HOLLYWOOD MEDICAL CLINIC- 750 S. FEDERAL HWY, HWD,FL

PLEASE REPLY TO ALL QUESTIONS/ PLEASE PRINT CLEARLY THANK YOU

Patient Information Pt Chart No(Office Use Only):

Family/Last Name: **First Name:**

Permanent U.S. Address:

City **State:** **Zip Code:**

Home Phone: ( ) - **Social Security No:**

Cell / Other Phone: ( ) **Email Address:** @

Date of Birth: / / **Age:** **Sex: M F**

mth day year Marital Status: S M D W

Ethnicity: **Primary Language:**

Emergency Contact Person: * list below * Relation to patient:

Name: **Telephone:**

Medical Reason for Visit today:

Patient Employed YES / NO **Occupation:**

Employer Name:

Work Telephone: **Ext.**

Do you have an Advanced Directive-Living Will? Yes / No *Please Select One

Would you like to receive Advanced Directive-Living Will Form? Yes / No *Please select one

INSURANCE INFORMATION WHO IS THE POLICY HOLDER : SELF / WIFE / HUSBAND / PARENT

INSURANCE NAME:

POLICY NO: **GROUP NO:**

<u>**(IF VISITING) LOCAL FLORIDA ADDRESS****</u>**

City **Zip Code**

Local Phone Number: ( )

Authorization for Release of Information

I hereby authorizae the release of any medical or other information necessary to process insurance claim(s) arising from my treatment(s) received at La Clinique Soleil & Urgent Care Center.

Signature of patient/or/authorized person Date

Assignment of Benefits

I hereby authorize payment of medical benefits directly to the physician/La Clinique Soleil & Urgent Care Center for medical services rendered.

Signature of patient/or/authorized person Date

HOW HAVE YOU HEARD OF US? Friend Internet Yellow/White Pages

Hollywood Medical Clinic
La Clinique Soleil

COMPREHENSIVE PATIENT HISTORY

Name: ____________________________________ Occupation: ________________________

Date of birth: ___/___/_____ Marital Status: ______________________ Number of children: ____________

Medications: *Please include prescriptions, over the counter, vitamins, herbs, supplements:*

Name	Dose	Name	Dose

Allergies: *To medications, X-ray dyes, latex, food, other:* ☐ *Yes* ☐ *No* *If YES, please list:*

Medical allergies: ______________________ Food/other allergies: ______________________

Past medical history

Please place a check beside disease and symptoms you have experienced in the past or are presently experiencing.

☐High blood pressure
☐Diabetes
☐Heart disease
- ☐Blocked arteries
- ☐Skips or rapid rate
- ☐Murmur/valve problems
- ☐Heart failure

☐High cholesterol
☐Cancer
Type: ______________
☐Thyroid disease
Type: ______________
☐COPD
☐Asthma
☐Pneumonia
☐Nasal allergies
☐Neck pain
☐Low back pain
☐Arthritis
Type: ______________
☐Gout
☐Kidney stones
☐Kidney disease
Type: ______________
☐BPH
☐Urinary tract infection
☐Venereal disease

Type: ______________
☐Hepatitis or jaundice
Type: ______________
☐Hemorrhoids
☐Colitis
Type: ______________
☐GERD (heartburn/indigestion)
☐Peptic ulcer disease
☐Gall bladder disease
☐Anemia
☐Blood disorder
Type: ______________
☐Skin disease
- ☐Acne
- ☐Psoriasis
- ☐Eczema
- ☐Other: ______________

☐Varicose veins
☐Poor circulation
☐Migraine headaches
☐Glaucoma
☐Macular degeneration
☐Fibromyalgia
☐Chronic fatigue syndrome
☐Depression/suicidal thoughts
☐Anxiety/panic
☐Alcohol abuse

☐Drug abuse
☐Neck or head radiation
☐Hot flashes/ night sweats
Fever
☐Cold or heat intolerance
☐Excessive thirst or urination
☐Unexplained weight gain/loss
☐Swollen glands
☐Easy bruising/bleeding
☐Fatigue
☐Dizziness/light-headedness
☐Headaches
☐Loss of vision/blurred vision/double vision
☐Hearing loss
☐Ringing in ears
☐Nose bleeds
☐Nasal congestion
☐Hoarseness/ sore throat
☐Swallowing problems
☐Cough
☐Wheezing
☐Shortness of breath
☐Chest pain tightness
☐Heart skipping/ pounding
☐Abdominal pain/discomfort
☐Nausea/vomiting

☐Constipation
☐Diarrhea
☐Change in bowel habits
☐Blood in/on bowel movements
☐Frequent urination
☐Difficulty urinating
☐Burning/pain with urination
☐Blood in urine
☐Difficulty controlling BM
☐Penile discharge
☐Difficulty with erections
☐Joint pain/swelling
☐Foot/ankle swelling
☐Rash
☐Changing mole
☐Skin lump or sore
☐Irritability/mood swings
☐Weakness
☐Numbness/tingling sensation
☐Balance problems
☐Poor concentration/focus on task
☐Memory loss
☐Recent falls

Gynecologic and obstetric history

Age at onset of periods: ______________ Frequency: ______________ Length of period: ______________

Number of each: Pregnancy: __________ Births: __________ Miscarriages: __________ Therapeutic abortions: __________

Please place a check beside symptoms you have experiences or are presently experiencing. Provide a brief description; including dates

Prolonged/abnormal bleeding ______________________ Abnormal discharge ______________________

Leakage of urine ______________________ History of abnormal pap smear ______________________

Pelvic pain________________________________ ____________________

____

Immunization history

Have you had immunization for:

Tetanus	☐No	☐Yes	When:_________
Pneumonia	☐No	☐Yes	When:_________
Shingles	☐No	☐Yes	When:_________
Hepatitis B	☐No	☐Yes	When:_________

List any other immunizations with dates:____________________

____

Preventative tests

When did you last have the following tests:

Pap smear	____________	Breast exam	____________	Stool check for blood	__________
Mammogram	____________	Colonoscopy	____________	Prostate exam	__________
Bone mineral density	____________	Cholesterol check	____________		

Family History

Has any member of your family (parents, grandparents, or other siblings) have been diagnosed with the following:

Illness	**Family member(s)**	**Approximate age when diagnosed**
Cancer		
Type:____________	____________________	__________
Type:____________	____________________	__________
Type:____________	____________________	__________
Hypertension (High blood pressure)	____________________	__________
Heart disease	____________________	__________
High Cholesterol	____________________	__________
Diabetes	____________________	__________
Stroke	____________________	__________
Mental Disease (anxiety, depression)	____________________	__________
Drug Addiction	____________________	__________
Alcohol addiction	____________________	__________
Glaucoma	____________________	__________
Bleeding disease	____________________	__________
Arthritis	____________________	__________
Type:____________	____________________	__________
Type:____________	____________________	__________
Kidney problems	____________________	__________
Asthma	____________________	__________
Hereditary disease	____________________	__________

Preventive lifestyle

Do you wear seatbelts?	☐No	☐Yes	If no, why? ____________________
Do you wear a bike helmet?	☐ No	☐ Yes	If no, why? ____________________
Do you exercise regularly?	☐ No	☐ Yes	If yes, what kind, duration, times per week? ____________________
Are you on a special diet?	☐ No	☐ Yes	If yes, what kind, ________________
Do you smoke?	☐ No	☐ Yes	If yes, how many packs per day?__________
Do you drink caffeinated beverages?	☐ No	☐ Yes	If yes, how many cups per day? __________
Do you drink alcoholic beverages?	☐ No	☐ Yes	If yes, how many drinks per day? _________
If there is a gun in the house, it unloaded and out of children's reach?	☐ No	☐ Yes	☐ Does not apply
Do you use drugs (marijuana, cocaine, crack, etc.)?	☐ No	☐ Yes	If yes, explain: ________________
Have you engaged in activity that has put you at risk for AIDS?	☐ No	☐ Yes	If yes, explain: ________________
Have you ever worked with chemicals, paint, asbestos, or other hazardous materials?	☐ No	☐ Yes	If yes, explain: ________________
Are you in a relationship in which you have been physically hurt (slapped, kicked, punched, bruised) by our partner?	☐ No	☐ Yes	☐ Does not apply
Do you ever feel afraid of your partner?	☐ No	☐ Yes	☐ Does not apply
Do you have an organ donor card?	☐ No	☐ Yes	
Do you use birth control?	☐ No	☐ Yes	If yes, which method? ______________

Patient Signature: ____________________ Date: __________ Revised by physician: ____________________ Date __________

Hollywood Medical Clinic
La Clinique Soleil

GENERAL CONSENT FOR TREATMENT

I, ____ , hereby authorize La Clinique Soleil, Hollywood Medical Clinic, the attending physician, or the designated physician, and other center employees to examine and treat me. I also authorize such treatment and procedures, as deemed necessary by the physician, including, but not limited to, the taking of x-rays, medications, blood samples, urine samples and other therapies as deemed necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made or implied to me as to the results that may be obtained by examination and treatment.

I hereby certify that I understand the above authorization.

Patient Name:____ Date of Birth:________

Patient Signature:____ Date:______________

Witness Signature:____ Date:______________

Legal Guardian Name
Authorized to Consent:_______________________________________ Date:______________

Legal Guardian Signature:____________________________________ Date:______________

CLINIQUE MEDMANAGEMENT GROUP, LLC

750 S. Federal Highway, Hollywood, FL 33020
Tel: (954) 342-8800 Fax: (954) 342-8700
www.lacliniquesoleil.com

750 South Federal Highway
Hollywood, Fl 33020

Phone: 954-342-8800
Fax: 954-342-8700

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____________________ Date of Birth: ____________________
Previous Name: ____________________ Social Security #: ____________________

I request and authorize ____ to

release healthcare information of the patient named above to:

Name (physician/hospital/clinic): ________________________________
Address: ________________________________
City: ____________ State: ________ Zip Code: ____________
Phone: ____________________ Fax: ____________________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ____________
____
☐ All healthcare information
☐ Other: ________________________________

Definition: Sexually Transmitted Disease (STD) as defined by law, includes herpes, herpes simplex, human papilloma virus, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative of positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ____________________________ Date: ____________________

750 S. Federal Highway, Hollywood Fl 33020
Tel : 954-342-8800 Fax : 954-342-8700
Email : clsoleil@bellsouth.net

Hollywood Medical Clinic
La Clinique Soleil

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*******YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT*******

I, ____, have received a copy of this office's Notice of Privacy Practices,

Name: ____

Signature: ____

Date: ____

FOR OFFICIAL USE ONLY

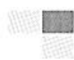
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergent situation prevented us from obtaining acknowledgement

_____ Other ____



750 S. Federal Highway, Hollywood FL 33020 Tel.: 954.342.8800 Fax: 954.342.8700

Website: www.cliniquesoleil.com Email: clsoleil@bellsouth.net

Dear Patient,

Please read and sign the following notice:

"Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice."

Dr. Sandro Bacchelli ~ La Clinique Soleil/ Hollywood Medical Clinic~

HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law.

I have read and understand the above information. I also understand that this document will be placed in my medical chart.

______________________________ ______________________________

Print Name **Date**

____

Patient or Legal Guardian Signature **Date**