Gutierrez-Perez Family Medicine

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It is our sincere pleasure to welcome you to our office. As a member of our practice, our medical office staff is dedicated to providing you with the highest quality care and services in the most courteous and efficient manner possible.

Attached you will find our new patient package forms

Please complete these forms prior to your appointment and bring the following with you to your first appointment.

1. **A government issued photo ID**
2. **Your current insurance card**
3. **All of the medications you are currently taking**
    a. **Prescription and over-the-counter**
4. **If you are a diabetic please bring your current meter and logs.**
5. **Completed new patient package forms.**

Please arrive 15 minutes prior to your appointment

Remember for some of your medical benefits to be payable by your insurance company we may have to authorize and /or arrange your medical care. You will need to visit with one of our Doctors before any authorizations are given.

Our current office hours are Monday, Tuesday, Thursday and Friday 8am to 4:30pm
Wednesday 8am to 6pm
Saturdays 9am to 2pm (closed last Saturday of the month)

If you experience a medical problem after our office hours, we are still available. We encourage you to call us at (407) 846-2050. If you are unable to contact us and have a medical emergency, please go to the nearest emergency room or call 911. It is important for you to call us as soon as possible to notify us of your emergency room visit, and schedule an appointment with us so that we can continue to coordinate your follow-up care.

Once again, welcome to our practice. We look forward to meeting you!

Gutierrez Perez Family Medicine

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Patient Registration

☐ **New Patient** ☐ **Established Patient Update**

Patient Information:

Patient's Full Name: Male ☐ Female ☐

Social Security #: Date of Birth:

Home Address: **Marital Status**: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Sep

City: State: Zip:

Home Phone: Cell Phone: Alternate #

Employer: Occupation:

Work Phone: Email: Ok to receive text or email messages ? YES NO

Preferred Pharmacy: Phone/Fax

address or location: (example 192 & John Young)

How did you hear about us?

Please select 2 boxes & complete primary language

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic ☐ Other ☐ Declined Primary Language: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or Africa American ☐ Native hawaiian or Other pacific Islander
☐ Other ☐ White ☐ Declined

Primary Insurance Information

Insurance Company: Ins. Phone #:

Insured / Card Holder's Name: Date of Birth SS#:

Policy #: Group #: Effective Date:

Secondary Insurance Information

Insurance Company: Insurance Phone #:

Insured / Card Holder's Name: Date of Birth SS#:

Policy # : Group #: Effective Date of Ins.

Emergency Contact

Name of Contact: Male ☐ Female ☐

Full Address: City: State Zip:

Home Phone: Cell: Work:

Relationship:

The above information is true and to the best of my knowledge. To my insurance companies and/or the social security administration, or their representative; I authorize and request the release of any information about me needed to process claims for services rendered to me by Gutierrez Perez Family Medicine and I authorize and request payment to be made to Gutierrez Perez Family Medicine on my behalf for services provided to me for which I do not pay for in full at the time services are rendered. I authorize Gutierrez Perez Family Medicine to submit claims for me on my behalf. I permit a copy of this authorization to be used in place of the original. I authorize Gutierrez Perez Family Medicine to release my protected health information to and/or to consult with other physicians and pharmacies either orally or written in order to carry out treatment, referrals, medication review, payment or health care operations as deemed necessary by them. My signature below will act as my authorization for the above as long as I am provided services by Gutierrez Perez Family Medicine.

Signature _____ Date: _____

**Signature here allows messages to be left at the listed numbers above via voicemail, person, etc.*

Medical History

Patient: _____ M F Date:

Last, First, Middle Date of Birth Age Gender Todays Date

Chief Complaint: (What brings you to the Doctor)

What type of symptoms are you having?

Do you have any of the below symptoms or problems? Where, When did it start, how long it last, is it associated to activity, or any other comments: (select yes/no and circle conditions)

	NO	YES	circle conditions that apply
Chest pain	☐	☐	at rest on exertion with breathing
Palpitations	☐	☐	
Shortness of Breathe	☐	☐	off and on constant
Coughing/Wheezing	☐	☐	
Nasal Congestion	☐	☐	sore throat acute chronic
Back Pain	☐	☐	
Fatigue	☐	☐	
Numbness/Tingling of arms hands or feet	☐	☐	
Anxiety/Depression	☐	☐	
Insomnia	☐	☐	trouble falling asleep trouble staying asleep
Hx of suidcide attempts	☐	☐	When: Suicidal plans or verbilization? YES NO
Breast pain, tenderness, lumps or nipple discharge	☐	☐	
Stomach Pain /Heartburn	☐	☐	
Abdominal Pain or Tenderness	☐	☐	
Constipation	☐	☐	
Diarrhea	☐	☐	How many times per day ? How many days?
Vomiting	☐	☐	How many times per day ? How many days?
Urinating Often	☐	☐	Specify **small** amounts or **large** amounts of urine?
Increase Thirst	☐	☐	
Difficulty with Urination	☐	☐	Problems with **starting** or **stopping** urine flow starting stopping
Pain with Urination	☐	☐	
Blood in Urine	☐	☐	
Rectal Bleeding	☐	☐	
Unusual Weight Gain or Loss	☐	☐	Gain Loss How much Time period
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Medical History

Patient: M F Date:

Last, First, Middle Date of Birth Age Gender Todays Date

ALLERGIES: Please list all allergies to medications, food, latex, tape, dye, etc. that you may have.

☐ I have no known allergies

Allergen	Type of Reaction	Mild, Severe, or Intollerance

CURRENT MEDICATIONS: Please list all medications you are currently taking:

Name of Medication:	Strength	How often do you take:	Who Prescribed

PAST MEDICATIONS: Please list all medications you have taken in the past:

Name of Medication:	Please list when discontinued and describe type of reaction.

CURRENT & PAST MEDICAL HISTORY: Please List all **current and previous** medical conditions you have

Condition: Example: High Blood Pressure	Date began or how long?	Comments

PAST SURGICAL HISTORY: Please include all surgeries and procedures you have had

Type of Surgery/Procedure	Date:	Hospital or Doctor Name

FAMILY HISTORY: Please list medical problems of family Members: **Are you Adopted: YES NO**

Medical Condition	Relative	Age	If Deaceased: Cause of Death and Age

Medical History

Patient: M F Date:

Last, First, Middle Date of Birth Age Gender Todays Date

Immunizations: Please list the date of your last immunizations:

Flu Shot Pneumonia Tetanus Shot

Zoster

Any other immunizations:

HEALTH MAINTENANCE: Please list date of last test and the result (was it abnormal)

LABS

Pap Abnormal ? Y N Mammogram

PSA Prostate Exam

Colonoscopy Polyps? Fecal Occult Blood(stool test) Blood detected?

Eye Exam Foot Exam

Specialist Appts? If you are under the care of any specialist please list Dr's Name, Speciality and reason

Name	Speciality	Condition being treated for	Next Appt?

SOCIAL HISTORY (please circle) or answer the below questions:

TOBACCO

Do you smoke or use any kind of tobacco? Yes No Never Quit

If **YES or QUIT** : What kind of Tobacco Cigarettes Chew Snuff Pipe Cigars

How many packs per day # How many years? Quit Date:

ALCOHOL

Do you drink Alcohol? Yes No Never Quit

If Yes: What Kind How Often: How much?

Do you have a history of alcohol abuse in the past? YES NO How many years?

DRUG

Do you use illegal drugs? YES NO

Do you have a history of drug use in the past? YES NO How many years?

What type of drugs?

SEXUAL HISTORY

Sexually Active: YES NO

Partners: Spouse Male Female Both Multiple Partners

Females only: Date of your last menstrual cycle: Hysterectomy? NO YES Full partial

Are you currently pregnant? Due Date?

Birth Control Use: YES NO Type:

# of Pregnancies # of Live Births: # of Miscarriages

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of Patient/Parent or Guardian Date: Signature of Physician Date:

Patient_____ Date of Birth:_____
Last, First, Middle

AUTHORIZATION TO OBTAIN MEDICATION HISTORY

By signing this below, I hereby authorize Gutierrez Perez Family Medicine to obtain Medication History related to the patient above, from Pharmacies, prior Physicians, Hospitals, and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

Signature of Patient / Guardian _____ Date _____

CONSENT FOR EVALUATION AND/OR TREATMENT

Florida State Law guarantees that you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health team, you must enter into the decision making process. This form has been design to acknowledge your acceptance of treatment recommended by your physician and or/physician extender.

I further acknowledge that I will have full opportunity to discuss this information with my physician and or physician extender and hereby consent to medical care / treatment.

I also acknowledge that the purpose of the care, reasonable alternative form of therapy, risk of the recommended and alternative care and the risks of foregoing care will be explained to me.

I hereby consent and authorize my physician and/or physician extender, the employees of this practice, and any other health professional as designated to perform any physical examination and routine diagnostic procedures upon me. I also consent to and authorize my physician and/or physician extender to prescribe a therapeutic regime, which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) and immunization(s) ordered by my physician and/or physician extender be performed on me despite the risks involved and complications that might be involved, which will be explained to me at the time they are ordered.

Signature of Patient / Guardian _____ Date _____

AUTHORIZATION TO RELEASE/DISCUSS INFORMATION

I _____ authorize Gutierrez-Perez Family Medicine to release and or discuss my health information, either written/orally by phone or in person , with:

Name	Relationship	Date of Birth	Phone #

This authorization is valid until: _____ or until _____.
Date Event

Signature of Patient / Guardian _____ Date _____

Patient_____ Date of Birth:_____
Last, First, Middle

Advanced Directives

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment. When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about their health care will still be respected, Florida Legislature created Advance Directives. Advance Directives are a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or express your wish to make an anatomical donation after death.

Have you executed an advance care directive?

____ YES, I have created the following Advance Directives:

____Living Will ____Health Care Surrogate Designation _____Anatomical Donation ___DNR

I have provided a copy of these forms to (Name):_____

Address:_____ Phone#_____

Please provide a copy of these forms to our office. I understand it is my responsibility to provide my physician a copy of my Advance Directive and if provided I authorize Gutierrez Perez Family Medicine to share these forms with any hospital, physician or medical provider requesting a copy on my behalf. I also agree to provide an updated copy to this office if any changes are made to my Advance Directives.

____ No, I have not executed an Advance Directive.

Would you like to receive more information about Advance Directives? ____YES ____ NO

_____
Print Patient/Legal Guardian Name

_____ _____
Patient/Legal Guardian Signature Physician Signature

_____ _____
Date Signed Date Signed

Office use only

Copy of the below documents given to patient:

___ Advance Directives, Patients Right to Decide, Florida Agency For Health Care Admin
___ Five Wishes, Aging with Dignity

Date Given: _____ Int_____

Patient:_____ Date of Birth_____ Todays Date: _____

PATIENT HEALTH QUESTIONNAIRE-9
(P H Q - 9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please "circle" to indicate your answer.

		Not at all	Several Days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself — or that you are a failure or have let yourself or you family done.	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite --- being so fidgety or restless that you have been moving around a lot more that usual.	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
	OFFICE CODING	0 +	_____ +	_____ +	_____

Total Score= _____

If you circled any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

_____ _____

Patient Signature Date:

_____

Physician Signature Date:

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer, Inc.

Name:_____ Date of Birth:_____ Today's Date _____

Domestic Violence Detection Form

This information is part of your medical record.

Your answers will not be communicated to anyone without your written consent, except as otherwise provided by law.

1. Overall, how would you describe your relationship?	much tension	some tension	no tension
2. You and your partner solve arguments	great difficulty	any difficulty	no difficulty
3. Do arguments ever result in you to feel suffocated or bad about yourself?	often	sometimes	never
4. Does each argument result in hitting, kicking or pushing?	often	sometimes	never
5. Do you ever feel afraid of what your partner says or does?	often	sometimes	never
6. Does your partner abuse you physically?	often	sometimes	never
7 Does your partner abuse you emotionally?	often	sometimes	never
8. Does your partner ever abused you sexually?	often	sometimes	never

X _____ _____

Patient Signature Date

If you do not feel comfortable talking about this today, you can call a hotline number at any time:

National Domestic Violence Hotline:
1-800-799-SAFE (7233) or TTY: 1-800-787-3224
http://www.ndvh.org/

Florida Coalition Against Domestic Violence Hotline:
1-800-500-1119 or TTY: 1-800-621-4202
http://www.fcadv.org/

Florida Department of Children and Families
Domestic Violence Hotline
1-800-500-1119
http://www.dcf.state.fl.us/domesticviolence/

Domestic Violence Intervention Program
A program dedicated to teaching new
abilities that replace violent abuse,
conflict resolution and contact Security

1-877-700-7066
email: support@floridasafety.org
http://www.floridasafety.org/coursetext.asp?class=33

Patient_____ Date of Birth:_____
Last, First, Middle

GUTIERREZ-PEREZ FAMILY MEDICINE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practice, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name

_____ _____
Signature Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We were not able to communicate with the patient.
- ☐ Other (Please provide specific detail) _____

_____

_____ _____
Employee Signature Date:

AUTHORIZATION TO OBTAIN or RELEASE PROTECTED HEALTH INFORMATION

I , _____ hereby authorize **Gutierrez-Perez Family Medicine** to obtain / release records

From / to:_____
Name of Individual, Healthcare Facility or Agency

_____
Address City State Zip

_____ _____
Phone Fax

This authorization will expire on the following date, event or condition:_____.

If I fail to specify an expiration date, event or condition, the authorization will expire in one (1) year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except the extent that the action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS is confidentially protected by Federal and State law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulation. I understand that I may select the information for the list below to be release by placing a check mark in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized redisclosure of my health information

Place a check by each item to be released or reviewed.

☐ Complete Record or

_____ Consultation/Progress Note ____All Diagnostic test results
_____ Pathology/Operative Reports ____ Lab Only
_____Radiology Only ____Therapy Records
_____Other _____

If applicable, I also give permission for the following to be disclosed

Initial each item to be disclosed

_____ Mental Health/Psychiatric Care **_____ STD**
_____HIV/AIDS **_____ Alcohol & Drug Abuse**

Patient Name:_____Date of Birth:_____
Address:_____
City:_____State:_____Zip:_____

Social Security #:_____ Telephone#_____

Patient's/Guardian Signature:_____Date:_____

Please mail or fax records to:

Gutierrez Perez Family Medicine
907A North Central Ave., Kissimmee, FL 34741
407-846-2050 voice 407-846-0338 fax