RON ARISON.M.D.
FRANCISCO G. BERMUDEZ, M.D.
ALEXANDER G. PARR, M.D.

South Florida Surgical Specialists, LLC

2438 EAST COMMERCIAL BLVD
FT LAUDERDALE. FL 33308

(P) 954-772-6740
(F) 954-772-6703

PLEASE COMPLETE THIS FORM IN ITS ENTIRITY

LAST NAME: _____ **FIRST NAME:** _____

HOME ADDRESS: _____ **APT #:** _____

CITY: _____ **STATE:** _____ **ZIPCODE:** _____

DATE OF BIRTH: _____

PRIMARY PHONE #: _____ **PRIMARY PHONE IS:** **CELL** **LANDLINE** **WORK**

CELL PHONE #: _____ **CELL PHONE CARRIER:** _____

MARITAL STATUS	Married	Single	Divorces	Separated	Window
OCCUPATION					
WORK STATUS	Full time	Part Time	Retired	Not Employed	Self Employed
ETHNICITY	African America	Hispanic	Asian	Native American	White
PREFERRED LANGUAGE	English	Spanish	Creole	Other	
PREFERRED METHOD OF CONTACT	Primary Phone	Email	Text	Postal	
APPT NOTIFICATION	Phone	Email	Text		
EMAIL ADDRESS					
EMERGENCY CONTACT			PHONE NUMBER		
RELATION TO PATIENT					

RESPONSIBLE PERSON FOR CHARGES – IF DIFFERENT FROM PATIENT

LAST NAME			**FIRST NAME**		
DATE OF BIRTH					
RELATION TO PATIENT	SPOUSE	PARTNER	CHILD	PARENT	

PRIMARY CARE MD		**PHONE NUMBER**	
NEPHROLOGIST		**PHONE NUMBER**	
CARDIOLOGIST		**PHONE NUMBER**	
PREFERRED PHARMACY		**PHONE NUMBER**	

We understand filling out forms is a hassle, but ALL the above information is required to register you and by insurance companies in order to bill for our services

MEDICATIONS

INCLUDE PRESCRIPTION, OVER-THE-COUNTER, VITAMINS, MINERALS, HERBALS AND DIETARY SUPPLEMENTS

MEDICATION NAME	DOSAGE	HOW MANY TIME A DAY YOU TAKE	HOW YOU TAKE IT BY MOUTH, INJECTION, UNDER YOUR TONGUE

INITIAL PATIENT VISIT FORM (PLEASE PRINT)

WHY ARE YOU HERE?_____

_____

MEDICAL PROBLEM	
HOSPITALIZATIONS NOT RELATED TO SURGERY (DATES)	
ALLERGIES	
PREVIOUS SURGERIES	

SOCIAL HISTORY

SMOKING	YES	NO	HOW MANY PACKS PER DAY		
IF YOU QUIT – HOW LONG AGO					
ALCOHOL	YES	NO	HOW FREQUENT		
RECREATIONAL DRUGS	YES	NO	TYPE		
COULD YOU BE PREGNANT	YES	NO			
HEPATITIS/CIRRHOSIS	YES	NO			
HIV/AIDS	YES	NO			

FAMILY HISTORY

RELATIVE	**MEDICAL CONDITIONS**	**ALIVE**		**AGE AT TIME OF DEATH**
FATHER		YES	NO	
MOTHER		YES	NO	
BROTHER		YES	NO	
BROTHER		YES	NO	
BROTHER		YES	NO	
SISTER		YES	NO	
SISTER		YES	NO	
SISTER		YES	NO	

Do you take Aspirin, Goody powder, Coumadin, Warfarin, Lovenox, Heparin or any other meds or herbs that may increase your chances of bleeding? **YES NO**

Do you have any blood disorders like hemophilia, sickle cell, protein C or S deficiency, factor V laden deficiency, history of blood clots? **YES NO**

Have you ever had anesthesia? **YES NO** Have you had any problems with anesthesia? **YES NO**

Dear Patient: To the best of your knowledge, please **CIRCLE** all signs, symptoms or medical problems which you may have had or currently have on the following list. Some items, ask specific questions that should be filled out.
Some of the following items on the list you may have never heard off or just can't remember if you ever had them. Only circle those items which clearly pertain to you.

If you have any questions with this form please fill the rest of it out and your surgeon will discuss this form with you.

Constitutional Symptoms	**Respiratory**	**Hematological/Lymphatic**
Weakness	asthma	Anemia
Fever	Snoring	Easy bruising
Change in appetite	Constant cough	Easy bleeding
Unintentional weight loss or weight gain	History of sleep apnea	Swollen glands
What is your usual weight _____	Blood when coughing	Swollen legs or arms
Eyes, Ears, Nose, and Throat	History of pulmonary embolus	Previous blood clot
Hoarseness	Shortness of breath while sleeping	Previous blood transfusion
Eye pain	Shortness of breath at rest	**Neurological**
Blurry vision	Shortness of breath when walking	History of fainting
Glaucoma	**Breast**	History of black outs
Cataracts	Nipple discharge	History of seizure
Vertigo	Breast mass	Tremors
Ear Pain	History of breast cancer	Tingling sensation in arms or legs
Nasal obstruction	When was your last breast exam? ____	**Renal**
Sinus Pain	Last mammogram?	Any type of renal failure
Difficulty swallowing	**Cardiovascular**	Any problems urinating
Tinnitus (ringing of the ears)	Chest pain	Enlarged prostate (BPH)
Do you wear glasses?	Palpitations	Are you on dialysis?
Do you use contact lenses?	Edema (swelling of the legs)	Do you have a fistula, other IV line
Vascular	Atrial fibrillation	History of bladder, prostate, renal cancer
Varicose veins	History of arrhythmia	**Genital (Male)**
Leg pain	Do you have a pacemaker?	History of hernia
Calf pain when walking	High blood pressure or hypertension	Penile discharge
Calf pain at rest	**Endocrine**	Lump in groin
Neck	Any thyroid problem	Testicular mass
History of neck lump	Thyroid cancer	Testicular pain
Swollen glands	Constant excessive thirst	Other genital sores
Neck pain	Frequent urination	**Genital (Female)**
Neck stiffness	History of diabetes	Pregnancies
Integumentary (skin)	Do you use insulin?	Deliveries
Skin bumps or lumps	Heat or cold intolerance	Abortions
History of skin cancer	History of parathyroid problems	Groin lumps or masses
Itching or rash	History of adrenal problems	Genital sores
Color changes	**Gastrointestinal**	Excessive bleeding
Musculoskeletal	History of frequent diarrhea	Discharge
Joint pain	Bloody stool	Age of first menstruation
Arthritis	Hemorrhoids	Age of last menstruation
Muscle pain or frequent cramps	History of frequent constipation	**Psychiatric**
Previous fractures	Noticeable change in the size of stool	Depression
	History of anal, rectal or colon cancer	Schizophrenia
		Bipolar disorder
		Anxiety

This form has been filled out to the best of my knowledge.

_____ _____
Patient's Signature Date

The following form has been reviewed by the surgeon with the patient.

_____ _____
Surgeon's Signature Date

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PATIENT FINANCIAL RESPONSIBILITY

1. It is **MY** responsibility to know and understand my insurance policy. It **IS NOT** the responsibility of the office staff to educate me regarding my policy
2. **I AM** responsible for my copayment (at the time of each visit), deductible and/or coinsurance.
3. If my policy requires me to have a referral/authorization for my office visit, it is **MY** responsibility to obtain the referral/authorization. Failure to obtain the proper referral/authorization will result in **ME** being responsible for the total cost of my visit.
4. A patient whose insurance has an annual deductible and has **NOT** reached their maximum deductible, will be required to pay our insurance reimbursement rate prior to surgery. Failure to pay **MY** deductible prior to surgery WILL result in my procedure being cancelled until payment is received.
5. Once our services have been rendered, we will submit your claim to your insurance company for payment. Your insurance company will process your claim and then notify you and our office as to your responsibility.
6. I will receive a statement indicating **MY** responsibility. For those patients that have paid deductibles will also receive statements if additional monies are due or a refund is due to the patient.
7. Within 60 days of your first billing statement, you will have to complete one of the following options: A)pay my account, B)call the office to set up a payment plan. Failure to comply will result in **MY** account being sent to collections. Once your account has been sent to collections, **NO** further services will be granted until **ALL** past due amounts are paid.
8. I will be charged a $25.00 rebooking fee for any missed appointments. The $25.00 rebooking fee will be paid to the office prior to any further appointments. Rebooking fees are not billable to your insurance company.
9. Multiple missed appointments without a 24 hour notification within a 12 month period will result in termination from our practice.

_____ _____

PATIENT NAME DATE OF BIRTH

_____ _____

SIGNATURE DATE

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HIPPA STATEMENT

The patient hereby consents to the use or disclosure of his/her individually identifiable health information and the patient's medical records information by South Florida Surgical Specialists in order to carry out treatment, payment or health care operations. 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 it notice, the patient may obtain a copy of the revised notice.

The 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 the patient's requested restriction(s), such restriction are then binding on the practice.

The patient acknowledges and agrees that the practice **may disclose** the patient's protected health information and the patient's medical records information to the following individuals who are the patient's family member, legal representative, guardian, health care surrogate or have power of attorney on behalf of the patient:_____

I agree that the practice **may restrict** the disclosure of my medical information to the following person(s)

_____

At all times the patient retains the right to revoke consent which must be submitted to the practice in writing.

The practice may refuse to treat the patient is he/she does not sign this consent form.

MEDICAL RECORDS RELEASE

I hereby authorize the practice to release my medical records for billing purposes, treatment purposes and health care operations.

PRINT NAME: _____

DATE OF BIRTH: _____

SIGNATURE: _____