NEW PATIENT WORKERS COMPENSATION INFORMATION

Patient (FULL, LEGAL) Name_____

Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐Married ☐Divorced ☐Widowed

DOB: _____ Last Four Digits of SSN:_____

Patient's Address:_____

Phone number: _____

Employer Name:_____

Preferred Language:_____

Have you ever been in this practice before? ☐Yes ☐No

Marital Status: ☐ Married ☐ Single ☐Widowed ☐ Other_____

Please Circle Race: ☐ Black/African American ☐ American Indian ☐Asian ☐ White
☐Hawaiian/Pacific Island ☐Other

Please circle Ethnicity: Hispanic/Latino ☐ Not Hispanic/Latino ☐

Date of Injury/DOI:_____

Employer Name:_____

Signature: _____ Date: _____

Name: _____ **DOB:** _____

Smoking Status: ☐ Former ☐ Never a smoker ☐ Current smoker, Packs per day_____

Weight_____ **Height**_____

Review of Systems: Do you have any of the problems related to the following symptoms? Check the appropriate box.

	Yes	No		Yes	No
Fatigue	☐	☐	**Abdominal Pain**	☐	☐
Fever	☐	☐	**Black or tarry stool**	☐	☐
Chills	☐	☐	**Bloody stool**	☐	☐
Eyes watering or discharge	☐	☐	**Urinary frequency**	☐	☐
Loss of hearing	☐	☐	**Urinary incontinence**	☐	☐
Nasal passage blockage	☐	☐	**Muscle weakness**	☐	☐
Sore throat	☐	☐	**Easy bruising**	☐	☐
Chest pain or discomfort	☐	☐	**Joint Pain, where**_____	☐	☐
Palpitations	☐	☐	**Dizziness**	☐	☐
Feeling of the feet being cold	☐	☐	**Fainting**	☐	☐
Shortness of breath	☐	☐	**Depression**	☐	☐
Cough	☐	☐	**Skin Lesion**	☐	☐
Coughing up blood	☐	☐	**Numbness in hands/legs/feet**	☐	☐
Nausea	☐	☐	**Tingling in hands/legs/feet**	☐	☐
Vomiting	☐	☐	**Swelling in legs/feet**	☐	☐

Family History: (please select all that apply)

	Father	Mother	Brother	Sister
Breast Cancer				
Ovarian Cancer				
Other Cancer				
Heart Disease				
Stroke				
Hypertension				
Diabetes				
Atherosclerotic Vascular Disease				
Aneurysm				
Other (please specify)				

For nurse, only: BP_____ HR _____ Temp _____ RR _____ Sat _____ Ht _____ Wt _____

Allergies: ☐ None **Latex Allergy:** ☐ Yes ☐ No **DOB:** _____

Medication Allergies Reaction:

_____

Food Allergies: ☐ No ☐ Yes

Dye Allergies: ☐ No ☐ Yes

Shellfish/Iodine Allergies: ☐ No ☐ Yes

Current Medications: ☐ Check here if attaching a home medication list.

Preferred Pharmacy: Name_____ Phone Number: _____

Is this a mail-in pharmacy? ☐ Yes ☐ No

Medication	Dosage	Times per day	Prescribing Doctor

Social History: Occupation: _____ **DOB:** _____

Alcohol: ☐ No ☐ Yes Drinks per day/week: _____

Drug Use or Addiction: ☐ No ☐ Yes Drug(s): _____

Caffeine use: ☐ No ☐ Yes How often? _____

Past Medical History: ☐ No Medical History Check all that apply.

- ☐ Aortic Aneurysm
- ☐ Carotid Artery Stenosis
- ☐ Stroke
- ☐ Peripheral Arterial Disease
- ☐ Varicose Veins
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Intermittent Claudication
- ☐ Atrial Fibrillation
- ☐ Murmur
- ☐ Heart Attack (MI)
- ☐ Venous insufficiency
- ☐ Colitis
- ☐ Constipation
- ☐ Diverticulosis/Diverticulitis
- ☐ Gallbladder disease
- ☐ Esophageal reflux
- ☐ Gastrointestinal Bleeding
- ☐ Hernia: _____
- ☐ Hemorrhoids
- ☐ Irritable Bowel Syndrome
- ☐ Intestinal obstruction
- ☐ Asthma
- ☐ COPD
- ☐ Chronic Kidney Disease
- ☐ Colon polyps
- ☐ Hematuria
- ☐ Kidney stones
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Sleep Apnea
- ☐ Arthritis
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Diabetes Mellitus
- ☐ Neuropathy
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hepatitis
- ☐ HIV
- ☐ Tuberculosis
- ☐ Alzheimer's Disease
- ☐ Chronic Pain
- ☐ Dementia
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ Anemia
- ☐ Coagulation Defects
- ☐ Sickle Cell Disease
- ☐ DVT: _____
- ☐ Pulmonary Embolism
- ☐ Lymphedema
- ☐ Cancer: _____
- ☐ Other: _____

Past Surgical History: ☐ **No Surgical History** ***Please list surgeries and approximate dates.***

- ☐ AAA Repair
- ☐ Angiogram
- ☐ Appendectomy
- ☐ Arthroscopy
- ☐ Graft/Fistula
- ☐ Brain Surgery
- ☐ Breast Biopsy
- ☐ Cataract Removal
- ☐ Cardiac Bypass
- ☐ Gallbladder Removal
- ☐ Heart Catheterization
- ☐ Heart valve replacement
- ☐ Hemorrhoid Surgery
- ☐ Hernia: _____
- ☐ Hysterectomy
- ☐ Transplant: _____
- ☐ Mastectomy [ ] L [ ] R
- ☐ Pacemaker
- ☐ Implanted Defibrillator
- ☐ Prostate Surgery
- ☐ Thyroid Surgery
- ☐ Tonsils/Adenoids
- ☐ Splenectomy
- ☐ Back Surgery
- ☐ Neck Surgery
- ☐ Foot Surgery [ ] L [ ] R
- ☐ Total Hip [ ] L [ ] R
- ☐ Total Knee [ ] L [ ] R
- ☐ Tubal Ligation
- ☐ PD Catheter
- ☐ Amputation:_____
- ☐ Carotid Surgery
- ☐ Leg bypass
- ☐ Stab phlebectomy
- ☐ Ablation [ ] L [ ] R
- ☐ Colon surgery

Other: _____
Other: _____

Patient Signature: _____ **Date:** _____

SURGICAL SPECIALISTS OF SOUTHWEST FLORIDA, P.A.
& SWFL VASCULAR CENTER

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ DOB: _____

☐ I give my permission to **Surgical Specialists of Southwest Florida, P.A.**, to disclose my protected health information to the following family or friends:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OR

☐ I request that all my protected health information be disclosed only to "Me" and no one else other than my other healthcare providers.

May we leave a message on your answering machine/voice message about your medical care? ☐ Yes ☐ No

By signing this form, you are granting consent to Surgical Specialists of Southwest Florida to use and disclose your protected health information for purposes of treatment payment, and health care operations. I authorize the release of my medical records to any physicians to whom I am referred. I understand that I am financially responsible for all charges of services to me, including the balance remaining after payment of possible insurance benefits. I assign the benefits payable for physicians' services to the physician furnishing the services.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at (239) 936-8555. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent. A copy of this form is to be considered valid as an original.

We utilize an automated system to remind you of your next appointment. By signing this you also give us permission to include you in this automated calling system. If you do not wish to be reminded of future appointments, please let the receptionist know this.

Patient Signature: _____ Date: _____

SURGICAL SPECIALISTS OF SOUTHWEST FLORIDA, P.A.
& SWFL VASCULAR CENTER

CONSENT FORM FOR ePrescribe PROGRAM

ePrescribe Program

ePrescribing is way for doctors to send an accurate, error free, and understandable electronic prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

Consent

By signing this consent form, you are agreeing that your provider may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all the above, I hereby provide informed consent to Surgical Specialists of Southwest Florida, PA to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Patient Name Patient DOB

_____ _____

Patient Signature Date

_____

Relationship to Patient