

PARADISE FAMILY HEALTHCARE

Kevin Miller, M.D.
Vanessa Hamalian, NP-C

(please print)

PATIENT INFORMATION

Mr. Mrs. Ms. Miss

Patient's Last name: _____ First: _____ Middle: _____ Sing / Mar / Div / Sep / Wid

Legal name (if different) _____ Former name: _____

Date of birth: ____ / ____ / ____ Age: _____ Sex: Male / Female

Street address: _____ Soc Sec #: _____ - _____ - _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Email address: _____ Preferred Method of Contact: Home Ph / Cell / Work Ph
Email / Patient Portal

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address) _____

Relationship to patient: _____ Home #: _____ Cell #: _____

The information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Paradise Family Healthcare or insurance company to release any information required to process my claims.

Patient /Guardian Signature _____ Date _____

MUST PROVIDE PICTURE IDENTIFICATION AND INSURANCE CARD UPON ARRIVAL.

1101 S. Tamiami Trail, Ste 108, Venice FL 34285
www.paradisefamilyhealthcare.net

Phone (941) 488-2332
Fax (941) 894-6230

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name _____ DOB: _____

Previous or referring doctor: _____

Date of last physical exam: _____

Childhood illnesses:

Measles		Mumps	
Rubella		Chicken Pox	
Theumatic Fever		Polio	

Immunizations:

Tetanus		Pneumonia	
Hepatitis		Chickenpox	
Influenza		MMR	

List any problems other doctor's have diagnosed (blood pressure, diabetes, etc): _____

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes / No

List any medications you are currently taking, including prescribed and vitamins:

Name of drug	Strength	Frequency taken

Allergies to medications:

Name of drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise

	Sedentary (no exercise)
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	Regular vigorous exercise (i.e., work or recreation, 4x/week or more for 30 min.)

Diet

Are you dieting? Yes / No

If yes, are you on a physician prescribed medical diet? Yes / No

Number of meals you eat in an average day? _____

Rank salt intake: Hi / Medium / Low

Rank fat intake: Hi / Medium / Low

Caffeine

	None		Tea	
	Coffee		Soda	

Alcohol

Do you drink alcohol? Yes / No

If yes, what kind? _____

How many drink per week? _____

Are you concerned about the amount that you drink? Yes / No

Have you considered stopping? Yes / No

Have you ever experienced blackouts? Yes / No

Are you prone to "binge" drinking? Yes / No

Do you drive after drinking? Yes / No

Tobacco

Do you use tobacco? Yes / No

What type of tobacco (cigarettes, chew, pipe, cigars, electronic)? _____

Number of years? _____

What year did you quit? _____

Drugs

Do you currently use recreational or street drugs? Yes / No

Have you ever given yourself street drugs with a needle? Yes / No

Sex

Are you sexually active? Yes / No

If yes, are you trying for a pregnancy? Yes / No

If not trying for a pregnancy, list contraceptive method. _____

Any discomfort with intercourse? Yes / No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to discuss this issue with your provider? Yes / No

Personal Safety

Do you live alone? Yes / No Do you have frequent falls? Yes / No

Do you have vision or hearing loss? Yes / No

Do you have a Living Will or Advance Directive? Yes / No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? Yes / No

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children		
Mother			M / F		
Siblings			M / F		
M / F			Mat. Grandmother		
M / F			Mat. Grandfather		
M / F			Pat. Grandmother		
M / F			Pat. Grandfather		

MENTAL HEALTH

Is stress a major problem for you?	Yes / No
Do you feel depressed?	Yes / No
Do you panic when stressed?	Yes / No
Do you have problems with your appetite?	Yes / No
Do you cry frequently?	Yes / No
Have you ever attempted suicide?	Yes / No
Have you ever thought about hurting yourself?	Yes / No
Do you have trouble sleeping?	Yes / No
Have you ever been to a counselor?	Yes / No

OTHER PROBLEMS

Do you, or have you had any symptoms in the following areas to a significant degree and briefly explain.

Skin	Throat	Intestinal	Recent changes in: Weight
Head / Neck	Lungs	Bladder	Energy Level
Ears	Chest / Heart	Bowel	Ability to sleep
Nose	Back	Circulation	Other:

WOMEN ONLY

Age at onset of menstruation: _____

Date of last menstruation: _____ Period every _____ days

Heavy periods, irregularity, spotting, pain, or discharge? Yes / No

Number of pregnancies? _____ Number of live births? _____

Are you pregnant or breastfeeding? Yes / No

Have you had a D&C, hysterectomy, or Cesarean? Yes / No

Any urinary tract, bladder, or kidney infections within the last year? Yes / No

Any blood in your urine? Yes / No

Any problems with control of urination? Yes / No

Any hot flashes or sweating at night? Yes / No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? Yes / No

Experienced any recent breast tenderness, lumps, or nipple discharge? Yes / No

Date of last pap and rectal exam? _____

MEN ONLY

Do you usually get up to urinate during the night? Yes / No

If yes, number of times: _____

Do you feel pain or burning with urination? Yes / No

Any blood in your urine? Yes / No

Do you feel burning or discharge from you penis? Yes / No

Has the force of your urination decreased? Yes / No

Have you had any kidney, bladder, or prostate infections within the last 12 months? Yes / No

Do you have problems emptying your bladder completely? Yes / No

Any difficulty with erection or ejaculation? Yes / No

Any testicle pain or swelling? Yes / No

Date of last prostate and rectal exam? _____

Paradise Family Healthcare, Inc.

Kevin Miller, M.D.

Consent for Use of PHI

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Paradise Family Healthcare to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Paradise Family Healthcare describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Paradise Family Healthcare reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Paradise Family Healthcare, Inc., 1101 S. Tamiami Trail, Ste. 108, Venice FL 34285.

With this consent, Paradise Family Healthcare may call my home, or other alternative location, and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including lab test results, among others.

With this consent, Paradise Family Healthcare may mail to my home, or other alternative location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, Paradise Family Healthcare may email to my home, or other alternative location, any items that assist the practice of carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Paradise Family Healthcare restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Paradise Family Healthcare to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Paradise Family Healthcare may decline to provide treatment to me.

Patient Name

Signature of Patient or Legal Guardian

Date

Print Name of Legal Guardian

PARADISE FAMILY HEALTHCARE, INC.

FINANCIAL RESPONSIBILITY FORM

At Paradise Family Healthcare, we strive to give you the best possible care. In order to serve this purpose, it is important that you understand the mechanisms of reimbursement. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is obtained by contacting your insurance carrier. We attempt to verify that your coverage is valid at the time of the visit. However, if your coverage is not in effect at the time of your visit, the financial responsibility for payment is yours. If you have had changes in your insurance coverage – even if there is only a small change in the co-payment amount or a change in the expiration date of the policy – you MUST notify us. Even a small discrepancy on the claim can lead to a denial of payment.

CO-PAYMENTS, CO-INSURANCES AND DEDUCTIBLES

Co-payments and co-insurances are your responsibility. Your insurance company expects us to collect them from you at the time of service. Understand that you will be expected to pay your co-payment for each and every date of service. You are also responsible for your deductibles. The deductible is determined by your individual contract with your insurance carrier. We do not have information about each person's deductible amount or how much of it has or has not been met.

INSURANCE PAYMENTS SENT TO YOU

If insurance payments are sent to you erroneously, you are responsible for forwarding them to our office.

NON-COVERED SERVICES

All patients are responsible if their insurance carrier denies payment for services rendered because they were "non-covered services". These non-covered services may include certain treatment types, blood work, supplies, or equipment, etc. To avoid this, please check with our insurance carrier prior to receiving any treatment.

COLLECTION CHARGES

Payment is due at the time of service. Occasionally, there may be a balance due on your account. In this case the balance will be expected when the statement is received. If you do not pay your balance in a timely manner, then we may send it to a collection agency and you will be liable for both the balance due and the fee that the collection agency charges us to collect your balance. This fee may add up to 50% of your balance.

NO SHOW CHARGES

All appointments must be cancelled or rescheduled with at least a 24 hour notice. If you are more than 10 minutes late, or do not show up for an appointment, there will be a \$50 fee added to your account.

BAD CHECKS

If a check bounces you will be liable for \$25.00 in addition to the fees that the bank charges against Paradise Family Healthcare.

I have read and fully understand this Financial Responsibility Form. I acknowledge my personal financial responsibility and I consent to continue with treatment.

Patient or Guardian Signature

Date

PARADISE FAMILY HEALTHCARE, INC.

KEVIN MILLER, M.D.

1101 S TAMIAMI TRAIL, STE 108

VENICE FL 34285

PH (941) 488-2332 FAX (941) 894-6230

PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient (print) _____

Date of Birth: _____

SSN: _____

Paradise Family Healthcare is authorized to furnish to / receive from:

Recipient/Discloser: _____

Phone: _____

Fax Number: _____

I authorize release of the following medical records:

- I give permission to release all of my medical records including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to potentially sensitive information which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.
- I give permission to release ALL records in the past two years, or if unavailable the most recent office visit, labs, and procedures (including spirometry, radiology, ECGs, etc)
- I give permission to release only records (specifically describe below):

I release Paradise Family Healthcare, Inc. and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Paradise Family Healthcare, Inc. provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization. *This authorization will remain in effect for 1 year from the date of signing.*

Patient Signature

Date

ADVANCED DIRECTIVES

I, _____, ask that my family, my doctors, other healthcare providers, my friends, and all other, follow my wishes as communicated by my Health Care Agent, or as otherwise expressed in this form. This form becomes valid when I am unable to make decisions or speak for myself. I revoke any healthcare advanced directives I have made previously.

The person I want to make health care decisions for me if I can't make them for myself.

If I am no longer able to make my own health care decisions, this form names the person I choose to make those decisions for me. This person will be my Health Care Agent (or other term used by my state, such as proxy, representative, or surrogate). This person will make my health care choices if both of these things happen:

- My attending or treating physician finds that I am no longer able to make health care choices, AND
- Another health care provider agrees that this is true.

If my state has a different way of finding that I am not able to make health care choices, then my state's method should be followed.

The Person I choose as my Health Care Agent Is:

Name

Phone

Address

If this person is unable or unwilling to make these choices for me, OR is divorced or legally separated from me, OR this person has died, then these people are my next choices:

Second Choice Name

Phone

Address

Third Choice Name

Phone

Address

The kind of Medical treatment I want or don't want

Life Support treatment means any medical procedure, device or medication to keep me alive. Life support treatment includes: medical devices to help me breath; food and water supplied by medical devices (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive.

Here is the kind of medical treatment that I want or don't want in the four situations listed:

Close to Death: If my doctor and another health care provider both agree that I am likely to die within a short period of time, and life support treatment would only delay the moment of my death, (choose one of the following):

- I want to have life support treatment.
- I do not want life support treatment. If it has been started, I want it stopped.
- I want to have life support treatment if my doctor believes it could help, but I want my doctor to stop giving me life support treatment if it is not helping my health condition or symptoms.

In a Coma and not Expected to wake up or recover: If my doctor and another health care professional both agree that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life support treatment would only delay the moment of my death (choose one of the following):

- I want to have life support treatment.
- I do not want life support treatment. If it has been started, I want it stopped.
- I want to have life support treatment if my doctor believes it could help, but I want my doctor to stop giving me life support treatment if it is not helping my health condition or symptoms.

Permanent and severe brain damage and not expected to recover: If my doctor and another health care professional both agree that I permanent and severe brain damage and I am not expected to get better, and life support treatment would only delay the moment of my death (choose one of the following):

- I want to have life support treatment.
- I do not want life support treatment. If it has been started, I want it stopped.
- I want to have life support treatment if my doctor believes it could help, but I want my doctor to stop giving me life support treatment if it is not helping my health condition or symptoms.

End Stage Condition: If my doctor and another health care professional agree that my health condition has worsened and I am no longer able to care for myself (choose one of the following):

- I want to have life support treatment.
- I do not want life support treatment. If it has been started, I want it stopped.
- I want to have life support treatment if my doctor believes it could help, but I want my doctor to stop giving me life support treatment if it is not helping my health condition or symptoms.

Printed name: _____

Signature: _____

Phone: _____ Date: _____

Witness Statement (Two Witnesses Needed)

I, the witness, declare that the person who signed or acknowledged this form is person known to me, that he/she signed or acknowledged this Health Care Agent and/or Living Will form in my presence, and that he/she appears to be of sound mind under no duress, fraud or undue influence.

Signature of Witness #1 _____

Printed Name of Witness: _____

Address: _____

Phone: _____ Date: _____

Signature of Witness #2 _____

Printed Name of Witness: _____

Address: _____

Phone: _____ Date: _____

IMPORTANT NOTICE TO MEDICAL PERSONEL:
I have completed my **ADVANCED DIRECTIVES.**

Signature

Please consult this document and/or my Health Care Agent in an emergency. My Agent is:

Name _____

Address _____

Phone _____

My Primary Care Physician Is:

Dr Kevin Miller

1101 S Tamiami Trail, Suite 108

Venice FL 34285

(941) 488-2332

My Advance Directive Document is located at:

