Paul G. Preste M.D. and Associates P.A. Today's Date: ____________

PATIENT INFORMATION RECORD

Patient's Legal Name: ________________________________ **Age:** ________

First **M.I.** **Last**

Address: ____

Street **City** **State** **Zip**

Contact #'s – Daytime: ______________ **Evening:** ______________ **Cell:** ______________

Emergency # ______________ **E-Mail Address:** ______________________________

Where do you prefer to receive calls/messages? ☐ **Home Number** ☐ **Work Number** ☐ **Cell**

☐ **In Writing** ☐ **Ok to leave message with detailed info.**

☐ **SMS/Healow** ☐ **Leave message only with no details**

Patients Date of Birth: ______________ **Sex:** ☐ **Male** ☐ **Female** ☐ **Non-Binary**

Marital Status ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **In a relationship**

Religion ______________ **Primary Language** ______________

Ethnicity ______________ **Race** ______________

Referred By: ________________________________

EMERGENCY CONTACT INFO

Contact Name: ______________ **Relationship:** ______________

Cell Number ______________ **Other Number** ______________

Reason for Visit ____

IS PATIENT'S CONDITION RELATED TO: Auto Accident: ☐ **Yes** ☐ **No** **Other Accident:** ☐ **Yes** ☐ **No**

INSURANCE INFORMATION

Patients Legal Name: ______________________ **Today's Date:** __________

Is your insruance a: ☐ **PPO** ☐ **HMO** ☐ **Medicare** ☐ **Medicaid** ☐ **Other:** __________

MEDICARE AND MEDICAID SIGNATURE AUTHORIZATION

Medicare and Medicaid patient certification – patient certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services. I request that this authorization apply to all claims, present and future. I understand that I am responsible for my health insurance deductible and coinsurance. I authorize the Hospital and all of its employees, independent contractors, business associates, agents and/or affiliates of same (collectively "Hospital") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods or otherwise even if I am charged for the call. I expressely consent to such automated calls and with such consent, I specifically waive any objection or claim I may have against the Hospital, for making such calls, including any claim under the Telephone Consumer Protection Act and any similar law and regulations as amended. This consent may not be orally revoked or modified but may be withdrawn at any time in writing.

Today's Date: __________

Print Patient's/Benificiary's Name: ______________________

Patient's/Benificiary's Signature: ______________________

COMMERCIAL INSURANCE, MANAGED CARE MEMBERS AND SECONDARY PAYOR AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claim(s). I request that the payment authorized be made on my behlaf. I assign the benefits payable for the physician services to the office of Paul G. Preste M.D. and Associates P.A. and Edward N. Smolar M.D. P.A. I request that this authorization apply to all insurance claims, present and future. I understand that I am responsible for payment of any balance not paid by my insurance company. I authorize the office and all of its employees, independent contractors, business associate, agents and/or affiliates of same (collectively "office") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods or otherwise even if I am charged for the call. I expressly consent to such automated calls and with such consent, I specifically waive any objection or claim I may have against the office, for making such calls, including any claim under the Telephone Consumer Protection Act and any similar law and regulations as amended. This consent may not be orally revoed or modified but may be withdrawn at any time in writing.

Today's Date: __________

Print Patient's/Insured Name (Parent's signature if a child:) ______________________

Signature of Insured: ______________________

Patient's/Insured Signature: ______________________

PATIENT HISTORY FORM

Patient's Name: ______________________ **Today's Date:** __________

Date of Birth: __________

It is helpful to gather information about your medical history for the physician to use in your examination. Please complete this form completely for the physician's review.

CONSTITUTIONAL SYMPTOMS

- Good general health lately ☐ No ☐ Yes
- Recent weight change ☐ No ☐ Yes
- Fever ☐ No ☐ Yes
- Fatigue ☐ No ☐ Yes
- Exercise regularly ☐ No ☐ Yes
- Eat a balanced diet ☐ No ☐ Yes

EYES

- Eyes disease or injury ☐ No ☐ Yes
- Wear glasses/contact lenses ☐ No ☐ Yes
- Blurred or double vision ☐ No ☐ Yes
- Glaucoma ☐ No ☐ Yes

EARS/NOSE/THROAT

- Hearing loss or ringing ☐ No ☐ Yes
- Earaches or drainage ☐ No ☐ Yes
- Chronic sinus problem problem or rhinitis ☐ No ☐ Yes
- Nose bleeds ☐ No ☐ Yes
- Mouth sores ☐ No ☐ Yes
- Bleeding gums ☐ No ☐ Yes
- Sore throat or voice change ☐ No ☐ Yes

CARDIOVASCULAR

- Heart trouble ☐ No ☐ Yes
- Chest pain or angina pectoris ☐ No ☐ Yes
- Palpitation ☐ No ☐ Yes
- Shortness of breath when walking ☐ No ☐ Yes
- Swelling of feet, ankles or hands ☐ No ☐ Yes
- Murmur ☐ No ☐ Yes
- Miral valve prolaspe ☐ No ☐ Yes

MUSCULKELETAL

- Joint pain ☐ No ☐ Yes
- Joint stiffness or swelling ☐ No ☐ Yes
- Weakness of muscles or joints ☐ No ☐ Yes
- Muscle pain or cramps ☐ No ☐ Yes
- Back pain ☐ No ☐ Yes
- Cold extremities ☐ No ☐ Yes
- Difficult in walking ☐ No ☐ Yes
- Sports injury ☐ No ☐ Yes

INTEGUMENTARY (SKIN,BREAST)

- Rash or itching ☐ No ☐ Yes
- Change in skin color ☐ No ☐ Yes
- Change in hair or nails ☐ No ☐ Yes
- Varicose veins ☐ No ☐ Yes
- Breast pain ☐ No ☐ Yes
- Breast lump ☐ No ☐ Yes
- Breast discharge ☐ No ☐ Yes
- Changing mole ☐ No ☐ Yes

NEUROLOGICAL

- Frequent or recurrent headaches ☐ No ☐ Yes
- Light headed or dizzy ☐ No ☐ Yes
- Convulsions or seizures ☐ No ☐ Yes
- Numbness or tingling sensations ☐ No ☐ Yes
- Tremors ☐ No ☐ Yes
- Paralysis ☐ No ☐ Yes
- Stroke ☐ No ☐ Yes
- Head injury ☐ No ☐ Yes

RESPIRATORY

Chronic or frequent coughs ☐ No ☐ Yes

Spitting up blood ☐ No ☐ Yes

Shortness of breath ☐ No ☐ Yes

Asthma or wheezing ☐ No ☐ Yes

GASTROINTESTINAL

Loss of appetite ☐ No ☐ Yes

Change in bowel movements ☐ No ☐ Yes

Nausea or vomiting ☐ No ☐ Yes

Frequent diarrhea ☐ No ☐ Yes

Constipation ☐ No ☐ Yes

Rectal bleeding or blood in stool ☐ No ☐ Yes

Abdominal pain ☐ No ☐ Yes

Peptic ulcer (stomach or duodenal) ☐ No ☐ Yes

Reflux ☐ No ☐ Yes

GENITOURINARY

Frequent urination ☐ No ☐ Yes

Burning or painful urination ☐ No ☐ Yes

Blood in urine ☐ No ☐ Yes

Incontinence or dribbling ☐ No ☐ Yes

Kidney stones ☐ No ☐ Yes

Sexual difficulty ☐ No ☐ Yes

Pain with periods ☐ No ☐ Yes

Use douche ☐ No ☐ Yes

Irregular periods ☐ No ☐ Yes

Vaginal discharge ☐ No ☐ Yes

Age at the onset of menstruation: ____________

Number of days menstruation lasts: ____________

Date of last menstrual period: ____________

Date before that: ____________

Age at first intercourse: ____________

History of vaginal/pelvic infection ____________

Number of pads or tampons per day: ____________

Menopause started at age of: ____________

Psychiatric

Memory loss or confusion ☐ No ☐ Yes

Nervousness ☐ No ☐ Yes

Depression ☐ No ☐ Yes

Insomnia ☐ No ☐ Yes

Endocrine

Glandular or hormone problems ☐ No ☐ Yes

Thyroid disease ☐ No ☐ Yes

Diabetes ☐ No ☐ Yes

(insulin ☐ non insulin ☐) *please circle one*

Excessive thirst or urination ☐ No ☐ Yes

Heat or cold intolerance ☐ No ☐ Yes

Skin becoming dryer ☐ No ☐ Yes

Change in hat or glove size ☐ No ☐ Yes

Hematology/Lymphatic

Slow to heal after cuts ☐ No ☐ Yes

Bleeding or brusing tendency ☐ No ☐ Yes

Anemia ☐ No ☐ Yes

Phlebitis ☐ No ☐ Yes

Past transfusion ☐ No ☐ Yes

Enlarged glands ☐ No ☐ Yes

Allergic/Immunologic

Allergic to medications ☐ No ☐ Yes

(if yes, please list)

Allergy:	Reaction:

Form of birth control: ________________________________

Pregnancies: List all pregnancies with dates, weights and any problems:

____

____

____

____

Total number of misscarriages: __________

Total number of abortions: __________

Total number of c-sections: __________

PAST MEDICAL HISTORY

Previous hospitalizations: Please list dates/reasons/hospital names:

Date of Admission:	Hospital Name:	Reasons:

Surgeries History

Date of Surgery:	Type of Surgery:	Surgeon/Location Name:

MEDICATIONS:

Local Pharmacy: Please write below your local pharmacy. Make sure to include the name and address, or phone number.

If you use any Specialty Pharmacies, please let the Medical Assistant know when in the room.

List of Medications and Over the Counter Supplements:

Medication Name:	Dosage:	Directions:	Reason for taking Rx:

List of Specialty Doctors: If you currently see or have seen any Specialists in the past, or have any Doctors to get previous records from, please list them below with contact info.

Doctor's Name	Specialty:	Contact Info:

PATIENT SOCIAL HISTORY

Use of alcohol: ☐ None ☐ Socially/Average number of drinks per week ________

Use of tobacco ☐ Never smoked ☐ Previous smoker: When did you quit? ________

Current smoker ☐ How many cigarettes per day? ________ Vape: ☐ No ☐ Yes

Medical Marijuana ☐ No ☐ Yes Recreational Marijuana ☐ No ☐ Yes

Use of drugs ☐ Never ☐ History of drug abuse ☐ Current drug user/Type of drugs ________

History of sexual assault ☐ ________ ☐ Domestic violence ________

FAMILY HISTORY

History of breast cancer in the family ☐ No ☐ Yes

History of colon cancer in the family ☐ No ☐ Yes

Other family history ________

Father: Year Born: ________ Diseases: ________ ☐ Alive ☐ Deceased/Cause of death ________

Mother: Year Born: ________ Diseases: ________ ☐ Alive ☐ Deceased/Cause of death ________

Siblings: Total number of brothers ________ Total number of sisters ________

Children: Total number of boys ________ Total number of girls ________

Other blood relatives: ________

Do you wish to have an assistant present during your exam? ☐ No ☐ Yes

Patient Signature: ________

Today's Date: ________

PREVENTIVE CARE

Women only:

Date of last Pap Smear: ______________

Date of last Mammogram: ______________

Date of last Dexa/Bone Density: ______________

Rectal Cancer Screening:

Date of last Colonoscopy: ______________

Date of last ColoGuard: ______________

Date of last FOBT: ______________

Vaccinations History:

Flu (influenza) Vaccine: ☐ Never had one ☐ Date of last vaccine ______________

Pneumococcal Vaccine: ☐ Never had one ☐ Date of last vaccine ______________

Tetnus Vaccine: ☐ Never had one ☐ Date of last vaccine ______________

DTap Vaccine: ☐ Never had one ☐ Date of last vaccine ______________

Hepatitis A Vaccine: ☐ Never had one ☐ Date of 1st vaccine ______________ Date of 2nd vaccine ______________

Hepatitis B Vaccine: ☐ Never had one ☐ Date of 1st vaccine ______________ Date of 2nd vaccine ______________

HPV Vaccine: ☐ Never had one ☐ Date of last vaccine ______________

Meningococcal Vaccine: ☐ Never had one ☐ Date of 1st vaccine ______________ Date of 2nd vaccine ______________

Shingles/Zoster Vaccine: ☐ Never had one ☐ Date of 1st vaccine ______________ Date of 2nd vaccine ______________

Covid-19 Vaccine: ☐ Never had one

1st Dose Date ______________ Pharmaceutical Name ______________

2nd Dose Date ______________ Pharmaceutical Name ______________

3rd Dose Date ______________ Pharmaceutical Name ______________

4th Dose Date ______________ Pharmaceutical Name ______________

5th Dose Date ______________ Pharmaceutical Name ______________

Jynneos (Monkeypox) Vaccine: ☐ Never had one ☐ Date of 1st vaccine ☐ Date of 2nd vaccine

PATIENT ACKNOWLEDGEMENT

I have been given a copy of the Preste Medical Notice of Privacy Practices, version effective 12/01/2022.

Signature of Patient or Representative: ______________________ **Today's Date:** ______________

Print Name of Patient or Representative: ____

Relationship of Representative to Patient: ____

Test Results may be left on my answering machine: ☐ **Yes** ☐ **No**

When calling my phone, results can also be left with – Name: ______________________________

IN EMERGENCY SITUATIONS ONLY:

PLEASE CHECK ONE BOX:

☐ DO NOT RELEASE ANY OF MY MEDICAL INFORMATION TO A FAMILY MEMBER OR FRIEND.

☐ PLEASE RELEASE MY MEDICAL INFORMATION IF NEEDED TO:

____

Relationship: ______________________________ Contact Number: ____________________

PAUL G. PRESTE M.D. and ASSOCIATES P.A. **USE ONLY**

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the Patient or the Patient's Representative, please explain your efforts to obtain their acknowledgement and the reason you could not obtain it: ____

____

____

24 Hour Cancellation & “No show” Fee Notice

Recognizing that everyone’s time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, the Physician’s of Paul G. Preste M.D. and Associates P.A. reserve the right to charge a fee of **$25.00** for each missed (No Show) appointment, which is, absent for a compelling reason, and is not cancelled within a 24 hour advance notice.

“No Show” fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple “No Shows” in any 12 month period may result in termination from our practice.

Thank you for your anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

______________________________ ____________________

Printed, Last Name, First Name   Date of Birth

______________________________ ____________________

Signature   Today’s Date

ADVANCE MEDICAL DIRECTIVE

Many people have become aware that medicine today has the ability to keep people alive for extended periods of time, even in hopeless situations. For many, this is a great concern and question, how can you be sure this does not happen to you? If you are at least 18 years of age and of sound mind, there is something you can do to make your wishes known. You have the right to execute an Advance Directive/Living Will. An Advance Directive is a witnessed statement, usually written and made in advance of a future event, that states a person's wishes about what life-sustaining treatments would be wanted if he/she became incapacitated and unable to express his/her wishes. There is no legal requirement to complete an Advance Directive. However, if you have not made an Advance Directive or Designated Healthcare Surrogate, healthcare decisions may be made for you by a court appointed guardian, your spouse, adult child, your parent, your adult sibling, an adult relative or a close friend, in that order. This person will be called a proxy.

DO YOU HAVE A LIVING WILL?

☐ **YES** ☐ **NO**

WOULD YOU LIKE TO HAVE A LIVING WILL?

☐ **YES** ☐ **NO**

Patient's Name: ______________________________

Patient's Signature: ______________________________

Today's Date: ______________________________

If you have a Living Will or Advance Directive, or plan to have one in the future, it is your responsibility to provide this office with a copy so that we may abide by your directives.