PATIENT INFORMATION

First Name:	Last Name:	Maiden Name:	Date of Birth: ☐ Male ☐ Female

Select One: ☐ Full Time Resident (Year Round) ☐ Winter Resident (Oct - Apr) ☐ Summer Resident (May - Sep)

Street Address:	SS#:
City, State, Zip:	☐ Married ☐ Single ☐ Divorced ☐ Widowed

Home Phone:	Cell Phone:	Work Phone:	Preferred Language:

Referring Physician:	Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Race:

☐ American Indian or Alaska Native _____ ☐ Native Hawaiian or Other Pacific Islander _____

☐ Asian _____ ☐ Other Race _____

☐ Black or African American _____ ☐ White _____

EMERGENCY CONTACTS

Name:	Relationship:	Phone:	Cell Phone:
Name:	Relationship:	Phone:	Cell Phone:
Name:	Relationship:	Phone:	Cell Phone:

GUARANTOR (if other than patient):

Name:	Relationship:
Street Address:	City, State, Zip:
Home Phone:	Work Phone: Cell Phone

PRIMARY INSURANCE or MEDICARE	**SECONDARY INSURANCE**
☐ Same as Patient ☐ Same as Guarantor ☐ Other	☐ Same as Patient ☐ Same as Guarantor ☐ Other

PLEASE HAVE YOUR INSURANCE CARD(S) AVAILABLE TO BE PHOTOCOPIED FOR YOUR ????

To improve interactions and communications with our patients, we have implemented automated systems for phone messages and for email communications concerning appointment reminders, past due balance alerts, and disease management initiatives, etc..

May we place automated phone calls or email messages with you? ☐ Yes ☐ No If "Yes", please indicate preferences below:

Health Notifications	Appointments	Announcements	Billing Information
☐ Email ☐ Phone	☐ Email ☐ Phone	☐ Email ☐ Phone	☐ Email ☐ Phone

Email Address:	How did you hear about us? ☐ TV ☐ Radio ☐ Newspaper ☐ Friend ☐ Physician

ASSIGNMENT AND RELEASE:

- I hereby assign my insurance benefits to be paid directly to Socrates Perez MD
- I agree to be solely responsible for all collection fees, attorney fees, and court costs necessary to collect payment on any portion of the delinquent balance, and, I hereby authorize Socrates Perez MD to conduct any and all financial investigative reports that they deem necessary to determine if service is to be provided and if any payment arrangements can be made.
- I understand that if I fail to cancel or reschedule an appointment, I may be charged a "NoShow" fee.
- I authorize the physician to release any medical information required to process the claim.
- I authorize electronic communications from Socrates Perez MD for healthcare maintenance purpose (i.e., emails, phone calls, and Socrates Perez MD-Communicator Portal messages).

Signature : _____ Date: _____

E-HealthHx
Financial Policies and Information

PLEASE READ CARFEFULLY

Our commitment is to provide the very best healthcare to you our patient. Your clear understanding of- and agreement to-our financial policies concerning your medical care is fundamental to our professional relationship with you. Should you have additional questions about our fees and financial policies, or about your responsibilities relating to your insurance coverage, please contact the Practice Manager.

PROFESSIONAL FEES: Our prices are representative of the usual and customary charges for our area. Our fees reflect the Provider's time dedicated to your care. That time includes the review of any prior medical records, diagnostic testing, authorizations and other insurance requirements as well as the coordination of your care with other physicians involved in your health care planning.

INSURANCE PAYMENTS: We participate in assignment of payment with specific insurance plans in the State of Florida. Your insurance coverage is a contract between you and your insurance plan. It is your responsibility to verify and know your insurance benefit coverage including your out of pocket requirements. If your insurance plan is one with which we participate and if you have provided valid proof of insurance for that plan we will submit your claim(s) as a courtesy to you, our patient.

PROOF OF INSURANCE: Before being seen by a Provider, you must complete the Patient Information Form; provide a driver's license or legal identification card; and1 provide a current valid insurance card as proof of Insurance. If the insurance information you provide is incorrect, you will be responsible for the balance of the claim

PATIENT PAYMENTS/SELF-PAY BALANCES: Your co-payments and deductibles, services not covered by your insurance plan, and, self- pay balances are due at the time of your appointment. Your balances are due upon receipt of the Millennium Physician Group statement unless you have made other arrangements prior to the service being rendered. You may pay by cash, check or credit card. We accept Visa, MasterCard, Discover and American Express and encourage you to utilize the "Credit Card on File" program for easy and convenient balance resolution. After 90 days of non-payment, your account may be turned over to a collection agency.

APPOINTMENTS: Please understand that your appointment is time that has been reserved for your health care needs. If you are running late, please call us as soon as possible; if you need to cancel your office and/or procedure appointment, **please call us 24-hours in advance.** If you fail to show up for a scheduled office appointment, you may be assessed a $25 No Show fee that will be due on your next office visit.

NON-COVERAGE SERVICES: Some services you receive may be non-covered or may be considered not necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.

MEDICARE BENEFICIARIES: Medicare will sometimes limit coverage of certain goods or services based on the diagnosis or the frequency in which they are performed. In the event that your provider identifies the potentia1 for denial of your claim for either of these reasons, in accordance with Medicare requirements, you will be asked to complete an Advanced Beneficiary Notification Form (ABN) which will provide you the opportunity to be given the expected cost to you for the services â€" prior to services being rendered. You will be able to elect the receive the services and be responsible for the cost Medicare assigns, or, elect to decline the services.

COLLECTION AGENCIES: If it becomes necessary to place your account with a third party collection agency due to non-payment, you may be discharged from our Practice. Should this occur, we will treat you on en emergency basis only for the next 30 days while you find alternative medical care.

BOUNCED CHECKS: A $50 charge will be applied for each check, returned by your bank. If you have had more than one bounced check, your Provider may elect to not accept future checks from you.

YOUR SIGNATURE ON THIS PAGE CONSTITUES AN AGREEMENT TO THIS POLICY.

I have read and agree to the above Financial Policies and Information. I hereby assign all medical and/or surgical benefits to which I am entitles through my insurance-government or private- to Socrates Perez MD, LLC. This assignment will remain in effect until revoked by me in writing. A copy of this assignment as valid as the original.

Printed Name of Patient: _____ Patient's D.O.B: _____

Signature of Person Responsible for the Account	Printed Name of Person Responsible for Account	Date

E-HealthHx
Collier County
Patient Representative Authorization

COMPLETE ALL SECTIONS OF THIS DOCUMENT BECAUSE INCOMPLETE FORMS WILL NOT BE PROCESSED

Patient Name: Patient Date of Birth:

☐ I DO NOT WANT TO NAME A PATIENT REPRESENTATIVE AT THIS TIME.

Patient Signature: _____ Date: _____

I, _____ ,HEREBY AUTHORIZE DR. _____ (OR HIS/HER AGENT)

TO DISCUSS MY CARE/CONDITION WITH THE FOLLOWING PERSON(S):

Name: _____	Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Relationship: _____	Relationship: _____
Phone #: _____	Phone #: _____

Medical information discussed/disclosed may include *(check all that apply):*

☐ Alcohol and/or Drug Abuse ☐ Sexual Transmitted Disease (STD) ☐ Mental Health ☐ Not Applicable
☐ Acquired Immunodeficiency Syndrome (AIDS) ☐ Human Immunodeficiency Virus (HIV) Infection

This authorization to discuss/disclose private health information. to the designated person(s) named above shall remain in effect for one year from the date of this signed release unless and until I have revoked the authorization by sending written notification to my HealthCare Provider at (select appropriate facility):

☐ *I understand that I have the right to inspect the medical records requested and that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by State or Federal Law.*

PATIENT _____ PATIENT _____ DATE _____
(Printed Name) (Signature of parent/legal guardian signature if patient is minor)

I would like to have copy of this authorization

E-HealthHx

Patient Name: _____ ID # _____ D.O.B.: _____ TODAY's DATE: _____

PATIENT"S CARE TEAM

	Name/Specialty	Address	Phone
Primary Care Physician			
Specialists			

PHARMACY

	Location/Address	Phone # (if known)
Preferred Pharmacy (local)		
Preferred Pharmacy (mail away)		

MEDICATIONS: include (herbal remedies, vitamins, frequent over-the-counter meds (aspirin, ibuprofen, tylenol, Tums, etc.)

Name	Dose-mg	Directions
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ALLERGIES

Are you allergic to Contrast Dye? ☐ **YES** ☐ **NO**

Allergic to:	Reactions:
1.	
2.	
3.	
4.	
5.	
6.	

IMMUNIZATION

Name:	Given	Date:	Name:	Given:	Date:
Flu			Tetanus		
Pneumonia			Hepatitis		
Zostivax (shingles)			Other		

Patient Name: _____ ID # _____ D.O.B.: _____ TODAY's DATE: _____

PAST MEDICAL HISTORY
PLEASE CHECK ALL THAT APPLY

☐ Alcohol Overuse	☐ Hepatitis
☐ Allergies (other than meds)	☐ High Blood Pressure
☐ Amputation (location)	☐ High Cholesterol
☐ Anemia	☐ HIV/AIDS
☐ Anxiety/Stress	☐ Hormone Replacement
☐ Arthritis	☐ Hospitalizations Other than operations
☐ Asthma	☐ Jaundice
☐ Back Pain	☐ Kidney Disease
☐ Barrett's Esophagus	☐ Kidney Stones
☐ Bleeding Disorder	☐ Measles/Mumps
☐ Blood Thinner Treatment	☐ Memory Loss/Alzheimerâ€™s
☐ Cancer (location)	☐ Nerve Damage/Neuropathy
☐ Cardiac Arrhythmias/Irregular Heart Rate	☐ Nervous Breakdown
☐ Cardiac Pacemaker/DeFib	☐ Osteopenia/Osteoporosis
☐ Chicken Pox	☐ Ostomies (location)
☐ Cirrhosis	☐ Other
☐ Colon Polyps	☐ Paralysis
☐ Colon Problems	☐ Parkinson's
☐ Congestive Heart Failure	☐ Prostate Problems
☐ Crohn's Disease	☐ Rash/Skin Condition
☐ Depression	☐ Rheumatic Fever
☐ Diabetes	☐ Seizures
☐ Emphysema /COPD	☐ Serious Injuries
☐ Erectile/Sexual Dysfunction	☐ Sexually Transmitted Dis.
☐ Falls	☐ Sleep Disorder/Insomnia
☐ Gallbladder Disease	☐ Stroke/TIA
☐ Gastritis	☐ Thyroid Disease
☐ GERD/Ulcer	☐ Urinary Problems
☐ Gout	☐ Vascular Disease
☐ Headaches/Migraines	☐ Vision Problems
☐ Heart Disease/Heart Attack	☐

SURGICAL HISTORY
PLEASE LIST ALL SURGERIES/PROCEDURES AND YEAR

	Surgery	Year
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
Do you have a Pace Maker?	☐ **Yes** ☐ **No**	

HEALTH MAINTENANCE
PLEASE LIST DATE OF LAST EXAM

	Year
Stress Test	
Echocardiogram	
EKG	
Chest X-Ray	
Mammogram	
Pap Smear	
PSA	
Bone Density	
Colonoscopy	

Patient Name: _____ ID # _____ D.O.B.: _____ TODAY's DATE: _____

FAMILY HISTORY:
If a blood relative (parent, sibling, child) has any of the following, PLEASE CHECK AND INDICATE WHICH FAMILY MEMBER.

☐ Do not know Family History	☐ Mother is Living ☐ Mother is Deceased Age of Death: Cause of Death:	☐ Father is Living ☐ Father is Deceased Age of Death: Cause of Death:

☐ Alcoholism	☐ Diabetes	☐ Mental Illness	☐ Other
☐ Breast Cancer	☐ Heart Attack	☐ Osteoporosis	☐
☐ Colon/Rectal Cancer	☐ Heart Disease	☐ Skin Cancer	☐
☐ Colon Polyps	☐ High Blood Pressure	☐ Stroke	☐
☐ Depression	☐ High Cholesterol	☐ Suicide	☐

SOCIAL HISTORY

Occupation:		Retired: ☐ Yes ☐ No	
Marital Status: ☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced		# of Children_____	# of Pregnancies_____

Alcohol: ☐ Yes ☐ No Type:_____ Frequency: Number of Drinks_____ ☐ day ☐ Week ☐ month	Smoke: ☐ Yes ☐ No Frequency:#_____ Pack/Day Number of Years_____ Quit Date:_____	Exercise: ☐ Yes ☐ No Type:_____ Frequency: Number of Times_____ ☐ day ☐ week ☐ month	Illicit Drug Use : ☐ Yes ☐ No ☐ Marijuana ☐ IV Drug Use

I hereby authorize to obtain for my medical records any medication history that is automatically downloaded from the Pharmacy Benefits Manager through Sure Scripts.

Patient Signature:

I hereby authorize my medical records and health care information to other medical providers and facilities upon their request in connection with my medical care and treatment.

Patient Signature:

I hereby authorize to exchange my immunization history with the Florida Immunization Registry.

Patient Signature: