIMARY INSURANCE COMPANY:_____

SECONDARY INSURANCE_____

Services are rendered on a cash basis. To facilitate payment, we accept checks, Visa, and MasterCard. We do not submit insurance claims unless you are in a group with which we participate. We file Medicare. ** Please note, **WE DO NOT FILE SECONDARY INSURANCE.** We collect your 20% and any deductible at the time of your arrival. If you have a known medigap insurance, we do not collect from you at the time of the visit. We do provide your secondary information to Medicare so that Medicare can cross it over; however, ultimately you are responsible for the balance if your secondary does not respond within 60 days.

IF YOUR MEDICAL HEALTH PLAN REQUIRES PREAUTHORIZATION FOR ANYTHING, YOU ARE RESPONSIBLE FOR OBTAINING IT.

*** All co-payments are due at the time of your arrival. *** No exceptions. ***

24 hour notice is required if you do not plan to keep your appointment. There is a $25.00 fail to show fee if you do not show up and do not call. Your signature below shows that you understand this office policy.

Your signature gives us your authorization to file your insurance claims if indicated, to receive payment for services rendered, and to release your medical records if requested for processing medical claims. Medical records will only be released as stated on the HIPAA forms that you sign.

Your insurance is a contract between you and your insurance company. You are ultimately responsible for all charges incurred at this office. You will be responsible for charges if the insurance denies the claims or if false insurance information is given.

_____ __ _____

SIGNATURE : States you understand the office policies as written above. **DATE**

Please let us take a copy of your driver's license. It is matched with the insurance cards and then kept in the chart. It helps us to associate your name and face when you call in.

RISK FACTORS / MEDICATION SHEET

NAME _____ CHART NUMBER_____ DATE _____

DO YOU NOW OR HAVE YOU EVER HAD:

1. A STROKE OR MINI-STROKE? (**IF "YES"** WHEN_____) Y____ N____
2. A HEART ATTACK? (**IF "YES"** WHEN_____) Y____ N____
3. HIGH BLOOD PRESSURE (ON MEDICATION)? Y____ N____
4. HIGH CHOLESTEROL (ON MEDICATION)? Y____ N____
5. DIABETES? (**IF "YES"** HOW MANY YEARS _____) Y____ N____
6. SEVERE DIZZINESS? Y____ N____
7. UNEXPLAINED HEADACHE? Y____ N____
8. A SUDDEN LOSS OR "SHADING" OF VISION? Y____ N____
9. SUDDEN MEMORY LOSS OR CONFUSION? Y____ N____
10. SUDDEN LOSS OF SPEECH? Y____ N____
11. WEAKNESS OR NUMBNESS OF FACE/ARMS/LEGS? Y____ N____
12. A CARDIAC EVALUATION, OR CAROTID ULTRASOUND? **(IF "YES")** Y____ N____

    WHEN?_____ WHERE?_____ RESULTS?_____
13. DO YOU OR HAVE YOU SMOKED? **(IF "YES")** Y____ N____

    HOW LONG?_____ PACKS PER DAY?_____
14. PAIN IN LEGS DURING WALKING THAT IS RELIEVED WITH REST? (CLAUDICATION) Y____ N____
15. CONSTANT LEG PAIN? Y____ N____
16. TINGLING/BURNING OR NUMBNESS OF THE FEET OR TOES? Y____ N____
17. POOR WOUND HEALING OR OPEN SORE ON FOOT OR TOES? Y____ N____
18. ARE YOU CURRENTLY TAKING BLOOD THINNERS? Y____ N____
19. HAVE YOU RECENTLY HAD LAB WORK DONE? Y____ N____

    WHEN _____ WHERE _____

Allergies

Are You Allergic To…	No	Yes	Are You Allergic To…	No	Yes	Are You Allergic To…	No	Yes
☐ Penicillin ☐ Sulfa Drugs			Any Foods			☐ Perfumes ☐ Pollens/Grass		
☐ Aspirin ☐ Codeine ☐ Morphine			**Please Explain:**			Any Other Drugs		
☐ Mycins ☐ Other Antibiotics						**Please Explain:**		
☐ Tetanus								

PLEASE LIST ALL YOUR PRESCRIPTION MEDICATIONS:
(Use Back Of Paper If Necessary)

_____

_____

_____

_____

_____

_____

PLEASE LIST ALL YOUR NON- PRESCRIPTION MEDICATIONS:
(Use Back Of Paper If Necessary)

_____

_____

_____

_____

_____

_____

Andrew J. Scoma, M.D., P.A.

Patient Questionnaire

Patient's Name_____Age_____ DOB_____ Sex_____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address_____ Phone Number _____

Occupation_____ Insurance _____ Referred By:_____

Personal History

Have You Ever Had...	No	Yes	Have You Ever Had...	No	Yes	Have You Ever Had...	No	Yes
Diphtheria			STD			Broken Bones		
Pneumonia			Seizures			**What?**		
Pleurisy			Anemia					
Circulation Trouble			Liver Disease / Hepatitis			Blood Disorder		
Heart Disease			Epilepsy			Concussion		
Arthritis			Migraine Headaches			Head Injury		
Stroke			Tuberculosis			Food Poisoning		
Bone Disease			Diabetes			Drug Poisoning		
Joint Disease			High Blood Pressure			Thyroid Disease		
Neuritis			Low Blood Pressure			Adrenal Problems		
Cholesterol			Nervous Breakdown			Testical/Ovary Problems		
Bursitis			Hay Fever			**Please Explain:**		
Sciatica			Asthma					
Kidney Disease			Hives			Fibromyalgia		
Polio			Pituitary Problem			Any Other Diseases		
Meningitis			Frequent ☐Colds ☐Sore Throat			**Please Explain:**		
Cancer **Type:**			Frequent ☐Infections ☐Boils					

Family History

	Father	Mother	Brother					Sister					Children					
			1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	6
Age (If Living)																		
Health (**G =** Good **B =** Bad)																		
Cancer Type:_____																		
Diabetes																		
Heart Trouble																		
High Blood Pressure																		
Stroke																		
Epilepsy																		
Nervous Breakdown																		
Thyroid Disease																		
Kidney Disease																		
Sickle Cell / Leukemia																		
Age (At Death)																		
Cause of Death																		

Surgery – Have You Had Surgery On:

	No	Yes		No	Yes	Have You:	No	Yes	Have You:	No	Yes
Tonsils			Ovaries			Had Hernia Repaired			Been Hospitalized		
Appendix			Thyroid			Other Operations			**Please Explain:**		
Gall Bladder			Prostate			**Please Explain:**					
Uterus			Transfusion								
			When?								

X-Rays

Ever Have X-Rays Of:	No	Yes	Date	Please explain:
Chest				
CT Scans				
MRI				
Ultrasounds				
Other				

NAME _____ CHART NUMBER_____ DATE _____

Systems

Have you Ever Had…	No	Yes
EYE ☐ Disease ☐ Injury ☐ Impaired Sight		
EAR ☐ Disease ☐ Injury ☐ Impaired Hearing		
Any Trouble With ☐ Nose ☐ Sinuses		
Any Trouble With ☐ Mouth ☐ Throat		
Please Explain:		
Fainting Spells		
Dizziness		
Convulsions		
Paralysis		
Headaches ☐ Frequent ☐ Severe		
Thyroid:		
☐ Overactive ☐ Underactive		
Enlarged Thyroid		
Enlarged Goiter		
Other:		
Cough ☐ Frequent ☐ Chronic		
Swelling of: ☐ Hands ☐ Feet ☐ Ankles		
Spitting Up Blood		
Night Sweats		
Shortness of Breath ☐ Exertion ☐ At Night		
☐ Chest Pain ☐ Angina Pectoris		
☐ Palpitations ☐ Fluttering Heart		
Swelling of: ☐ Hands ☐ Feet ☐ Ankles		
Varicose Veins		
☐ Stomach Trouble ☐ Ulcers		
☐ Gas ☐ Belching		

Have you Ever Had…	No	Yes
Appendicitis		
Liver Disease		
Gall Bladder Disease		
Colitis		
Other Bowel Disease		
Hemorrhoids		
Rectal Bleeding		
Constipation		
Diarrhea		
Black Tarry Stools		
Any Changes In Bowel Action ☐ Stools		
Please Explain:		
Kidney ☐ Disease ☐ Stones		
Bladder Disease		
Blood In Urine		
Albumin in Urine		
Difficulty in Urination		
Narrowed Urinary Stream		
Abnormal Thirst		
Prostate Trouble (Men)		
Erectile Dysfunction (Men)		
Change in ☐ Appetite ☐ Eating Habits		
Change in Weight		
Loss ☐ How Much _____lbs.		
Gain ☐ How Much _____lbs.		
Extreme ☐ Tiredness ☐ Weakness		
Skin Disease		

Emotions		
Are You Often…	**No**	**Yes**
Depressed		
Anxious		
Irritable		
Jumpy		
Jittery		
Difficulty Concentrating		
Women Only:		
Menstrual History…		
Age At Onset _____		
Date of Last Period _____		
Are You…	**No**	**Yes**
Regular		
Do You Have…		
☐ Tension ☐ Depression		
☐ Hot Flashes ☐ Pain		
Pregnancies…		
Children Born Alive (# _____)		
Cesarean Sections (# _____)		
Prematures (# _____)		
Still Born (# _____)		
Miscarriages (# _____)		
Any Complications:		

Habits

Do You…	No	Yes
Exercise		
How Often _____		
What Type Of Exercise? _____		
_____		
Awaken Rested		
Sleep Well		
Average 8 Hours Sleep (Per Night)		
Have Regular Bowel Movements		
Sex - Entirely Satisfactory		
Like Your Work (_____ Hours Per Day)		
☐ Work Indoors ☐ Work Outdoors		
Watch Television (_____ Hours Per Day)		
Read (_____ Hours Per Day)		
Have a Vacations (_____ Weeks Per Year)		
Have You Ever Been Treated For Alcoholism		
Have You Ever Been Treated For Drug Abuse		
Recreation: Do You Participate In Sports or Have Hobbies Which Give You Relaxation At Least 3 Hours Per Week.		

Do You Use…	Never	OCC.	FREQ.	Daily
Laxatives				
Vitamins				
Sedatives				
Tranquilizers				
Sleeping Pills, etc.				
Aspirins				
Appetite Depressants				
Coffee / Tea (____Cups Per Day)				
Alcoholic Beverages				
Tobacco: ☐ Chewing Tobacco				
☐ Cigars ☐ Pipe ☐ Snuff				
☐ Cigarettes (_____Packs Per Day)				

Thyroid Medication □ No □ Yes **In The Past?** □No □ Yes

Now On _____

Daily Dose: _____

Have You Ever Taken…

Insulin □ No □ Yes **Tablets For Diabetes** □ No □ Yes

Hormone Shots □ No □ Yes **Hormone Tablets** □ No □ Yes

Immunizations

Have you had…	No	Yes
Flu Shot (If "***YES***" What Year? _____)		
Tetanus Shot (If "***YES***" What Year? _____)		
Shingles Vaccination (If "***YES***" What Year? _____)		

Have you had…	No	Yes
Pneumonia Vaccination (If "***YES***" What Year? _____)		
Hepatitis Vaccination (If "***YES***" What Year? _____)		
Other: (If "***YES***" What Year? _____)		

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by Andrew J. Scoma, M.D., P.A., F.A.C.E. (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient: _____

_____

_____

The Patient agrees that the Practice may disclose the following types of information contained in the Patient's medical records (please initial the appropriate categories listed below):

_____ HIV/AIDS Information

_____ Mental Health Information

_____ Substance Abuse Information

_____ Sexually Transmitted Disease Information

_____ If Patient is under the age of eighteen (18), Pregnancy Information

Patient agrees and consents to the Practice releasing information to Patient in the following alternative manners (please initial the appropriate spaces below):

_____ Via Regular Mail with any envelopes being marked personal and confidential and addressed to Patient.

_____ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient's name, social security number and unique personal identifier).

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date:_____ Time _____ AM/PM

_____
Patient Signature (or Authorized Representative*)

_____
Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient:

_____
_____
_____
_____
_____