Elizabeth A. Triana, M.D.

3155 Harbor Blvd, Suite 100 Family Practice (941)625-1990
Port Charlotte, FL 33952 Fax (941)625-1991

Patient Information Sheet

Today's Date: _____

Name: _____ Sex: □ Female □ Male

Social Security Number: _____Date of Birth: _____ Age: _____

Local Home Address: _____

City: _____ Zip Code: _____

Local Phone Number: _____Cell Phone Number: _____

Employer's Name: _____

Employer's Address: _____

City: _____ Zip Code: _____

Phone Number: _____

Marital Status: □ Married □ Divorced □ Single □ Widowed

Spouses Name: _____

Name of person to notify in case of emergency: _____

Phone: _____

Insurance (Please provide us with your cards for Photo Copying and Review)

Primary Insurance Company: _____

Supplemental Insurance Company: _____

Consents:
I authorize Dr. Triana's office to bill my insurance carrier or carriers on my behalf and assign payments to Dr. Elizabeth Triana. This is to include commercial insurance carriers and or Medicare Part B and supplemental insurance. I authorize the release of my Medical records to my insurance carriers if requested in order to pay my claims with Dr. Triana. I understand that payment of fees incurred are my responsibility and agree to pay the portion allowed, but not covered by my insurance and further understand that a default of payment may result in my account being sent to a collection agency. Any additional costs to collect payment of this debt will be paid by me (patient/guardian).

Patient's or Guardian's Signature: _____

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Patient Consent For Use and Disclosure of Protected Health Information

With my consent, **Elizabeth A. Triana, M.D. – Family Practice** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Triana's **Notice of Privacy Practices** for a more complete description of such uses and disclosures.

I have the right to review the **Notice of Privacy Practices** prior to signing this consent.

Elizabeth A. Triana, M.D. –Family Practice 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 Dr. Triana at 3155 Harbor Boulevard, Suite 100, Port Charlotte, FL 33952.

With my consent, Dr. Triana and/or her staff may call my home or other designated location and leave a message on voicemail, an answering machine, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, or any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Elizabeth A. Triana, M.D. – Family Practice** may mail to my home or other designated 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.

I have the right to request that **Elizabeth A. Triana, M.D. – Family Practice** restricts how it uses or discloses my PHI to carry out PHO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form I am consenting to this practice's use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations. 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, Dr. Triana may decline to provide treatment to me.

You may release my PHI to : _____
(Family Member)

_____ _____/_____/_____
Signature of Patient or Legal Guardian Date

Print Patients Name: _____

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As required by the Accountability Act of 1996 (HIPPA), this practice may not use or disclose your individually identifiable health information without your authorization except as provided in out Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice, _____
(name of practice/doctor)
to release health information of _____
(print patient name)
Date of Birth: _____ Soc. Sec. #: _____

Other names, maiden name: _____

Information to Release: Consult from date of service _____

OR ___ Entire Medical Record ____ Lab Reports ___ Mammogram
___ X-Ray Report of _____
___ Other _____

Reason for Release: _____
Send Medical Records to:
Name:_____
Address: _____
_____
_____ Phone: _____
Restrictions: I understand that the recipient of this form may not use or disclose this information except the expressed purposes identified above, unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

I understand that the information in my health record may include information relating to sexually transmitted disease, required immunodeficiency syndrome (AIDS), or humane immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Exclusions: (please initial) Drug/Alcohol ___, Mental Health/Psychiatric ___, HIV/AIDS ___, Sexually Transmitted Disease ___, Other ___, description of
other _____

This Authorization is effective this date: _____ through_____

Signature: _____Print Name: _____

I am ___Patient ___Guardian ___Conservator ___Patient's Representative **Date:_____**

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Patient Name: _____ Account No.: _____ DOB: ___/___/____
Initial Visit Form (p.1): Please Provide the following medical information to the best of your ability:
Date : _____ Age: _____ List All Allergies to Medications:

What Problems are you here for today?

_____ _____
_____ _____
_____ _____
_____ _____

Past Medical History: 1.) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses: for "Yes" answers, please explain.

	Yes	No			Yes	No	
Diabetes (Circle: type I / type II)	□	□	_____	**Stomach or Intestinal Probs**	□	□	_____
Hypertension (high blood press)	□	□	_____	**Allergy Problems/Therapy**	□	□	_____
Thyroid Problems	□	□	_____	**Kidney Problems**	□	□	_____
Heart Disease/Cholesterol Probs	□	□	_____	**Neurological Problems**	□	□	_____
Respiratory Problems	□	□	_____	**Cancer**	□	□	_____
Bleeding Disorder	□	□	_____	**Other Medical Diagnosis**	□	□	_____

_____
_____
_____
_____

2.) Please list any operations (and dates) you have ever had (*including tonsils and adenoids*)

_____
_____
_____
_____

3.) Please list current medications (and amounts, times per day) :
(include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC meds including sinus/allergy/weight loss meds)

_____
_____
_____
_____

Social History:	Yes	No	**Please List Details Below**
Do you se tobacco?	□	□	**List Type and How Much:** _____
If no, did you use it previously?	□	□	**List Type and How Much:** _____ **When did you quit?**
Do you drink alcohol?	□	□	**List Type and How Much:** _____
Do you use recreational drugs?	□	□	**List Type and How Much:** _____

What is your occupation?

_____
_____

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses: If yes, please indicate which relative(s) have the problem.

	Yes	No	
Heart problems/murmurs	□	□	_____
Allergy	□	□	_____
Diabetes	□	□	_____
Cancer	□	□	_____
Bleeding disorder	□	□	_____
Anesthesia problems	□	□	_____

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Patient Name: _____ Account No.: _____ DOB: ___/___/____

Outpatient Initial Visit Form (p. 2): Please provide the following medical information to the best of your ability:

Review of Systems:

1.) **Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms**
2.) **For any "Yes" responses, please check the "Current" box if this symptom relates to the reason for your visit today.**

		Yes	No	Current		Yes	No	Current
General	**Chills**	□	□	□	**Weight Loss or Gain**	□	□	□
	Fatigue	□	□	□	**Daytime Sleepiness**	□	□	□
Allergy	**Environmental Allergy**	□	□	□	**Sneezing Fits**	□	□	□
Neuro	**Headache**	□	□	□	**Weakness**	□	□	□
	Passing Out	□	□	□	**Numbness, Tingling**	□	□	□
Eyes	**Eye Pain/Pressure**	□	□	□	**Vision Changes**	□	□	□
	Watery or Itchy Eyes	□	□	□				
ENT	**Hearing Loss**	□	□	□	**Ear Noises**	□	□	□
	Dizziness	□	□	□	**Lightheadedness**	□	□	□
	Nasal Congestion	□	□	□	**Sinus Pressure or Pain**	□	□	□
	Hoarseness	□	□	□	**Problem Snoring, Apnea**	□	□	□
	Throat Clearing	□	□	□	**Throat Pain**	□	□	□
Respi	**Cough**	□	□	□	**Coughing Blood**	□	□	□
	Wheezing	□	□	□	**Shortness of Breath**	□	□	□
Cardiac	**Chest Pain**	□	□	□	**Palpitations**	□	□	□
	Wake Short of Breath	□	□	□	**Ankle Swelling**	□	□	□
GI	**Difficulty Swallowing**	□	□	□	**Heartburn**	□	□	□
	Abdominal Pain	□	□	□	**Nausea/Vomiting**	□	□	□
	Bowel Irregularity	□	□	□	**Rectal Bleeding**	□	□	□
GU	**Frequent Urination**	□	□	□	**Painful Urination**	□	□	□
	Blood in Urine	□	□	□	**Prostate Problems**	□	□	□
Heme/Lym	**Swollen Glands**	□	□	□	**Sweating at Night**	□	□	□
	Bleeding Problems	□	□	□	**Easy Bruising**	□	□	□
Endo	**Feel Warmer than Others**	□	□	□	**Feel Cooler than Others**	□	□	□
MSK	**Joint Aches**	□	□	□	**Muscle Aches**	□	□	□
SKIN	**Rash**	□	□	□	**Hives**	□	□	□
	Itching	□	□	□	**Skin or Hair Changes**	□	□	□
PSYCH	**Depression**	□	□	□	**Anxiety or Panic**	□	□	□

Please Stop Here

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Patient Name: **D.O.B**

Social History

Marital Status: Married / Single / Widowed / Divorced / Engaged / Significant Other

Do you have any biological children? If so, please specify age and gender of each:

_____

_____

Who do you live with?

_____

Do you have any pets? If so, please specify:

_____

What is your occupation?

_____

Nutritional Status: Poor/ Fair/ Good/Excellent/ Vegetarian

Do you Exercise? If so, please specify type and duration:

_____

_____

Sexual Activity: Not sexually active/ Monogamist/ Multiple Partners

Contraceptive Use: None/ Oral Contraceptive/ Family Planning/ Condoms/ Intrauterine Device/ Hysterectomy/ Vasectomy/ Abstinence

Smoking Status: If so, please include history, duration and amount per day:

_____

_____

Alcohol Status: If so, please include history, duration and amount per day:

_____

_____

Do you use illicit drugs?

_____

Do you wear your seatbelt? _____

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Past Medical History

Please list any diseases or health related problems that you have (including but not limited to high blood pressure, high cholesterol, coronary artery disease, strokes, kidney disease, anxiety, depression, osteoporosis, arthritis, or any other disease processes.)

_____

_____

_____

_____

_____

_____

Surgeries or Medical Procedures

Please list any surgeries or medical procedures that you have had in the past and the approximate year of the procedure.

_____

_____

_____

_____

_____

_____

Additional Information (Women Only)

How many times have you been pregnant? _____

How many children do you have? _____

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Family History (Please Circle One)

Mother: Deceased or Alive

History Of: Alzheimer's
Arthritis
Asthma
Cancer: Please specify type: _____
Coronary Artery Disease
High Cholesterol
Alcohol Abuse
Diabetes: Please specify type: _____
Depression
Hypertension
Obesity
Osteoporosis
Kidney Disease
Stroke
Thyroid Disorder: Please specify: _____

Father: Deceased or Alive

History Of : Alzheimer's
Arthritis
Asthma
Cancer: Please specify type: _____
Coronary Artery Disease
High Cholesterol
Alcohol Abuse
Diabetes: Please specify type: _____
Depression
Hypertension
Obesity
Osteoporosis
Kidney Disease
Stroke
Thyroid Disorder: Please specify: _____

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Siblings: Brothers: 1, 2, 3, 4 or _____ Sisters: 1, 2, 3, 4 or _____

Deceased or Alive

Please comment on each of your sibling's medical history below.

_____

_____

_____

_____

_____

_____

Extended Family History:

Cancer: Please specify type: _____
Coronary Artery Disease
High Cholesterol
Alcohol Abuse
Diabetes: Please specify type: _____
Hypertension
Depression
Kidney Disease
Stroke

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PLEASE

DON'T BE A NO SHOW

Our office staff is flexible and designed to meet the schedule one day at a time. If you miss an appointment you have committed to the doctors, nurses, techs, and secretaries time and care.

It is a costly experience without your prior cancellation within a days notice, and you will be charged $40 dollars for the missed appointment.

I understand the policy:

(Signature)_____

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Medical Records Copying Charges

Note that under the Health Insurance Portability and Accountability Act (HIPPA) a covered entity can charge cost-based fees for providing the medical records to patients.

Rule 64B8-10.003, Florida Administrative Code

As of 01/01/2014, there will be a fee for releasing medical records, upon request.

Per the Florida Administrative Code, the following fees will apply:

- No more than $1.00 per page for the first 25 pages
- $.25 for each additional page

Payment is required prior to releasing medical records. The patient is required to pick the records up in person upon payment. This includes requesting records for your own personal records and/or records requested for transferring care to other providers.

Please note that upon requesting records for transferring care, records will not be faxed to the new provider. Patients must pick up the records in person. Records will also not be mailed.

Dr. Elizabeth A. Triana M.D.

Patient Name: _____

Patient Signature: _____