Infectious Disease Physicians, P.A.

Diplomates, American Boards of Internal Medicine and Infectious Disease

H. Barry Baker, MD, FACP
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Snapper Creek Professional Center
7800 S.W. 87th Ave, Suite B260
Miami, FL. 33173
Phone: (305) 595-4590
Fax: (305) 279-2278

Date: _____

Last/First Name_____ Date of Birth_____ Sex:___ Age:___

Street Address_____

City_____ State_____ Zip Code_____

Employer:_____

Business Address _____

Home Phone_____ Work Phone_____ Cell Phone_____

Email Address_____ SS#_____

Marital Status_____

Ethnicity _____ Preferred Language_____

American Indian or Alaskan Native ____ Asian ____ Black____ Caucasian____ Other____ Declined____

Primary Care Doctor_____ Referring Doctor_____

Nearest Relative (if no spouse)_____ Relationship_____

Address_____ Phone_____

Spouse_____ Spouse's Employer_____

Spouse work phone or contact number_____

Primary Insurance (including Medicare, Medicaid, Commercial, etc.):

Name of Insurance Company_____ PPO/HMO/IND(circle one)

ID#_____ Group#_____ Subscriber Name_____

Secondary Insurance (including Medicare, Medicaid, Commercial, etc.):

Name of Insurance Company_____ PPO/HMO/IND(circle one)

ID#_____ Group#_____ Subscriber Name _____

Consent for Treatment: I voluntarily consent to the rendering of care and treatment. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician. _____Initial

Guarantee of Account: I understand that I am fully responsible for all charges made to my account. I herby authorize **Infectious Disease Physicians, P.A.** to release any medical information necessary to process claims or any information requested from my records. I hereby assign payment of medical benefits to **Infectious Disease Physicians, P.A.** for services rendered as described. ___**Initial**

Medicare Lifetime Assignment: I request that payment of authorized Medicare benefits be made on my behalf to **Infectious Disease Physicians, P.A.** for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. ___**Initial**

Medicare and Medicaid Patient Certification: Patient Certification Authorization to Release Information and Payment Request I certify that the information given to me in applying for payment under Title XVIII and/or Title XIX, of Social Security ACT, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician (s) services. I understand that I am responsible for my health insurance deductibles and co insurance. ___**Initial**

HMO Disclaimer (Medicare Patient's Only): I certify that I am not presently enrolled in any (HMO). Subsequent rejection of a claim due to current enrollment in an HMO plan will constitute responsibility for payment of claim on my part. ___**Initial**

Signature: _____ Date:_____

Electronic Medical Records Storage: To improve patient care, **Infectious Disease Physicians, P.A.** transmits patients' office visit dictations to a transcription company known as E-Scribe. This method of transmitting office notes enables our physicians to continually improve the medical care provided to you and the other patients.
I authorize **Infectious Disease Physicians, P.A.** to transmit portions of my medical records to E-Scribe. I understand that this information will be accessible by my physicians or, my physicians authorized staff, and authorized for E-Scribe employees only. E-Scribe will secure my records from unauthorized access, and will not distribute patient-identifiable information to anyone except authorized individuals.

Signature:_____ Date:_____

Notice to all HMO and PPO patients:

Your "HMO" or "PPO" health insurance plan has specific rules you must follow in order for you to avoid liability for full payment of services rendered. We participate with many HMO and PPO plans. It is your responsibility as a patient to provide us with an updated referral/authorization on the day of your scheduled appointment. Our office cannot be held responsible for obtaining referrals/authorizations. In order to keep as close to our schedule as possible, if you do not have an authorization/referral our appointment schedulers will reschedule you for a later date. To avoid this problem, we suggest you contact you primary care physician in advance. This will allow sufficient time to provide an authorization.

We strongly urge you to learn in exact terms:

1. What your insurance plan covers and does not cover.
2. If you must present a referral/authorization for each visit.
3. What your patient responsibility is for each visit (co-payment and/or deductible).
4. Which hospitals have a contract with your plan.

You are responsible for co-payments and deductibles on the day that services are rendered. Our office accepts cash, checks, Visa, MasterCard, and American Express for your convenience.

Finally, this is you insurance plan. Please familiarize yourself with every rule of the health plan you are enrolled in, it can save you a substantial amount of money! Your insurance company will mail you a summary of charges, payments, denials, or request for further information. Please review all insurance correspondence.

Please sign and return to the front desk after reading. If you have any questions, feel free to speak to one of our office personnel.

I have read and understand the above information.

Patient Name(print):_____

Signature:_____ Date:_____

MEDICAL HISTORY

Reason for Visit (Present Illness)

_____

_____

_____

_____

Past Medical History: If you answered yes below when diagnosed?

High Blood Pressure	Yes _____ No _____	_____
Diabetes	Yes _____ No _____	_____
Asthma	Yes _____ No _____	_____
Tuberculosis	Yes _____ No _____	_____
Lung Disease	Yes _____ No _____	_____
Heart Disease	Yes _____ No _____	_____
Heart Murmer	Yes _____ No _____	_____
Increased Lipids	Yes _____ No _____	_____
Kidney Disease	Yes _____ No _____	_____
Arthritis	Yes _____ No _____	_____
Seizures	Yes _____ No _____	_____
Stroke	Yes _____ No _____	_____
Infectious Diseases	Yes _____ No _____	_____
Crohns Disease	Yes _____ No _____	_____
Ulcerative Colitis	Yes _____ No _____	_____
Cancer	Yes _____ No _____	Type_____
Blood disorder	Yes _____ No _____	Type_____
Thyroid Disease	Yes_____ No_____	_____

Venereal Diseases Yes _____ No _____ Type_____

Hepatitis A, B or C _____

Other _____

Past Surgical History

1. _____
2. _____
3. _____
4. _____
5. _____

Past Hospitalizations

1. _____
2. _____
3. _____
4. _____
5. _____

Social History

Smoking _____ Packs per day _____

Drinking _____ Amount ingested _____

Drug use Yes or No If yes, drug of choice _____

Pets _____ Type _____

Traveled in the past 6 months Yes _____ No _____ Where?_____

Do you eat raw meat or fish? Yes _____ No _____

Single _____ Married _____ Divorced _____ Widowed _____

Sexual Preference: Heterosexual _____ Gay _____ Lesbian _____ Bisexual _____

Medication List

	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Pharmacy Name _____ Phone #_____

Allergies

1. _____

2._____

3. _____

4. _____

5. _____

Family History Age Significant Illness

Parents _____

Siblings _____

Children _____

Review of Systems: If you answered yes to any of the questions below please explain.

Fever	Yes_____ No_____	_____Degrees
Chills	Yes_____ No_____	_____
Night Sweats	Yes_____ No_____	_____
Weight loss or gain	Yes_____ No_____	How much?_____
Fatigue	Yes_____ No_____	_____
Headaches	Yes_____ No_____	_____
Siezures or convulsions	Yes_____ No_____	_____
Fainting or loss of consciousness	Yes_____ No_____	_____
Dizziness	Yes_____ No_____	_____
Double Vision	Yes_____ No_____	_____
Sore throat	Yes _____ No_____	_____
Swollen Glands	Yes _____ No _____	_____
Runny Nose	Yes _____ No _____	_____
Nose Bleed	Yes _____ No _____	_____
Sinus Drainage	Yes _____ No _____	_____
Ear Ache	Yes _____ No _____	_____
Cough	Yes _____ No _____	_____
Sputum Production	Yes _____ No _____	_____
Coughing up Blood	Yes _____ No _____	_____
Cough on Swallowing	Yes _____ No _____	_____
Shortness of Breath	Yes _____ No _____	_____
Chest Pain	Yes _____ No _____	_____
Palpitations	Yes _____ No _____	_____

Abdominal pain Yes _____ No _____ _____

Nausea Yes _____ No _____ _____

Vomiting Yes _____ No _____ _____

Vomiting Blood Yes _____ No _____ _____

Constipation Yes _____ No _____ _____

Reflux Yes _____ No _____ _____

Diarrhea Yes _____ No _____ _____

Blood in Stool Yes _____ No _____ _____

Frequency of Urination Yes _____ No _____ _____

Burning on Urination Yes _____ No _____ _____

Blood in Urine Yes _____ No _____ _____

Urethral Discharge Yes _____ No_____ Type _____

Menstrual abnormalities Yes _____ No _____ _____

Presently pregnant Yes _____ No _____ _____

Menopause Yes _____ No_____ _____

Joint Pain Yes _____ No _____ _____

Joint Swelling Yes _____ No _____ _____

Muscle Pain Yes _____ No _____ _____

Muscle Weakness Yes _____ No _____ _____

Decreased Sensation feet/hands Yes _____ No _____ _____

Pain Yes _____ No _____ Location _____

_____ _____ _____

_____ _____ _____

Names of other Physicians

Infectious Disease Physicians, P.A.
7800 S.W. 87th Avenue #B260
Miami, FL 33173

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within the practice for the purpose of providing you with quality healthcare.

- Your confidential healthcare information may be released to your insurance provider for the purpose of the office receiving payment for providing you with needed healthcare services.

- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.

- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.

- Your confidential healthcare information may be released to public health organizations or federal organizations in the event of a communicable disease or to report a defective device or unknown event of a biological product (food or medication).

- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.

- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.

- You may be contacted by the office to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

- You have the right to restrict the use of your confidential healthcare information. However, the office may choose to refuse your restriction if it conflicts with providing quality healthcare or in the event of an emergency.

- Your have the right to review and photocopy any/all portions of your healthcare information.

- You have the right to know who has accessed you confidential healthcare information and for what purpose.

- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form on an electronic transmission or on paper.

- The office is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.

- Our office will abide by the terms of this notice. The office reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making any changes.

- You have the right to complain to the office if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the office:

Attn: Office Manager
Infectious Disease Physicians
7800 SW 87the Avenue B260
Miami, FL 33173

- All complaints will be investigated. No personal issue will be raised for filing a complaint with the office.

For further information about this Privacy Notice, please contact
- Office Manager (305)595-4590
- This notice is effective as of 02/13/09

Privacy Notice:

I have received a copy of the policy notice regarding my confidential healthcare information and how it may be used within this office/practice.

Print Name: _____

Signature: _____

Date:_____ Witnessed By:_____

It is our desire for our staff to use your name, address and or telephone number for contacting you to remind you about scheduled appointment, reevaluations, messages to call our office, or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effect on your care from the Infectious Disease Physicians, P.A., or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Patient Signature:_____

This authorization may be revoked by you at any time. Revocation may be accomplished by advising in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Patient Record of Disclosure

I wish to be contacted in the following manner:

1. Home telephone number:_____
   - O.K. to leave a message with detailed information
   - Leave a message with a call-back number only

2. Work telephone number:_____
   - O.K. to leave a message with detailed information
   - Leave a message with a call-back number

3. O.K. to fax to this number:_____

4. O.K. to mail to my home address:_____

Patient Name: _____

Patient Signature: _____

Date of Birth: _____

Today's Date: _____

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RECORD REQUEST FORM

Infectious Disease Physicians is Requesting _____
Patient Name

_____/_____/_____ and _____-_____-_____ to provide to consent to release confidential healthcare
D.O.B
information to Infectious Disease Physicians for the purpose of Medical Records.

_____ Doctors Notes

_____ Diagnostic Testing

_____ Laboratory Results

_____ All HIV Records

_____ All Patient Information

CONDITIONS:

- The patient has the right to revoke this consent at any time. Revoking of this consent must be made in writing, signed and dated.
- This consent is between Infectious Disease Physicians, P.A. and the patient named above. No other individuals/organizations have permission to obtain the patient's confidential healthcare information under this consent.
- This consent form will be stored in the patient's office chart, or warehouse location for a period of seven (7) years.

Patient Signature: _____ Date: _____

Office Representative: _____ Date: _____