



4340 Newberry Rd, Suite 103, Gainesville, FL 32607
 Phone: 352 372-9414 Fax: 352 271-5393

NEW PATIENT MEDICAL HISTORY

NAME _____ AGE _____ DOB _____ DATE _____

REASON FOR VISIT: _____ HOW LONG HAS IT BOTHERED YOU? _____

Primary Care Physician: _____

List Other Physicians you see and why: _____

PERSONAL MEDICAL HISTORY - CONDITIONS THAT APPLY TO YOU:

| | Yes | No | Year | | Yes | No | Year |
|---------------------------|--------------------------|--------------------------|------|--|--------------------------|--------------------------|------|
| Diabetes Mellitus | <input type="checkbox"/> | <input type="checkbox"/> | | Hypothyroidism (low thyroid) | <input type="checkbox"/> | <input type="checkbox"/> | |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | | Hyperthyroidism (high thyroid) | <input type="checkbox"/> | <input type="checkbox"/> | |
| High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | | Goiter or Thyroid Nodules | <input type="checkbox"/> | <input type="checkbox"/> | |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | | Thyroid Cancer | <input type="checkbox"/> | <input type="checkbox"/> | |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | | Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | |
| Impaired Hearing | <input type="checkbox"/> | <input type="checkbox"/> | | Frequent Falls or Balance Issues | <input type="checkbox"/> | <input type="checkbox"/> | |
| Impaired Vision | <input type="checkbox"/> | <input type="checkbox"/> | | Fractures: if yes please list site below | <input type="checkbox"/> | <input type="checkbox"/> | |
| Nerve Damage (neuropathy) | <input type="checkbox"/> | <input type="checkbox"/> | | High Calcium | <input type="checkbox"/> | <input type="checkbox"/> | |
| Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | | Kidney Stones | <input type="checkbox"/> | <input type="checkbox"/> | |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | | Heart Burn/Acid Reflux (GERD) | <input type="checkbox"/> | <input type="checkbox"/> | |

List other Medical Conditions, fractures or recent Hospitalizations: _____

HEALTH MAINTENANCE: If you have had any of the following done, please indicate when it was most recently done (Month/Year):

Flu Vaccine: _____ Bone Density Scan (DXA): _____
 Pneumonia Vaccine: _____ Dilated Eye Exam: _____

| SURGERIES - YOU HAVE HAD | DATE | REASON/COMPLICATIONS |
|--------------------------|------|----------------------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

PERSONAL SOCIAL HISTORY:

Occupation: _____ Yours: _____ Spouses!: _____

Place of Employment: _____

Education (circle level completed): High School (9, 10, 11, 12) College (1, 2, 3, 4) Masters PhD Other

Marital Status: (circle) Single Married Widowed Separated Divorced

Who lives at home with you? _____

Exercise: What type of exercise do you get? (circle please)
 Walking jogging bicycling swimming golf tennis other _____

_____ Minutes each day? _____ Moderate occupational or recreational exercise?
 _____ Days per week? _____ Sedentary work and light exercise only?

NAME: _____

MRN: _____

DATE: _____

Do **YOU** use currently (or in the past) any of the following products?

| Yes | No | Product | Amount | How Long | When Quit |
|-----|----|-----------------|--------|----------|-----------|
| | | Cigarettes | | | |
| | | Cigars | | | |
| | | Chewing tobacco | | | |
| | | Alcohol | | | |
| | | Caffeine | | | |
| | | Street Drugs | | | |

ABOUT YOUR FAMILY:

If yes whom?

(M=mother, F=father, B=brother, A=aunt, U=uncle, S=sister, GM=grandmother, GF=grandfather, C=child)

| | Yes | No | | Yes | No |
|---------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|
| Cancer (type) | <input type="checkbox"/> | <input type="checkbox"/> | Hip Fracture before age 80yrs | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Kidney Failure | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes Mellitus | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Obesity | <input type="checkbox"/> | <input type="checkbox"/> |
| High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | Strokes | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Elevated Thyroid (hyperthyroid) | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack/MI | <input type="checkbox"/> | <input type="checkbox"/> | Low Thyroid (hypothyroid) | <input type="checkbox"/> | <input type="checkbox"/> |
| Strokes | <input type="checkbox"/> | <input type="checkbox"/> | Enlarged Thyroid (Goiter) | <input type="checkbox"/> | <input type="checkbox"/> |
| Elevated Calcium | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Other: _____
_____**FEMALES ONLY:**

- At what age was your first menstrual period? _____ Number of periods in the last year? _____
- When was your most recent period? _____ Longest time between periods (days/months) _____
- Are your periods regular? _____
- # of Pregnancies: _____ # of Miscarriages: _____ Birthweight of largest baby: _____
- If applicable, what was your age at menopause? _____ Did you receive hormone therapy? _____ How Long? _____
- Date (year) of last mammogram _____

REVIEW OF SYMPTOMS: (Check all that apply to YOU CURRENTLY)

| | | | |
|--|---|---|--|
| <p>GENERAL:</p> <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Appetite Loss <input type="checkbox"/> Appetite Gain <input type="checkbox"/> Persistent Infections <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> None of the above | <p>SKIN:</p> <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Hair Loss <input type="checkbox"/> Nail changes <input type="checkbox"/> Dryness <input type="checkbox"/> Increased Hair Growth <input type="checkbox"/> Ulcers <input type="checkbox"/> Purple stretch marks <input type="checkbox"/> None of the above | <p>EYES/EARS</p> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Eye Pain <input type="checkbox"/> Puffiness around the eye <input type="checkbox"/> Eye Glasses/Contacts <input type="checkbox"/> Visual Loss <input type="checkbox"/> Ear drainage <input type="checkbox"/> Ear pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Hearing loss <input type="checkbox"/> None of the above | <p>NOSE</p> <input type="checkbox"/> Loss of taste or smell <input type="checkbox"/> Postnasal drip <input type="checkbox"/> Hayfever <input type="checkbox"/> Stop breathing at night |
| <p>NECK</p> <input type="checkbox"/> Neck pain <input type="checkbox"/> Neck swelling <input type="checkbox"/> None of the above | <p>RESPIRATORY</p> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Snoring <input type="checkbox"/> Sputum Production <input type="checkbox"/> None of the above | <p>BREAST</p> <input type="checkbox"/> Breast Mass <input type="checkbox"/> Breast Pain <input type="checkbox"/> Male Breast Enlargement <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> None of the above | <p>HEART/CIRCULATION</p> <input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Pain in legs with walking <input type="checkbox"/> Swelling of hands or feet <input type="checkbox"/> None of the above |
| <p>GASTROINTESTINAL</p> <input type="checkbox"/> Heartburn <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Jaundice <input type="checkbox"/> Gets full quickly at meals <input type="checkbox"/> None of the above | <p>GENITOURINARY FOR WOMEN</p> <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Frequent urination at night <input type="checkbox"/> Urgency with urination <input type="checkbox"/> Pain with urination <input type="checkbox"/> Absence of menstruation <input type="checkbox"/> Menstrual Irregularities <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Change in sex drive <input type="checkbox"/> None of the above | <p>GENITOURINARY FOR MEN</p> <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Frequent urination at night <input type="checkbox"/> Urgency with urination <input type="checkbox"/> Change in urinary stream <input type="checkbox"/> Change in sex drive <input type="checkbox"/> Difficulty with erections <input type="checkbox"/> Testicular mass <input type="checkbox"/> None of the above | <p>MUSCULOSKELETAL</p> <input type="checkbox"/> Back Pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Change in glove, hat or shoe size <input type="checkbox"/> None of the above |
| <p>NERVOUS SYSTEM</p> <input type="checkbox"/> Fainting spells <input type="checkbox"/> Headaches <input type="checkbox"/> Decreased Memory <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Tremor <input type="checkbox"/> Unsteadiness <input type="checkbox"/> None of the above | <p>PSYCHIATRIC</p> <input type="checkbox"/> Depression <input type="checkbox"/> Mood Swings <input type="checkbox"/> Anxiety <input type="checkbox"/> Insomnia <input type="checkbox"/> Crying spells <input type="checkbox"/> None of the above | <p>ENDOCRINE</p> <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive urination <input type="checkbox"/> None of the above | <p>BLOOD</p> <input type="checkbox"/> Anemia <input type="checkbox"/> History of transfusions <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> None of the above |

What additional information should the doctor have about you? _____



Physician Specialists

Ear, Nose & Throat

- Ann Glowasky, MD
- Jeffrey Phillips, MD
- Brian Kerr, MD
- Daniel J. Hall, MD, FACS
- Alex Rafanan, PA-C

Endocrinology

- Sandra Werbel, MD
- Sadaf Jeelani, MD
- Colleen Digman, MD
- David Kireta, P.A.-C
- Renee Berens, P.A.-C

Facial Plastic Surgery

- Daniel J. Hall, MD, FACS

Audiology

- Ryan Baker, Au.D
- Diana Guercio, Au.D
- Steven Petrakis, Au.D
- Ashley Espinosa, Au.D

Aesthetics

- Mary Hazen, P.A.-C

Thyroid Disorders

Eye Surgery

Otology

Hearing & Balance Disorders

Nose & Sinus Care

Laryngeal

Voice & Swallowing Disorders

Facial Plastic Surgery

Diabetes Management

Audiology

Head & Neck Surgical Oncology

ENT Allergy

Aesthetics

No Show Policy

MR# _____

Accent Physician Specialists asks for 48 hours notice if you cannot come for your visit. Failure to come to your appointment or cancel it will result in a \$50.00 charge. We will make an exception to this policy if your appointment time is less than 48 hours from the time we scheduled it. In this instance, we will only require 24 hours notice. If you have two appointments, one with the doctor and one for testing such as audiology or ultrasound, the fee will be \$50 per appointment, resulting in a \$100 charge.

If you are more than 15 minutes late for your appointment, we will reschedule your appointment for a later date.

This is not a policy that we prefer, but our survival as a practice depends on our patients being good partners as we try to provide the best healthcare that we can.

I have read and acknowledge the above policy.

Signature

Print Name

Date



Physician Specialists

Authorization to Release Insurance and Medical Information

Patient Name: _____

Date of Birth: _____ Sex: M F

Mailing Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Best Phone #: _____ Cell Phone: _____

Parent/Guardian Name: _____

Date of Birth: _____

Mailing Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

E-mail address: _____

Primary Care Physician: _____ Referred By: _____

Insurance Information

Primary Insurance: _____ Policy ID# _____

Policy Holder's Name: _____

DOB: _____

Policy Holder's Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Insurance: _____

Policy Holder's Name: _____ Policy ID# _____

DOB: _____

Policy Holder's Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

I authorize Accent Physician Specialists to provide the treatment deemed necessary to care for the above named patient. I authorize the release of medical records and information to or from any medical practice or insurance plan concerning the diagnosis, treatment, and determination of care.

SIGNATURE OF PATIENT/PARENT OR GUARDIAN

DATE

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

As a courtesy, Accent Physician Specialists, P.A. will file my insurance claim. Insurance payment for services and treatment are directed to Accent Physician Specialists, P.A. I understand that payment for services rendered and supplies provided is ultimately my responsibility and payment is due when billed, whether or not my insurance company had paid.

I hereby authorize the insurance carrier with whom I have a policy to pay benefits directly to Accent Physician Specialists, P.A. for rendered services. I agree to pay all charges that are not paid in full by my assigned insurance. In the event that I default on payment of my account, I agree to be held responsible for all fees, which could be 40% of the total amount due as well as the interest accrued on the amount in default, court costs and reasonable attorney fees.

I have received, read and understood the Accent Physician Specialists, P.A. Assignment of Benefits and Financial Responsibility statement above. _____ (Please Initial)

H.I.P.A.A. Notice of Privacy Practices

I have received, read and understood the Accent Physician Specialists, P.A. H.I.P.A.A. Notice of Privacy page. _____ (Please Initial)

Notice of Release of Information

In case of emergency, please list any parties you authorize access to health information. Understand that *only* the parties listed below are authorized to receive knowledge of your treatment, medications, appointments or surgery. This list may be revoked at anytime by notifying Accent Physician Specialists, P.A. in writing.

| Name | Relationship | Phone Number |
|------|--------------|--------------|
| | | |
| | | |
| | | |

Please list the person(s) that you give consent and/or authorize to bring your minor child to his/her appointment(s) at Accent Physician Specialists. This includes them being able to sign for your minor child to receive treatment. This does **NOT** include surgery consent forms. **A parent or court appointed legal guardian MUST be present at the pre-op appointment to sign surgical consent forms.**

| Name | Relationship | Phone Number |
|------|--------------|--------------|
| | | |
| | | |
| | | |

SIGNATURE OF PATIENT/PARENT OR GUARDIAN

DATE