Medical Associates of Brevard Endocrinology
2290 W. Eau Gallie Blvd., Suite 100 Melbourne, FL 32935-3134
Phone: (321-309-9000 Fax: (321) 309-9002

Rajesh K. Desai, M.D. ***Nikhita Dhruv, M.D.*** ***Ervin Szoke, M.D.***

PATIENT INFORMATION

Please PRINT

PATIENT NAME_____ ☐ **MALE** ☐ **FEMALE**
(LAST) (FIRST) (MI) (NICKNAME)

DOB ____/____/_____ **SOCIAL SECURITY #**_____-____-_____ **MARITAL STATUS:** ☐ **Single** ☐ **Married** ☐ **Other**

ADDRESS_____
(STREET) (CITY, STATE) (ZIP CODE)

HOME PHONE (____) _____-_____ **CELL PHONE** (_____) _____-_____ **WORK PHONE** (____) _____-_____

EMAIL ADDRESS_____@_____

PHARMACY NAME_____**LOCATION**_____ **PHONE** (____) ____-_____

EMPLOYER _____ **OCCUPATION**_____

NAME OF SPOUSE OR PARENT _____ **EMERGENCY CONTACT INFORMATION:**

ADDRESS _____ **NAME**_____

_____ **RELATIONSHIP**_____

_____ **PHONE #** (____) _____-_____

REFERRING PHYSICIAN_____**FAMILY PHYSICIAN**_____**PHONE #** (____) _____-_____

INSURANCE INFORMATION – PRIMARY

INSURANCE CO. _____ **POLICY #** _____ **GROUP #**_____
☐ *Please check if the policy holder is the same as the patient*

POLICY HOLDER NAME_____ **DOB** ____/____/_____ **S.S. #** _____-_____-_____

INSURANCE INFORMATION - SECONDARY

INSURANCE CO. _____ **POLICY #** _____ **GROUP #**_____
☐ *Please check if the policy holder is the same as the patient*

POLICY HOLDER NAME_____ **DOB** ____/____/_____ **S.S. #** _____-_____-_____

I understand that I am financially responsible for all charges for services rendered to me, including co-payments, co-insurance, out-of pocket deductibles and non-covered services. I authorize the payments from my insurance company(s) according to my medical benefits be made payable to Medical Associates of Brevard for professional services rendered. I understand that I will receive statements reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered, I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Medical Associates of Brevard as well as to my insurance company(s).

LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is accurate and current.

Signed _____ **Date** _____/_____/_____

New Patient Health History Form
MEDICAL ASSOCIATES OF BREVARD- ENDOCRINOLGY

Acct #: _____ DOB: ____ ____ ____ (dd mm yyyy)

Today's Date: _____ Patient Name _____ (Last First) ☐ Male ☐ Female

Allergies/Reaction _____

Chief Complaint / History of Present Illness

- Location [Where is the pain/problem?
- Severity [How severe is the pain/problem?
- Timing [Does this pain/problem occur at a specific time?]
- Associated signs/symptoms?
- Quality [Example: color of sputum]
- Duration [How long have you had this pain/problem? Or when did it start?
- Context [Where were you at the onset of this pain/problem?
- Modifying factors [What makes the pain/problem worse or better? Any previous episodes?

Medical History

- Patient Medical History

Yes	No	Diabetes
Yes	No	Hypertension
Yes	No	Cancer
Yes	No	Stroke
Yes	No	Heart trouble
Yes	No	Arthritis/gout
Yes	No	Convulsions
Yes	No	Bleeding tendency
Yes	No	Acute infections
Yes	No	Venereal disease
Yes	No	Hereditary defects

Previous hospitalizations/surgeries/serious injuries — When?

_____ _____
_____ _____
_____ _____
_____ _____

Have you ever had blood transfusions? No Yes when and where? _____

Medical Tests [also give date and facility where performed]

Chest X -Ray _____
Cholesterol _____
Colonoscopy _____
Flexible sigmoidoscopy _____
Endoscopy _____
Thyroid Biopsy _____
Thyroid Scan _____
Thyroid Ultrasound _____
EKG/treadmill _____
Mammogram _____
DEXA _____
CT Scan _____
MRI _____

- Patient Social History

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Use of alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Use of tobacco ☐ Never ☐ Previously, but quit How many years? ____ Cigarettes ____ Cigars ____ Pipes ____ Chewing tobacco ____ Snuff ____
Use of drugs ☐ Never Type/frequency _____
Excessive exposure at home or work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Air-borne particles ☐ Noise Occupation _____
Education: ☐ High School/GED ☐ College Degree ☐ Graduate Degree/Professional ☐ Other

- Family Medical History

	Age	Good	Poor	Illnesses	Cause of Death
Father					
Mother					
Sibling					
Sibling					
Sibling					
Sibling					
Other					

- Current Medications

Name	Dosage

MAB
MEDICAL ASSOCIATES OF BREVARD

ENDOCRINOLOGY NEW PATIENT HEALTH HISTORY INFORMATION

Today's Date: _____/ _____/_____ **ACCT #:**_____

Patient Name:_____ **DOB:**_____/ _____/_____ ☐ **Male** ☐ **Female**
Last First MM DD YYYY

Instructions: Place an X next to all that apply ONLY if you have symptoms at present.

General/ Constitutional
_____ Energy Poor
_____ Appetite Poor
_____ Fever, Chills, or Night Sweats
_____ Weight Change
_____ Heat or Cold Intolerance

HEENT/Neck
_____ Eyesight Worsening
_____ Blurred Vision
_____ Double Vision
_____ Eye Pain
_____ Other Visual Symptoms
_____ Deterioration in Hearing
_____ Buzzing in Ears
_____ Nose and Sinus Discharge
_____ Painful or Tender Sinuses
_____ Frequent Congestion
_____ Frequent Nosebleeds
_____ Neck Pain
_____ Neck Lumps or Swelling
_____ Neck Stiffness
_____ Sore Throat
_____ Hoarse Voice
_____ Enlarged Lymph Nodes
_____ Dental Problems
_____ Easy Bleeding of Gums

Respiratory
_____ Cough
_____ Wheezing
_____ Excessive Sputum
_____ Shortness of Breath
_____ Blood in Sputum
_____ Loud Snoring or Problems Breathing While Sleeping
_____ Excessively Tired During the Day
_____ Sleep Apnea

Cardiovascular
_____ Feeling Lightheadedness
_____ Rapid Heartbeat
_____ Passing Out Episodes
_____ Chest Pain
_____ Claudication
_____ Palpitations
_____ Shortness of Breath on Exertion
_____ Swelling of the Ankles

Gastrointestinal
_____ Abdominal Pain
_____ Change in Stool
_____ Constipation
_____ Diarrhea
_____ Difficulty in Swallowing
_____ Pain on Swallowing
_____ Heart Burn
_____ Nausea
_____ Vomiting
_____ Blood in Stools or Other Body Secretions
_____ Early Satiety

Genitourinary
_____ Dysuria or pain in urination
_____ Hematuria
_____ Frequency
_____ Nocturia or Other Symptoms

Musculoskeletal
_____ Back Pain
_____ Joint Pain
_____ Generalized Muscle Aches
_____ Moring Stiffness of Joints

Neurologic
_____ Dizziness
_____ Frequent Headaches
_____ Tingling/Numbness
_____ Weakness
_____ Tremors
_____ Depression or Anxiety
_____ Emotional Problems
_____ Focal Deficits
_____ Loss of Consciousness
_____ Seizures
_____ Weakness or Neuropathy

Skin
_____ Abnormalities of skin, nails, or hair growth
_____ Skin Rash
_____ Easy Bruising Bleeding from Cuts

Male Genital
_____ Difficulty Starting Urination
_____ Weak Stream
_____ Discharge from Penis
_____ Difficulty Obtaining Erection
_____ Painful Testicles
_____ Swelling or Lumps on Testicles
_____ Prostate Trouble

Female Genital
_____ List Age Onset of Menstrual Cycle _____
_____ If Menstruation Has Ceased, List Age at Which It Stopped _____
_____ Menstrual Problems
_____ Take Birth Control
_____ Date of Last Pap/GYN Visit
_____ Hormone Replacement Therapy

Breasts [Male and Female]
_____ Soreness of Breasts
_____ Discharge from Breasts
_____ Recent Enlargement
_____ History of Breast Cancer
_____ Gynecomastia

Ankle/Foot
_____ Foot/Ankle Injury or Fracture
_____ Foot/Ankle Pain
_____ Foot/Toe Deformity
_____ Bunions/Hammer Toes

Special Problems or Symptom

_____

_____

_____

_____

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■ FINANCIAL RESPONSIBILITY ■ CO-PAYS ■ HMO ■ AUTHORIZATION TO PAY PHYSICIAN ■ RELEASE OF INFORMATION ■ RETURNED CHECKS ■ MISSED APPOINTMENTS

I understand that I must provide a legible copy of my current insurance card(s) with claims address and telephone number. The insurance I provided is what I have in effect on this date. I understand that I will be asked to provide my insurance card at each visit. I understand I will be responsible for any and all unpaid balances due to erroneous or incomplete information regarding your insurance information at the time of service.

FINANCIAL RESPONSIBILITY: We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient and he/she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance and will credit any such collections to the patient's account. I understand and agree that regardless of my insurance status, I am financially responsible for the balance of my account. I acknowledge that I am responsible for any deductible, co-pay, or other balance not covered by my insurance carrier. I understand that billing my secondary insurance carrier is a service provided as a courtesy to me and it is my responsibility for all follow up with my insurance carrier.

INSURANCE REQUIREMENTS: You are responsible for knowing the requirements of your insurance plan regarding where you can go for your lab work, diagnostic testing or any referrals to other physicians made by our office. We request that you verify with your insurance carrier before proceeding with any diagnostic testing that the facility where you are scheduled is covered by your plan.

COPAYMENT AND/OR DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. I understand that I will be charged a $25 service fee if my co-pay is not made at the time of service. Please note that insurance is a contract between you and your carrier.

HMO PATIENTS: If you have an HMO plan, you are responsible for making sure that you have a current referral number for each visit. If a current referral number is not received in time for your visit, your choices are: [1] You may reschedule until a referral is received by our office or [2] You may sign a waiver, making you financially responsible for the visit. (*This is the full allowable payment not just your copayment.)*

AUTHORIZATION TO TREAT: I hereby authorize any treatment agreed upon with the physician which may be deemed advisable.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the provider for services, if any, otherwise payable to me for his/her services as described.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the provider to release full details of my medical history for the purposes of healthcare management and/or for processing of all medical claims on my behalf. I hereby authorize the provider to release any information acquired in the course of my treatment necessary to process insurance claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. A photocopy of these assignments shall be valid as the original.

RETURNED CHECKS: Checks returned to us by the bank will be assessed a $35 service charge, in addition to the original amount of the check. You will have 10 days to clear up the outstanding check. We will only accept cash, debit or credit card (Visa/MasterCard) for any future visits.

MISSED APPOINTMENTS: If you need to cancel or reschedule an appointment, we request that you kindly give a 48 hour notice.

I have read and fully understand and agree with the policies contained within for MAB Endocrinology

Signed _____ **Date** _____/_____/_____

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HIPAA RELEASE

I authorize Medical Associates of Brevard to discuss my health care information with:

(Name)	(Relationship)	(Phone #)
(Name)	(Relationship)	(Phone #)

Signed _____ **Date** _____/_____/_____

I authorize Medical Associates of Brevard to leave a detailed message on my answering machine.

Signed _____ **Date** _____/_____/_____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Provider Notice of Privacy Practices for Medical Associates of Brevard. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

_____
Print Name of Patient or Personal Representative

_____
Signature of Patient or Personal Representative **Date**

_____
Signature of Witness **Date**

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Full Name_____ **DOB** _____ **Acct#** _____

is requesting Medical Associates of Brevard Endocrinology *(check one)*

☐ **Release health information TO** ☐ **Obtain health information FROM**

Name:
Address:
Phone:
Fax:

Information to be disclosed relates to service dates beginning _____ **and ending** _____

☐ **Entire medical record**
☐ **Lab Results**
☐ **Test Results (X-ray, U/S, CT, MRI, etc)**
☐ **Billing Information**
☐ **Other:**

The purpose of the disclosure:

☐ **For my own records**	☐ **Change of Doctor**
☐ **Referral to Specialist**	☐ **Insurance**
☐ **Continuing Care**	☐ **Job**
☐ **Legal/Attorney**	☐ **Other**

CONDITIONS and NOTIFICATIONS:

I hereby authorize the use or disclosure of the personal health information as described above. This includes any federal and state protected information under Florida Statute 394.459 (9) psychiatric information, Florida Statute 397.053 and Florida Statute 396.112 Drug and/or Alcohol Abuse information and Florida statute 381.609 Human Immunodeficiency Virus test results [AIDS and related conditions]. This authorization for release of information expires 12 months from the date of signature. You may revoke this authorization at any time by writing to the Office Manager at the address listed above. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with Florida State Statutes. This authorization is being given to Medical Associates of Brevard Endocrinology.

I also understand that pursuant to Florida Administrative Code 64B8-10.003 there may be a charge for reproducing medical records including postage. For the first 25 pages, the cost shall be $1.00 per page. For each page in excess of 25 pages, the cost shall be 25 cents.

Patient Signature: _____ **Date:**_____

FOR OFFICE USE ONLY

Total pages copied: _____ **Cost: $**_____ **Postage: $**_____ **Total Cost: $**_____

Date Paid: _____ ☐ **Cash** ☐ **Check** ☐ **Credit Card** **Receipt #**_____ **Received By:** _____

- ☐ **Mail Records** **Date Mailed:** _____ **Mailed By:** _____
- ☐ **Fax Records** **Date Faxed:** _____ **Faxed By:** _____
- ☐ **Pick Up Records** **Date Picked Up:** _____ **Picked Up By:** _____
- **Photo ID and signature of patient is required. Verified By:** _____ **Date:** _____