Orlando Internal Medicine
Your Care is Our Concern!

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Dear Patient,

We are pleased to welcome you to Orlando Internal Medicine, where Your Care Is Our Concern! It is our goal that this letter will provide you with helpful information regarding your upcoming visit. For your convenience we have included New Patient Forms as well as a map to our location. Please complete and return these forms either by fax, USPS mail or hand deliver to our office before your scheduled appointment to expedite your initial visit with us. If you are unable to complete and return these forms before your appointment, please arrive **20 minutes prior** to your scheduled appointment.

Please notify us at least 24 hours in advance if you are not able to keep this appointment.

Please bring the following:

- These Forms Completed if not already faxed or sent to our office
- All current medications in their original bottles
- Insurance card(s)
- Your Co-Payment
- Photo ID

Sincerely,

The Physicians & Staff

ORLANDO INTERNAL MEDICINE

1507 S. Hiawassee Rd ● Suite 107● Orlando, Florida 32835 ● (407) 445-9545 ● Fax (407) 445-9365

ORLANDO INTERNAL MEDICINE

PATIENT INFORMATION

Name _____
Last First Middle Any Other Preferred First Name

Address _____
Street or P.O. Box Apt. #

_____
City State Zip

Home Phone _____ Work Phone _____ Ext. _____

Cellular Number ___ Email Address _ ◯Work / Home ◯

Sex ◯ Male / Female ◯ Birth Date _____ Marital Status _____ Referred By: _____

Ethnicity: **Please select one:** Non Hispanic • Hispanic • Decline to Answer
Race:**Select one:** White • Black • Asian • Native American/Eskimo • Pacific Islander • Other/Unknown• Decline to Answer

Social Security # _ Driver's License # _____

Employer _____ Spouse or Parent Name & Work Phone _____

Pharmacy Name / Location ___ Pharmacy Phone _____

PRIMARY INSURANCE HOLDER (or Person Responsible for the Bill):

☐ PLEASE CHECK IF RESPONSIBLE PARTY IS A PATIENT OF THIS PRACTICE
(Fill out any information that is different from above)

Name _____
Last First Middle **Relation to Patient**

Address _____
Street or P.O. Box Apt. #

_____
City State Zip

Sex ◯ Male / Female ◯ Birth Date _____ Social Security # _____

Home Phone _____ Pager or Cellular Number _____

Employer _____ Work Phone _____ Ext. _____

Primary Insurance Co. _____

Secondary Insurance Co. _____

EMERGENCY INFORMATION ☐ Please check if primary contact is a patient of this practice.

Contact in case of emergency – List at least two people and include phone numbers and relation: _____

In order to keep costs at a minimum for our patients, payment is collected at the time services are rendered. If you have insurance with one of the groups with which we participate, we will file a claim. It is the responsibility of the insured to know the assigned PCP and network locations. We will provide to all others a statement with the information required by your insurance company so that you can easily forward your claim for reimbursement. Any balances that are unpaid after 90 days will be be turned over to a collection agency unless a signed payment arrangement has been made.

Insurance Authorization and assignment

I hereby authorize ORLANDO INTERNAL MEDICINE to release my insurance carrier any information concerning my illness and treatment, including possible HIV, AIDS, psychiatric or drug & alcohol information. I hereby assign to the physician all payments for medical services rendered to myself and dependents. I understand that I am responsible for any amount not covered by my insurance including fees for "no show" appointments, completion of documents and telephone consultations, all of which I acknowledge are not billable to insurance. I understand that any returned checks may be re-deposited electronically and will have fees assessed.

Medical Consent

I authorize all medical providers at ORLANDO INTERNAL MEDICINE to treat me medically in the office or hospital for any illness or injury that I may incur.

Signature of Patient or Responsible Party_____Date _____

03/2021

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ORLANDO INTERNAL MEDICINE

MEDICAL HISTORY

Please fill out completely and accurately. This becomes part of your permanent record and will help us to make recommendations regarding your care.

PATIENT NAME:_____ DATE OF BIRTH:_____

PAST MEDICAL HISTORY:

Have you a history of:	Check if yes
ALLERGIES / HAY FEVER	❑
ANEMIA	❑
ARTHRITIS	❑
ASTHMA / EMPHYSEMA / COPD	❑
BLOOD CLOT	❑
CANCER	❑
CHEST PAINS / ANGINA	❑
CHOLESTEROL PROBLEMS	❑
DEPRESSION OR ANXIETY	❑
DIABETES	❑
HEADACHES / MIGRAINES	❑
HIGH BLOOD PRESSURE	❑
HIV / AIDS	❑
INTESTINAL DISORDERS	❑
MITRAL VALVE PROLAPSE OR RHEUMATIC FEVER	❑
OTHER HEART PROBLEMS	❑
SEIZURES	❑
SLEEP DISORDERS	❑
STROKE / TIA	❑
THYROID PROBLEMS	❑
ULCERS	❑

DRUG USE : _____

TOBACCO USE: _____
(PACKS PER DAY & # OF YEARS)

ALCOHOL USE: _____
(AVERAGE AMOUNT OR FREQUENCY)

EXERCISE:_____ HOBBIES:_____

EDUCATION COMPLETED: _____

# of Pregnancies:_____ # of Deliveries:_____ # of Miscarriages:_____

Frequency of Periods:_____ Last Menstrual Period_____ Last PAP _____

Any Foreign Travel_____

FAMILY HISTORY:

	√	Which family member? Maternal or Paternal
DIABETES		
HIGH BLOOD PRESSURE		
HEART ATTACK		
HIGH CHOLESTEROL		
STROKE		
ASTHMA		
SUICIDE/DEPRESSION		
ALCOHOLISM		
CANCER (& WHAT TYPES)		
OTHER		

Current Medications & doses:_____

_____

_____

Allergies to Medicine and your reaction: _____

_____

Spouse/Children/Parents' Names & Ages:_____

_____

Previous Illness/Injuries/Hospitalizations/Surgeries including year:_____

_____

_____

_____

Last Tetanus Booster:_____ **Occupation & Employer:**_____

The above information is true and complete to the best of my knowledge.

Signature_____ **Today's Date:**_____

03/2021

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EXHIBIT 5 - PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Orlando Internal Medicine may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Orlando Internal Medicine'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. Orlando Internal Medicine reserves the right to revise its Notice of Privacy Practices at anytime to meet changing legal requirements. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Orlando Internal Medicine - Privacy Officer at 1507 S. Hiawassee Road, Suite #107, Orlando, FL 32835.

With my consent, Orlando Internal Medicine may call my home or other designated 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 call pertaining to my clinical care, including laboratory results among others.

With my consent, Orlando Internal Medicine 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.

With my consent, Orlando Internal Medicine may e-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.

By signing this form, I am consenting to Orlando Internal Medicine's use and disclosure of 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, Orlando Internal Medicine may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Patient's Name

Date

I authorize Orlando Internal Medicine to discuss any and all of my PHI, including medical, psychiatric, drug or alcohol abuse, HIV testing, ARC or AIDS information with the following individuals:

(Name & relationship)

(Name & relationship)

Signature of Patient or Legal Guardian

Date

03/2021

ORLANDO INTERNAL MEDICINE

PLEASE FILL OUT THIS FORM FOR COMPLIANCE WITH THE PATIENT SELF DETERMINATION ACT, PASSED 1992 BY THE STATE OF FLORIDA.

ADVANCED DIRECTIVES

PATIENT NAME:_____ DATE OF BIRTH: _____

An Advanced Directive can be in the form of a living will, durable power of attorney, or health care surrogate. Is there an Advanced Directive written and executed on your behalf (or the patient's behalf, if you are responsible for the patient)? Yes_____ No ☐

If yes, is this Directive in the form of:

☐ a Living Will,
☐ a Durable Power of Attorney, or
☐ a Health Care Surrogate

If you have executed an Advanced Directive in any of the above formats, have you provided this office with a copy for your medical records? Yes ☐ No ☐

If you would like more information regarding Advanced Directives, please ask our office staff.

_____ _____
Signature of Patient or Responsible Party Date

We can also incorporate a copy of any of your directives into your medical records for future reference if you provide a copy to our office.

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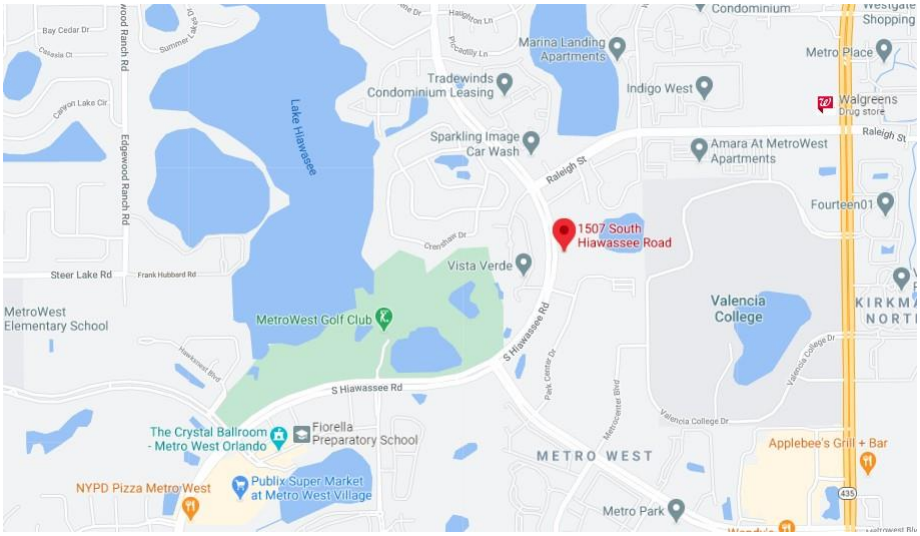

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