Paul G. Preste M.D. and Associates P.A.

PATIENT INFORMATION RECORD

Allergies: ________________ **Age:** ________________

Patient's Legal Name: ______________________________ Today's Date: ____________
First M.I. Last

Address: ____
Street City State Zip

Phone #'s – Daytime: ____________ Evening: ____________ Emergency: ____________ Cell: ____________

Where do you prefer to receive calls?: ❑ Home Number ❑ Work Number ❑ Cell Number ❑ In Writing
❑ OK leave message with detailed info ❑ Leave message with call-back number only

Patient's Date of Birth: ____________________ Sex: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Partner Religion: ________ Primary Language: ____________

Ethnicity: ____________________ Race: ____________________

Social Security No.: ________ – ______ – ________ Referred By: ____________________

Email Address: ____

Responsible Party: ______________________________ Telephone: (___)- ____________
First M.I. Last

Address: ____
Street City State Zip

Responsible Party Social Security No.: ________ – ______ – ________ Date of Birth: ____________

Employer: ______________________________ Telephone: (___)- ____________

Address: ____
Street City State Zip

Next of Kin: ____________ Relationship: ________ Telephone: Res:(___)-________ Work:(___)- ________

I. INSURANCE INFORMATION:

Is Your Insurance a: ❑ PPO ❑ HMO ❑ Medicare ❑ Medicaid ❑ Other: ____________________

II. IS PATIENT'S CONDITION RELATED TO:

Employment (Current or Previous): ❑ Yes ❑ No Auto Accident: ❑ Yes ❑ No Other Accident: ❑ Yes ❑ No

PRIMARY

INSURANCE COMPANY NAME: ______________________________

Address: ____
Street City State Zip

Group Number: ____________________ Medicare/Policy Number: ____________________

Name of Insured: ____________________ Insured's Date of Birth: ____________________

Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Student over 18

Other (Please describe): ______________________________

SECONDARY

INSURANCE COMPANY NAME: ______________________________

Address: ____
Street City State Zip

Group Number: ____________________ Medicare/Policy Number: ____________________

Name of Insured: ____________________ Insured's Date of Birth: ____________________

Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Student over 18

Other (Please describe): ______________________________

*** * * * FOR OFFICE USE ONLY * * * ***

Identification Presented: ❑ Passport ❑ Driver's License ❑ State I.D. ❑ Insurance Card

TURN OVER AND COMPLETE

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 expressly 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.v

Date: ______________________________

Print Patient's/Beneficiary's Name: ______________________________

Patient's/Beneficiary's Signature: ______________________________

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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 behalf. I assign the benefits payable for 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 associates, 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 revoked or modified but may be withdrawn at any time in writing.

Date: ______________________________

Print Patient's/Insured's Name (Parent's Signature if child): ______________________________

Signature of Insured: ______________________________

Patient's/Insured's Signature: ______________________________

Paul G. Preste M.D. and Associates P.A

PATIENT HISTORY FORM

Date: ______________

Patient's Name: ______________________________ **Birthdate:** ______________

Reason for Visit: ______________________________

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

- Eye 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 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 with walking ❑ No ❑ Yes
- Swelling of feet, ankles or hands ❑ No ❑ Yes
- Murmur ❑ No ❑ Yes
- Mitral valve prolapse ❑ 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

MUSCULOSKELETAL

- 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
- Difficulty 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 recurring 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

PSYCHIATRIC

- Memory loss or confusion ❑ No ❑ Yes
- Nervousness ❑ No ❑ Yes
- Depression ❑ No ❑ Yes
- Insomnia ❑ No ❑ Yes

ENDOCRINE

- Glandular or hormone problem ❑ No ❑ Yes
- Thyroid disease ❑ No ❑ Yes
- Diabetes ❑ No ❑ Yes

  (Insulin or non insulin – 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

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 PAP smear: ____
Date of last menstrual period: ____
Date before that: ____
Age at first intercourse: ____
Date of last mammogram: ____
History of vaginal/pelvic infection ❑ No ❑ Yes
Number of pads or tampons per day: ____

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts ❑ No ❑ Yes
Bleeding or bruising 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)

FORM OF BIRTH CONTROL: ____

List all pregnancies with dates, weights and problems (Please include miscarriages, terminations and pre-term:

PAST MEDICAL HISTORY

Previous hospitalizations/surgeries/serious injuries: ____

Medications: ____

PATIENT SOCIAL HISTORY

Marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Use of alcohol: ❑ Never Number per week: ____
Use of tobacco: ❑ Never ❑ Previously quit – Date quit: ____ ❑ Current packs per day: ____
Use of drugs: ❑ Never ❑ Type/frequency: ____
History of: ❑ Sexual assault: ____ ❑ Domestic violence: ____

FAMILY MEDICAL HISTORY

	Age	Diseases	If deceased, cause of death
Father:			
Mother:			
Siblings:			
Children:			
Other blood relatives:			

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

Patient Signature: ____

Physician reviewed: ____ **Date:** ____

Paul G. Preste M.D. and Associates P.A.

PATIENT ACKNOWLEDGEMENT

I have been given a copy of the Preste Medical Notice of Privacy Practices, version effective September 23, 2013.

Signature of Patient or Representative: ______________________ 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: ______________________ Phone: __________

* *

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: ______________________

____

____

FORM #3871 Rev-1 10/13

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 Physicians 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 you 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 Date

Paul G. Preste M.D. and Associates P.A.

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 would 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: ______________________________

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.**