MDY PRIMARY CARE MEDICINE, P.L.

MARGARET R YEE, M.D.

PATIENT INFORMATION

PLEASE PRINT CLEARLY

DATE_____

NAME_____
LAST FIRST MIDDLE

LOCAL ADDRESS_____

CITY_____STATE_____ ZIP_____

PERMANENT ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE (____) _____ ALTERNATE PHONE(___)_____

SS#_____ SEX M or F BIRTHDATE_____ AGE_____

RACE _____ ETHNICITY (Circle One) Hispanic or Non-Hispanic LANGUAGE_____

EMAIL ADDRESS: _____

MARITAL STATUS (Circle One) Single, Married, Divorced, Legally Separated, Widowed

PREFERRED PHARMACY:_____
(Name and address)

EMERGENCY INFO:
NAME_____RELATION_____ PHONE_____

PRIMARY INSURANCE INFORMATION:

SUBSCRIBERS NAME (GUARANTOR)_____

SS#_____ BIRTHDATE_____ RELATION Self/Spouse/Child/Other

INS COMPANY NAME_____ DED $_____or COPAY $_____

POLICY#_____ GROUP# _____ EFF DATE_____

EMPLOYER NAME _____

PATIENT'S STATEMENT:

DO YOU DESIRE TO HAVE A LIVING WILL? (Circle One) YES NO

I hereby allow MDY Primary Care Medicine, P.L. to accept assignment of benefits to which I am entitled from my insurance company. I authorize any holder of medical information about me or my dependents to be released to HCFA and its agents. I also authorize my Insurance Company to receive any information needed to determine the benefits payable for related services. I agree that I am responsible for payment of any remaining balance after insurance payments have been made, including collection costs. I also understand that if my account is not paid under the terms of our agreement, I and my immediate family members may be henceforth dismissed from the practice.

Signed_____ Date_____

MDY PRIMARY CARE MEDICINE, P.L.
102 PARK PLACE BLVD
DAVENPORT, FL 33837

Patient Name:_____ Date of Birth:_____

BASIC POLICY Payment for service is due in full at the time service is provided.

FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also file most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

MEDICARE PATIENTS We will bill Medicare for you. All co-insurance (20%) or deductibles are due and payable at the time service is provided. We will file secondary insurance, for your reimbursement, as a courtesy. If you secondary insurance pays to you it is your responsibility to send the payment to us.

NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

MEDICAL RECORDS FAX I authorize MDY Primary Care Medicine, P.L. to transmit my records electronically. If they are received by another party in error, I absolve MDY Primary Care Medicine, P.A. of any and all liability relating to such submission of said records.

Signature_____ Date_____

CONSENT FOR TREATMENT AND LIFETIME AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby give consent to MDY Primary Care Medicine, P.L. to provide whatever treatment they deem necessary to the patient.

I certify that the information I furnish is true and correct. I am fully aware that it is a felony to falsify any information relating to my medical condition.

I hereby authorize MDY Primary Care Medicine, P.L. to submit a claim to my insurance carrier, or its intermediaries for all covered services rendered by the physician. I also authorize my insurance carrier, or its intermediaries to issue payment directly to the physician. A photocopy of this assignment is considered to be as valid as an original.

I hereby authorize MDY Primary Care Medicine, P.L. to furnish complete information requested by my insurance carrier, or its intermediaries regarding services rendered.

I further agree that I am responsible for payment of any remaining balance after insurance payments have been made, including any collection costs or legal fees incurred to collect these balances.

Signature of Patient:_____ Date:_____

Signature of Guardian _____ Date:_____

HISTORY & PHYSICAL

DATE

NAME

M F MARITAL STATUS S M W D SEP

DATE OF BIRTH

ADDRESS

PHONE (H) (O)

OCCUPATION/ EMPLOYER

INSURANCE

Formedic

PAGE # CHART #

FAMILY HISTORY

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) EPILEPSY
2) MIGRAINE
3) MENTAL ILL.
4) GLAUCOMA
5) DIABETES
6) THYROID DISEASE
7) HAYFEVER
8) ASTHMA
9) ANEMIA
10) BLEEDS EASILY
11) OSTEOPOROSIS
12) ARTHRITIS
13) HEART DISEASE
14) STROKE
15) HYPERTENSION
16) LIPID DISORDER
17) ALCOHOLISM
18) HEPATITIS
19) CANCER
20)

HOSPITAL ADMISSIONS

not including pregnancies

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING

ALLERGIES

VACCINE

	YEAR OF LAST
Tetanus / Td	
Influenza (FLU)	
Pneumonia	
Hepatitis	
Tuberculosis	

TEST / EXAM

	YEAR OF LAST
Rectal/Stool	
Cholesterol	
Eye	

MEDICAL HISTORY

MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

MAIN PROBLEMS 1) 2) 3)

- ☐ Decreased hearing
- ☐ Ringing in ear
- ☐ Ear infections - *frequent*
- ☐ Dizzy spells ☐ Fainting spells
- ☐ Failing vision ☐ Eye pain
- ☐ Double or blurred vision
- ☐ Nose bleeds - *recurrent*
- ☐ Sinus trouble
- ☐ Sore throats - *frequent*
- ☐ Hoarseness - *prolonged*
- ☐ Hayfever / Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
- ☐ Shortness of breath:
  - ☐ on exertion ☐ lying flat
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heart murmur ☐ Swollen ankles
- ☐ Irregular pulse ☐ Palpitations
- ☐ Leg pain - *when walking*
- ☐ Varicose veins / Phlebitis
- ☐ Cold numb feet
- ☐ Loss of appetite - *recent*
- ☐ Difficulty swallowing
- ☐ Heartburn ☐ Peptic ulcer
- ☐ *Persistent* nausea / Vomiting
- ☐ Abdominal pain- *chronic*
- ☐ Gall bladder trouble
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Bloody or tarry stools
- ☐ Hemorrhoids ☐ Hernia
- Urination - Overactive Bladder
  - ☐ Overnight > than twice
  - ☐ More than 8 times / 24 hrs.
  - ☐ Urgency to urinate ☐ with leakage
- ☐ Decrease in force/flow ☐ Painful
- ☐ Stress incontinence-urine leakage with exercise / movement
- ☐ Blood in urine ☐ Kidney stones
- ☐ Urine infections - *frequent*
- ☐ Sexually transmitted diseases
- ☐ Weight-loss ☐ Gain-*recent*
- ☐ Anemia ☐ Bruise easily
- ☐ Blood transfusions
- ☐ Cancer ☐ Chronic fatigue
- ☐ Diabetes ☐ Thyroid disease
- ☐ Seizures ☐ Stroke
- ☐ Tremor / hands shaking
- ☐ Numbness / tingling sensations
- ☐ Headaches - *frequent*
- ☐ Arthritis / Rheumatism
- ☐ Back pain - *recurrent*
- ☐ Bone fracture / joint injury
- ☐ Osteoporosis
- ☐ Foot pain ☐ Gout
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Sleeping or concentration difficulty
- ☐ Depression ☐ Nervousness
- ☐ Agitation ☐ Memory loss
- ☐ Moodiness ☐ Suicidal thoughts
- ☐ Phobias ☐ Mental illness
- ☐ Feelings of worthlessness
- ☐ Rheumatic Fever ☐ Scarlet Fever
- ☐ Chicken Pox ☐ Polio ☐ Mumps
- ☐ Measles ☐ German Measles
- ☐ Tuberculosis ☐ Herpes
- ☐ Aids / HIV
- ☐ Alcohol oz. per week
- ☐ Coffee / Tea cups per day
- ☐ Smoking cig/day #years year quit
- ☐ Excercise
- ☐ Street Drugs
- ☐ Accupuncture / tatoos

Hair loss: ☐ progressive ☐ recent

FEMALES - *Please complete*

Menstrual flow:

☐ Reg. ☐ Irreg. ☐ Pain / Cramps

Days of Flow Length of cycle

Date -1st day of last period

☐ Pain / Bleeding during or after sex

Number of:

Pregnancies Abortions

Miscarriages Live births

Birth control method

B.C. pill (name)

☐ Flushing / Menopause

Date of last PAP test

☐ Normal ☐ Abnormal

Date of last Mammogram

☐ Normal ☐ Abnormal

SYNOPSIS

2000A FORMEDIC® 12D WORLDS FAIR DR SOMERSET NJ 08873

APPROVED BY FORMEDIC'S PHYSICIAN ADVISORY BOARD PCHPLE®

DECLARATION OF ADVANCE DIRECTIVES

Declaration to Decline Life-Prolonging Procedure (Living Will)

- ☐ I have made such a declaration in writing.
- ☐ I have NOT made such a declaration in writing.

Health Care Surrogate

- ☐ I have designated a Health Care Surrogate in writing.
- ☐ I have NOT designated a Health Care Surrogate in writing

Durable Power of Attorney

- ☐ I have appointed a Durable Power of Attorney for Health Care decisions.
- ☐ I have NOT appointed a Durable Power of Attorney for Health Care decisions.

Copy of Living Will/Proxy/Surrogate/Power of Attorney on chart

☐ YES ☐ NO

I have been provided with information written/verbal regarding the Patient Self Determination Act.

Signature Date

Print Name

Yearly Reconfirmation

I acknowledge that this information remains accurate

Signature Date

Signature Date

Signature Date

Signature Date