**Village Internal Medicine and Geriatrics**
13953 NE 86th Terrace, Suite 100
Lady Lake, FL 32159
Phone: (352) 259-0238 Fax: (352) 750-0831

# Confidential Information Patient Registration

Last Name ______________Middle Initial ______ First Name ____________Race ____________

SSN________________ Dominant Hand R / L Birth Date _____________ Sex: Male / Female

Address___________________________________________________________________________

City ____________________________________________ State _________ Zip ______________

Home Phone ______________________ Office _________________ Cell ____________________

Email Address______________________________________________________________________

Marital Status: Married / Single / Divorced / Widowed / Separated

Spouse's Name__________________________ SSN _________________ Birth Date_____________

Person Who Does Not Live With You to contact in case of emergency

Name___________________________Tel.#___________________Relationship_________________

Employer __________________________________________________________ Retired / Full / Part

Prior Physician __________________________ Phone:_______________ Referred By ____________

Primary Insurance Company__________________________________________________ Medicare

Address___________________________________________________________________________

City___________________________________State_______Zip___________ Phone______________

Policy #____________________ Group#___________________ Start Date ____________________

Secondary Insurance Company_________________________________________________________

Address___________________________________________________________________________

City___________________________________State_______Zip___________ Phone______________

Policy #____________________ Group#___________________ Start Date ____________________

**I AUTHORIZE DR. JANE Z. CAI TO EXAMINE AND TO PERFORM SUCH PROCEDURES, AS SHE FEELS IN HER JUDGEMENT ARE REASONABLE AND NECESSARY IN THE DIAGNOSIS AND TREATMENT OF MY CASE. I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULTS OF TREATMENT AND EXAMINATION DONE BY DR. JANE Z. CAI. I AUTHORIZE PAYMENT DIRECTLY TO DR. JANE Z. CAI AND UNDERSTAND I AM RESPONSIBLE FOR ANY BALANCE DUE. I HEARBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR MEDICAL FACILITY TO PROVIDE ALL INFORMATION CONCERNING MEDICAL HISTORY AND TREATMENT TO DR. JANE Z. CAI.**

________________________________________ ______________________________

Patient / Guarantor Signature Today's Date

## Brief Medical History

**Name** ______________________________________________ SSN ____________________

**Past History:** (medical diseases, serious illness or accidents, include dates)

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

**List Past operations**: ___________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

**Childhood Diseases:** Normal ☐ Other (i.e. scarlet fever, rheumatic fever, etc.)

___________________________________________________________________________

___________________________________________________________________________

**Drug allergies or adverse drug reactions:** None ☐ Other__________________________

_______________________________________________________Date _____________

**Check All Below where appropriate**

**Social History:**

Marital Status: Married ☐ Single ☐ Divorced since_____ Widowed since _____

Living Will: Yes ☐ No ☐

Occupation: __________________________________ Retired date ________________

**Tobacco**: None ☐

Currently Smoke ☐ _____ Packs/day for ___ years

Previously Smoked ☐ _____ Packs/day for ___ years Stopped in _______

Chew Tobacco ☐ Cigars/Pipe ☐

**Alcohol:** None ☐ Minimum ☐ Moderate ☐ Heavy ☐

**Or Specify what you drink:** **Wine:** None ☐ 2oz daily ☐ Over 2oz daily ☐

**Beer:** None ☐ 1 daily ☐ 2 daily ☐ Over 4 a day ☐

_______________________________________☐ daily or ☐ weekly

**Caffeine:** None ☐ 1-3 cups ☐ 4-6 cups ☐ More than 6 cups ☐

**Hobbies:** ___________________________________________________________________

Brief Medical History Continued: Name ______________________________________________

**Family History:**

| | Alive | /Deceased | Age | Health Problems |
|---|---|---|---|---|
| Father: | ☐ | ☐ | ____ | ________________________________ |
| Mother | ☐ | ☐ | ____ | ________________________________ |
| Brother/Sisters | ☐ | ☐ | ____ | ________________________________ |
| | ☐ | ☐ | ____ | ________________________________ |
| Son /Daughters | ☐ | ☐ | ____ | ________________________________ |
| | ☐ | ☐ | ____ | ________________________________ |
| | ☐ | ☐ | ____ | ________________________________ |

**Please give the most recent date that you had the following:**

Vaccinations: Flu shot___________ Pneumovax _________ MMR ___________ TD __________

Zostavax____________ Others____________________

Health Maintenance: Colonoscopy _____ Sigmoidoscopy__________ Bone Density___________

Female Patient: Mammogram ___________ PAP SMEAR________________________________

Male Patient: PSA ____________________ Prostate Exam _______________________________

**Please check any symptoms you are having and explain below:**

**General:** Appetite change ☐ Weight change ☐ Fever ☐ Chills ☐

**Head:** Headache ☐ Trauma ☐ Visual Changes ☐ Double vision ☐ Ringing ☐ Hearing loss ☐ Infection ☐ Drainage ☐ Pain ☐

**Nose / Throat:** Nosebleeds ☐ Gum bleeding ☐ Tongue soreness ☐ Sinuses ☐ Difficulty swallowing ☐ Hoarseness ☐

**Lungs:** Shortness of breath ☐ Cough ☐ Wheezing ☐ Coughing up blood ☐

**Heart:** Chest pain ☐ Heart skips ☐ Rapid heart rate ☐ Shortness of breath ☐

**Abdomen:** Pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Black stools ☐ Blood in stool ☐

**GU:** Men - Difficulty urinating ☐ Trouble holding urine ☐ Up at night to urinate ☐ Blood in urine ☐ Discharge from penis ☐

Women - Difficulty urinating, Incontinence ☐ Blood in urine ☐ Abnormal periods ☐

Menopause since_______________ Number of Pregnancies _____________

Number of live Births___________ Number of Miscarriages_____________

**Joints/Muscles:** Pain ☐ Weakness ☐ Joint swelling ☐ Backache ☐

**Neurological:** Dizziness ☐ Loss of consciousness ☐ Seizures ☐ Transient loss of function in arms or legs ☐ Memory loss ☐

**Endocrine:** Chills ☐ Hot flashes ☐ Constipation ☐ Diarrhea ☐ Palpitations ☐

**Skin:** Lesions ☐ Rashes ☐ Nonhealing /Bleeding lesions ☐ Moles ☐

**Other:** ___________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

Brief Medical History Continued Name ______________________________________________

**Please bring All Medications with you (in original bottles) and list them below**

| **Medications** <br> **(Name)** | **Strength** <br> **(MG)** | **How taken** <br> (Once Daily, Twice, Etc.) | **Taken for** <br> (Diabetes, etc.) |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
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## *"Your Health Is Our First Priority"*

**WELCOME** to our office. We consider it a privilege to have this opportunity to serve you. As of November 1, 2002, we have made a change in our financial policy. We would like to take this time to help you understand our policy.

For the insurance plans that we are providers for and that we bill, please provide us with your insurance card for copying. After confirmation of your insurance coverage, you will be expected to meet your deductible, pay your percentage and you will receive a bill for any amount that is not covered by your plan.

For an insurance company that we are not providers, a total payment of the office visit may be expected at the time of appointment. We will gladly assist you to file your insurance company in that case.

If we have not received payment from your insurance company within thirty days from the filing date of any insurance, the balance will become your responsibility.

It is understood there will be a $20.00 service charge for any returned checks. This is above the amount of the check and is to be paid by cash or money order.

It is also understood there will be an additional $20.00 collection charge if we turn the account to a collection agent for any unpaid the balance.

We feel that a firm understanding of the financial involvement is essential for medical benefit before beginning treatment in order to maintain a favorable environment and to assist you, the patient, to plan accordingly.

Payment will be expected at the time of services. Thank you for your understanding in this matter.

____________________________________ ______________________

PATIENT / GUARDIAN SIGNATURE DATE

____________________________________ ______________________

GUARANTOR SIGNATURE DATE

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# AUTHORIZATION TO RELEASE INFORMATION

In an attempt to preserve the confidential nature of the doctor/patient relationship, it is requested that you complete the information listed below regarding appointments and other administrative matters.

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

______________________________________________________________________________
______________________________________________________________________________

Please list the family members or other significant others, if any, whom we may inform about your medical condition only **in the case of an emergency:**

______________________________________________________________________________
______________________________________________________________________________

Please print the address of where you would like your billing statement and/or correspondence from our office to be sent:

______________________________________________________________________________
______________________________________________________________________________

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTTAL."
Yes__________________ No__________________________

Please print the telephone number, if any, where you want to receive calls about your appointments, lab and x-ray results, or other health care information.

Can confidential messages (appointment reminders) be left on your home answering machine or voicemail? ______________________________________________________________________

If you do not have voicemail, can a confidential message be left at your place of employment?
________________________________________________

________________________________________________________________Date: _____________
Patient Signature

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# PATIENT CONSENT FORM

I consent to the use or disclosure of my Protected Health Information (PHI) by Dr. Cai for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of The Villages Internal Medicine and Geriatrics, Inc. I understand that diagnosis or treatment of me by Dr. CAI may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Villages Internal Medicine and Geriatrics, Inc., is not required to agree to the restrictions that I may request, and may request I seek another Internal Medicine Specialist. However, if Dr. Cai accepts the restriction that I may request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that The Villages Internal Medicine and Geriatrics, Inc., has taken action in reliance on this consent.

My protected health information (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Dr. Cai's notice of Privacy Practices prior to signing this document. Notice of HIPAA LAW is on the wall in the Lobby. The notice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations. This notice also describes my rights and the duties with respect to my protected health information by The Villages Internal Medicine and Geriatrics, Inc.

The Villages Internal Medicine and Geriatrics, Inc., reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of private practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

______________________________________________________________________

Signature of Patient or Personal Representative Date

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# Summary Notice of Privacy Practices

Our office is committed to keeping your protected health information (PHI) private without compromising the quality of the medical care we provide for You.

In order to comply with HIPAA regulations you will he given a copy of our entire notice of privacy practices on your first office visit after April 13, 2003.

We can use and disclose your PHI for treatment, payment and health care operations without additional specific authorization from you.

You can sign a form to give us permission to send PHI to others if you have additional specific requests. Our office manager can provide you with the authorization form you need to do this.

You have the right to inspect, receive a copy of; and amend your PHI. You also have the right to request restrictions on the use of your PHI.

You have the right to know when disclosures of your PHI have been made for reasons other than treatment, payment or health care operations.

You have the right to complain about any perceived violations to the privacy regulations to the office manager who is the privacy officer for our practice.

You may also file a concern with the U.S. Department of Health and Human Services.

Please read the copy of the entire Notice of Privacy Practices and let our privacy officer know if you have any questions.