TRIPLE O MEDICAL
SERVICES P.A.

2580 Metrocentre Blvd, Suite 3 West Palm Beach, Florida 33407
Tel: 561-832-6770 Fax: 561-832-3292 Email: www.tripleomedical.com

PATIENT INFORMATION FORM

Primary Care Provider: _____ Who should we **THANK** for referring you:_____

Were you seen in the hospital by one of our providers: __Yes __ No
If yes, which hospital? ___ St. Mary's ___ Good Sam ___ West Palm ___ Kindred

Patient Information

Patient Name: _____ ___Dr. __Mr. __Mrs.__ Ms.
First Middle Last

Date of Birth: _____/ _____/ _____ Social Security Number: _____-_____-_____

Marital Status: ____Single ___Married ____Divorced ___Separated ___Widowed

Gender: ____Female ____Male

Race/Ethnicity: ___Caucasian ____African American ___Hispanic ___Other_____

Contact Information

Home Address: _____
Number Street Apt # City State Zip Code

Home Phone Number: _____ Cell Phone; _____ Work Phone: _____

Email Address: _____

In case of an emergency, who should we contact?

_____ _____ _____
First Name Last Name Phone Number Relationship

Insurance Information

Insurance Name: _____ ID# _____
If you are not the policy holder, please list the policy holder's name and date of birth below:

Name: _____ Date of birth: _____

I certify that I (or my dependent) have insurance coverage with _____(insurance company) and assign all insurance benefits, if any, directly to Triple O Medical Services, P.A. I understand that I am financially responsible for all charges, whether or not they are paid by my insurance company. I hereby authorize Triple O Medical Services, P.A. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance claim submissions.

_____ _____
Patient (or Guardian) Signature Date

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Health History Questionnaire

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

List any diagnosed medical problems

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐NO ☐YES

List your prescribed drugs and over-the-counter medications, including vitamins and inhalers

Name of Drug	Strength	Frequency Taken

Allergies to Medications

Name of Drug	Reaction

WOMEN ONLY		
Age of 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 infection within the past year?	☐Yes	☐No
Any blood in your urine?	☐Yes	☐No
Any problems with control of urination?	☐Yes	☐No
Any hot flashes or night sweats?	☐Yes	☐No
Do you have menstrual tension, pain, bloating, irritability or other symptoms around your period?	☐Yes	☐No
Experienced any 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, how many times: _____		
Do you feel pain or burning with urination?	☐Yes	☐No
Any blood in your urine?	☐Yes	☐No
Do you feel burning discharge from the penis?	☐Yes	☐No
Has the force of your urination decreased?	☐Yes	☐No
Have you had any kidney, bladder or prostate infection in the past year?	☐Yes	☐No
Do you have any problems emptying your bladder completely?	☐Yes	☐No
Any difficulty with ejaculation or erection?	☐Yes	☐No
Any testicle pain or swelling?	☐Yes	☐No
Date of last prostate and rectal exam?		

Other Problems		
Check if you have, or have had any symptoms in the following areas to a significant degree. Please explain		
☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy Level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort
☐ Lungs	☐ Circulation	

Family History		
Check if anyone in your family has any of the following conditions. Please explain		
☐ Hypertension	☐ Diabetes Mellitus	☐
☐ Cancer	☐ Thyroid Problems	☐
☐ High Cholesterol	☐ Genetic Disorder	☐
☐ Kidney Disease	☐	☐
☐ Asthma	☐	☐

HEALTH HABITS AND SOCIAL HISTORY		
ALL QUESTIONS CONTAINED HERE ARE OPTIONAL AND ARE STRICTLY CONFIDENTIAL		
Caffeine	☐None ☐ Coffee ☐ Tea ☐ Cola	
	# of cups/cans per day?	
Alcohol	Do you drink alcohol?	☐Yes ☐No
	If yes, what kind?	
	How many drinks per week?	☐Yes ☐No
	Are you concerned about the amount 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
	☐Cigarettes – packs per day ☐Chew - #/ day ☐Pipe - #/day ☐Cigars - #/day	
	☐ # of years ☐ or year quit	
Drugs	Do you currently use recreational or street drugs?	☐Yes ☐No
	Have you ever given yourself drugs with a needle?	☐Yes ☐No
Travel	Have you ever traveled outside of the United States?	☐Yes ☐No
	Have you traveled within the past 5 years outside of the United States?	☐Yes ☐No
	If yes to above, where?	
Home	Do you have pets at home?	☐Yes ☐No
Sex	Are you sexually active?	☐Yes ☐No
	If yes, are you trying for pregnancy?	☐Yes ☐No
	If not trying for pregnancy, list contraceptive or barrier method:	
	Any discomfort with intercourse?	☐Yes ☐No
	Illness related to HIV, such as AIDS, has become a major public health problem. Risk factors for this include intravenous drug use and unprotected sexual intercourse. Would you like to speak to your provider about your risk for this illness?	☐Yes ☐No

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 eating or your appetite?	☐Yes ☐No
Do you cry frequently?	☐Yes ☐No
Have you ever attempted suicide?	☐Yes ☐No
Have you ever seriously thought about hurting yourself?	☐Yes ☐No
Do you have trouble sleeping?	☐Yes ☐No
Have you ever been to a counselor?	☐Yes ☐No

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COPAYMENTS AND RESCHEDULE AGREEMENT

Copayments/Deductibles

- All copayments are expected to be paid prior to being seen by a healthcare provider.
- All payments are due in full. We cannot accept payment arrangements on copayments or deductibles.

Appointment

- Please arrive on time for your appointment.
- If you have a change in information, please prepare to arrive 15 minutes prior to your scheduled appointment time so we can update your account.
- You have a 10 minute grace period for your scheduled appointment time. If you exceed this time, you will be asked to reschedule your appointment.

Cancellation/No Show

- We require a 24 HOUR NOTICE if you are unable to keep your scheduled appointment.
- If you fail to comply with the above, then you will be charged a $30.00 cancellation/no show fee.
- No exceptions can be made.

It is the responsibility of the patient to pay all outstanding balances prior to scheduling another appointment.

I understand the above and my signature below acknowledges my understanding of this policy.

_____ _____

Patient (or Guardian) Signature Date

Triple O Medical Services, P.A.

Consent to treat/Authorization

Patient Name: _____

The undersigned hereby authorizes Triple O Medical Services, P.A. to examine and furnish the patient named above with all medical treatments, obtain all laboratory tests, and provide medications and supplies as Triple O Medical Services, P.A. may deem necessary.

Authorization is hereby granted for Triple O Medical Services, P.A. to release to the undersigned individual's insurance company or companies, their agents or other third party payers, all confidential information (including copies of confidential medical/mental health records) as may be requested or necessary for the completion of claim processing related to my treatment.

The undersigned authorizes the direct payment of fees due to Triple O Medical Services, P.A. for services rendered, by the undersigned. I understand that I am financially responsible for services rendered.

I authorize Triple O Medical Services, P.A. to use e-prescribing (electronic prescribing) to transmit prescriptions to the pharmacy of my choice, and dispensed medication history. I understand that a complete and accurate medication list is essential to effective and safe medical care.

I have received a copy of Triple O Medical Services, P.A. Office Policies

A copy of this authorization may be used in place of the original. The consent to treat will remain in effect as long as I remain a patient at this practice or until I withdraw my consent

_____ _____ / _____

Date Patient Legal Guardian

_____ _____

Time Witness

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Acknowledgement of Receipt of Privacy Policy

The undersigned has read and understands the Privacy Policy of Triple O Medical Services, P.A. and acknowledges receipt of this policy.

_____ _____
Signature – Patient or Authorized Representative Date

_____
Representative Relationship to Patient

_____
Printed Name

Office Use Only:

Chart Number _____

OR

I attempted to obtain patient's signature, however he/she refused to sign this form.

Reason for refusal: _____

Employee Name: _____

Employee Signature: _____ Date: _____

PATIENT CONFIDENTIALITY

In this office, **Patient Confidentiality** is a prime concern. Please indicate below with whom our office can or cannot leave a message.
Please check where appropriate.

	YES	NO	DOESN'T APPLY
Spouse	○	○	○
Parent	○	○	○
Children	○	○	○
Answering Machine	○	○	○
Home	○	○	○
Work	○	○	○

Are you able to receive calls at your workplace? Yes ○ No ○
May we call you at your workplace and state who is calling? Yes ○ No ○

Due to confidentiality regulations, should a family member, friend or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you, the patient.

Please check with whom we may discuss your situation.

	YES	NO	DOESN'T APPLY
Spouse	○	○	○
Parent	○	○	○
Children	○	○	○

Parent, Children and /or Significant Others

Name:_____
Relationship:_____
Phone:_____

Name:_____
Relationship:_____
Phone:_____

Signature:_____ Date:_____

Triple O Medical Services PA.

Privacy Notice

(HIPAA PRIVACY RULES)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Practice's Privacy Commitment to you.
We understand that information about you is personal. We are committed to protecting your information. This notice tells you how our practice uses and discloses information about you. It tells you about your rights.

UNDERSTANDING THE INFORMATION THAT TRIPLE O MEDICAL HAS:
You provided certain information to Triple O Medical when you needed services from us. This information included your name, address, birth date, phone number, social security number, and health insurance policies. It may also have included health information. For some medical treatments, other health care providers send additional medical information such as doctor's statements, x-rays, or lab tests results.

YOUR HEALTH INFORMATION RIGHTS
You have the following rights regarding the health information that Triple O Medical has about you. (Note: These rights may be limited by Florida Law or court orders).

- You have the right to see and obtain a copy of your health information. An exception is psychotherapy notes.

- You have the right to ask Triple O Medical to change health information that is incorrect or incomplete. Triple O Medical may deny your request under certain circumstances. You have the right to request a list of the disclosures that Triple O Medical has made of your health information beginning in April 2003.

- You have the right to request a restriction on certain uses or disclosures of your health information. Triple O Medical is not legally required to agree with your request.

- You have the right to request that Triple O Medical communicate with you about your health in a way that will help you keep the information confidential.

- You have the right to receive a copy of this notice.

PRIVACY LAW'S REQUIREMENTS:
Triple O Medical is required by law to:

- **Maintain the privacy of your health information.**
- **Give you this notice of legal duties and privacy information.**
- **Follow the terms of this notice.**
- **Not use or disclose any information about you without your permission, except for the reasons given in this notice.**
- **If the privacy practices changes in the future, we will provide a new notice to you.**

HOW TRIPLE O MEDICAL USES AND DISCLOSES HEALTH CARE INFORMATION:

- **For payment**
- **For medical treatment with another physician or institution**
- **For healthcare operations**
- **For Government agencies providing benefits or services**
- **For research**
- **As required by law or court order**

TO REPORT A PROBLEM:
If you believe your privacy rights have been violated, please contact our Privacy Officer Bola Oni (561) 832-6770

THIS PRIVACY PRACTICES DESCRIBED ON THIS NOTICE HAS BEEN EFFECTIVE APRIL 2003.