



GULF VIEW GENERAL SURGERY, LLC

111181 HEALTH PARK BLVD SUITE 3050, NAPLES, FL 34110 PHONE (239)260-1115 Fax: (239)260-1089

For office use/ MR#: _____

Patient Information

Patient's Name: _____ **Birth Date:** _____
First Middle Last (MM/DD/YYYY)

Home Phone: _____ **Cell Phone:** _____
Sex: Male Female

Address: _____
City, State Zip Code

Status:
 Single Divorced Married Widowed
 Separated Living with significant other
Race/Ethnicity: _____

Social Security: _____

Religion: _____ **Employer:** _____

Patient's Occupation: _____ **Phone:** _____

Current Employer's Address: _____

Spouse or Parent: _____ **Phone:** _____

Emergency Contact:
Name _____ **Relation:** _____ **Phone:** _____

E-mail _____ **Appointment Reminder:** Email Call Text

Preferred Language: _____

How did you hear about us?

- Friend / Relative Patient Internet Newspaper Physician _____
- Other _____

Insurance Information:

Primary Insurance		
Insurance Name	Effective Date	End Date
Principal Subscriber Name	Policy Number:	Group #
Subscriber Date of Birth	Relation to Patient	Employer
Secondary Insurance (If applicable)		
Insurance Name	Effective Date	End Date
Principal Subscriber Name	Policy Number:	Group #
Subscriber Date of Birth	Relation to Patient	Employer



FINANCIAL AGREEMENT

I understand that I'm directly responsible for all the charges incurred for medical service for myself and my dependents regardless of insurance coverage. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date. I furthermore agree to pay legal interest, collection expense, and attorneys' fees incurred to collect any amount I owe.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable.

AGREEMENT: This above information is for the purpose of obtaining credit and is warranted to be true.

CANCELATION POLICY: If you have any inconvenience for showing to your appointment please call us at least 24 hours before your appointment, in order to reschedule it. **Our No-Show fee will be \$50**, and it has to be paid before your next appointment.

RETURNED CHECKS: Your account will be charged \$30 fee for each returned check.

Signature: X _____ Date: _____
Patient / Parent / Guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form you acknowledge receipt of the Notice of Privacy Practices for Gulf View General Surgery, LLC . Our Notice of Privacy Practice provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change.

X _____
Signature Patient's/ Parent/ Guardian

Date

Name of Patient or Representative (Print please)

Relationship to Patient

Office use:

We attempted to obtain written acknowledgement, but couldn't be obtained for the following reason:

- Patient or Representative Refused to Sign
- Emergency Situation Prevented Signature
- Other: _____

Provider Representative Signature

Date



**GULF VIEW GENERAL SURGERY, LLC
NEW PATIENT QUESTIONNAIRE**

Patient's Name: _____ Height: _____ Weight: _____ Female Male

Age today: _____	3. Last Primary Doctor _____
1. Describe the primary reason of your visit:	4. Do you use tobacco products? <input type="checkbox"/> No, I have never smoked. <input type="checkbox"/> No, I quit smoking _____ months/years ago. <input type="checkbox"/> Yes, I smoke _____ packs per day, Years _____ <input type="checkbox"/> Other: _____
2. Do you use alcoholic beverages? <input type="checkbox"/> Yes, Type _____ <input type="checkbox"/> <p align="center">Amount: _____</p> <input type="checkbox"/> No	

Preferred Pharmacy Name: _____

Address: _____ **Zip Code:** _____

Phone: _____

PAST MEDICAL HISTORY

<u>BRAIN</u> <input type="checkbox"/> TIA (transient ischemic attack) <input type="checkbox"/> Stroke <u>ENDOCRINE</u> <input type="checkbox"/> Insulin dependent diabetes <input type="checkbox"/> Non-insulin dependent diabetes <input type="checkbox"/> Hypercholesterolemia <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Severe Osteoporosis <u>HEART</u> <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Myocardial infarction (heart attack) <input type="checkbox"/> Hypertension/High Blood Pressure <u>INFECTIOUS</u> <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cellulitis <input type="checkbox"/> Syphilis <input type="checkbox"/> Joint infection	<u>KIDNEY</u> <input type="checkbox"/> Chronic renal failure <u>LUNG</u> <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Chronic bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <u>MUSCULOSKELETAL</u> <input type="checkbox"/> Low back pain <input type="checkbox"/> Sciatica <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> Degenerative disk disease <input type="checkbox"/> Juvenile Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Psoriasis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Severe Osteoporosis <u>CANCER</u> Type: _____	<u>PSYCHIATRIC</u> <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Major depression <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Schizophrenia <u>STOMACH AND INTESTINE</u> <input type="checkbox"/> GERD/Reflux <input type="checkbox"/> Gastric ulcer <input type="checkbox"/> Irritable Bowel Syndrome <u>VASCULAR</u> <input type="checkbox"/> DVT <input type="checkbox"/> Phlebitis <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> OTHER: 1. _____ 2. _____ 3. _____
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ALLERGIES

NO KNOWN ALLERGIES

<u>MEDICINE</u>	<u>REACTION</u>	<u>GENERAL</u>	<u>REACTION</u>
<input type="checkbox"/> Aspirin	_____	<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Erythromycin	_____	<input type="checkbox"/> Adhesive	_____
<input type="checkbox"/> NSAIDs	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Penicillin	_____		
<input type="checkbox"/> Sulfa	_____		

FAMILY HISTORY

<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Heart Disease	_____		_____
<input type="checkbox"/> Diabetes	_____		_____

OTHER PAST SURGICAL HISTORY

<p><u>BREAST</u></p> <p><input type="checkbox"/> Lumpectomy (<i>left or right side</i>)</p> <p><input type="checkbox"/> Mastectomy (<i>left or right side</i>)</p> <p><u>CARDIOVASCULAR</u></p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Coronary artery Bypass</p> <p><input type="checkbox"/> Valve replacement</p> <p><u>ORTHOPEDIC</u></p> <p><input type="checkbox"/> Joint Replacement</p> <p><input type="checkbox"/> Spine</p> <p><input type="checkbox"/> Sports/Trauma</p>	<p><u>GASTROINTESTINAL</u></p> <p><input type="checkbox"/> Hernia repair</p> <p><input type="checkbox"/> Resection of large bowel</p> <p><input type="checkbox"/> Removal gall bladder</p> <p><u>VASCULAR</u></p> <p><input type="checkbox"/> Abdominal aortic aneurysm</p> <p><input type="checkbox"/> Femoral Bypass</p> <p><input type="checkbox"/> Dialysis shunt</p> <p><input type="checkbox"/> Varicose vein stripping</p>	<p>OTHER:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p> <p>6. _____</p> <p>7. _____</p> <p>8. _____</p> <p>9. _____</p>
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MEDICATION INFORMATION

(Please circle the medications you are taking.)

<p><u>High Blood Pressure:</u></p> <p><input type="checkbox"/> Accupril (Quinapril)</p> <p><input type="checkbox"/> Atenolol</p> <p><input type="checkbox"/> Capoten (Captopril)</p> <p><input type="checkbox"/> Cardizem (Diltiazem)</p> <p><input type="checkbox"/> Cardura (Doxazosin)</p> <p><input type="checkbox"/> Cozaar (Losartan)</p> <p><input type="checkbox"/> Diovan (Valsartan)</p> <p><input type="checkbox"/> Vasotec (Enalapril)</p> <p><input type="checkbox"/> Zestril (Lisinopril)</p> <p><input type="checkbox"/> Lopressor/Toprol (Metoprolol)</p> <p><input type="checkbox"/> Lotensin (Benazepril)</p> <p><input type="checkbox"/> Norvasc (Amlodipine)</p> <p><input type="checkbox"/> Procardia (Nifedipine)</p>	<p><u>Cholesterol Lowering Drugs:</u></p> <p><input type="checkbox"/> Lipitor (Atrovastatin)</p> <p><input type="checkbox"/> Pravachol (Pravastatin)</p> <p><input type="checkbox"/> Zocor (Simvastatin)</p> <p><u>Diuretics (Water Pills):</u></p> <p><input type="checkbox"/> Dyazide (HCTZ + Triamterene)</p> <p><input type="checkbox"/> Lasix (Furosemide)</p> <p><input type="checkbox"/> Hydrochlorothiazide (HCTZ)</p> <p><u>Diabetes:</u></p> <p><input type="checkbox"/> Glucophage (Metformin)</p> <p><input type="checkbox"/> Glucotrol (Glipizide)</p> <p><input type="checkbox"/> Insulin (Humulin)</p> <p><u>Gastrointestinal (Stomach):</u></p> <p><input type="checkbox"/> Nexium (Esomeprazole)</p> <p><input type="checkbox"/> Prevacid (Lansoprazole)</p> <p><input type="checkbox"/> Prilosec (Omeprazole)</p> <p><input type="checkbox"/> Zantac (Ranitidine)</p>	<p><u>NSAIDs:</u></p> <p><input type="checkbox"/> Advil/Motrin (Ibuprofen)</p> <p><input type="checkbox"/> Aleve (Naproxen or Naprosyn)</p> <p><input type="checkbox"/> Bextra</p> <p><input type="checkbox"/> Celebrex</p> <p><input type="checkbox"/> Mobic</p> <p><u>Pain:</u></p> <p><input type="checkbox"/> Darvocet (Acetaminophen + Propoxyphene)</p> <p><input type="checkbox"/> Dilaudid</p> <p><input type="checkbox"/> Duragesic Patch (Fentanyl Patch)</p> <p><input type="checkbox"/> Endocet/Percocet/Tylox (Oxycodone Acetaminophen)</p> <p><input type="checkbox"/> Lortab/Vicodin (Hydrocodone + Acetaminophen)</p> <p><input type="checkbox"/> MS Contin</p> <p><input type="checkbox"/> Neurontin</p> <p><input type="checkbox"/> Oxycodone/Oxycontin</p>
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<p><u>Heart Medication:</u></p> <p><input type="checkbox"/> Lanoxin (Digoxin)</p> <p><input type="checkbox"/> Nitroglycerin</p> <p><u>Blood Thinners:</u></p> <p><input type="checkbox"/> Aspirin</p> <p><input type="checkbox"/> Coumadin (Warfarin)</p> <p><input type="checkbox"/> Plavix</p>	<p><u>Rheumatology:</u></p> <p><input type="checkbox"/> Methotrexate</p> <p><input type="checkbox"/> Plaquenil</p> <p><input type="checkbox"/> Prednisone</p>	<p><input type="checkbox"/> Tylenol #3(Acetaminophen + Codeine)</p> <p><input type="checkbox"/> Ultram (Tramadol)</p> <p>Percocet</p> <p>Vicodin</p>
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OTHER MEDICATION(S):

REVIEW OF SYSTEMS

Please mark any symptoms that you are currently experiencing.

<p><u>GENERAL</u></p> <p><input type="checkbox"/> Good general health</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Feeling tired all the time</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Weight gain of more than 10 lbs</p> <p><input type="checkbox"/> Weight loss of more than 10 lbs</p> <p><u>SKIN</u></p> <p><input type="checkbox"/> Rashes</p> <p><input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Abnormal Lumps</p> <p><input type="checkbox"/> Painful breast</p> <p><u>HEENT</u></p> <p><input type="checkbox"/> Blurry vision</p> <p><input type="checkbox"/> Sinusitis</p> <p><input type="checkbox"/> Fainting</p> <p><u>NECK</u></p> <p><input type="checkbox"/> Difficulty swallowing</p>	<p><u>RESPIRATORY</u></p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Wheezing</p> <p><u>CARDIOVASCULAR</u></p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Irregular heartbeat</p> <p><input type="checkbox"/> Heart murmur</p> <p><u>GASTROINTESTINAL</u></p> <p><input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Nausea/vomiting</p> <p><input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> Blood in stool</p> <p><u>GENITOURINARY</u></p> <p><input type="checkbox"/> Blood in Urine</p> <p><input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> Loss of bladder control</p> <p><input type="checkbox"/> Increased frequency of Urination</p> <p><input type="checkbox"/> Kidney Stones</p>	<p><u>MUSCULOSKELETAL</u></p> <p><input type="checkbox"/> Fractures/sprains</p> <p><input type="checkbox"/> Osteoporosis</p> <p><input type="checkbox"/> Joint swelling</p> <p><u>NEUROLOGICAL</u></p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Headaches/ migraine</p> <p><input type="checkbox"/> Convulsions /seizures</p> <p><input type="checkbox"/> Loss of consciousness</p> <p><u>PSYCHIATRIC</u></p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Change in sleep pattern</p> <p><input type="checkbox"/> Depression</p> <p><u>ENDOCRINE</u></p> <p><input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> Appetite changes</p> <p><input type="checkbox"/> Diabetes</p> <p><u>HEMATOLOGY</u></p> <p><input type="checkbox"/> Enlarged lymph nodes</p> <p><input type="checkbox"/> Prolonged bleeding</p> <p><input type="checkbox"/> Spontaneous bleeding</p>
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OB/GYN (females only)

PREGNANCIES: _____ Year(s): _____ Surgeries: _____

Abortions/Miscarriages: _____ Year(s): _____

Term Pregnancy: _____ Preterm: _____

Breast feeding, total months between all babies: _____

Age of First Menstrual Period: _____

Date of Last Menstrual Period: _____

Use of Hormones or Contraceptives: _____

All Other Systems Negative

Others: _____

Other problems (please describe):



GULF VIEW GENERAL SURGERY Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our Internal Medicine practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

GULF VIEW GENERAL SURGERY LLC Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

PRIVACY OFFICER
GULF VIEW GENERAL SURGERY, LLC
11181 HEALTH PARK BLVD SUITE 3050
NAPLES, FL 34110

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

This notice is effective September 1, 2014.