JOSE R. ANTUNES, M.D., P.A.

2400 FRUITVILLE ROAD SARASOTA, FLORIDA 34237

941-365-0333 FAX: 941-955-3181

PATIENT INFORMATION **DATE:**_____

NAME:_____
LAST MIDDLE FIRST

ADDRESS:_____
NUMBER STREET APT

_____
CITY STATE ZIP

HOME PHONE: _____ CELL PHONE:_____

BIRTHDATE: _____SEX:_____ **SOCIAL SECURITY**#:_____

MARITAL STATUS:____S____M ____D ____W SPOUSE NAME:_____

OUT OF STATE ADDRESS

ADDRESS:_____

HOME PHONE: _____ WORK PHONE:_____

NOTIFY IN EMERGENCY

NAME:_____

ADDRESS_____ PHONE:_____

PLACE OF EMPLOYMENT

COMPANY:_____

ADDRESS:_____ PHONE:_____

PRIMARY INSURANCE:_____ ID#:_____

SECONDARY INSURANCE:_____ ID#: _____

REFERRING DOCTOR

NAME: _____ PHONE #:_____

ADDRESS:_____

I HEREBY AUTHORIZE DR. ANTUNES TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED. I REQUEST PAYMENT FROM THE ABOVE LISTED INSURANCE COMPANY, MEDICARE OR MEDICAID BE MADE DIRECTLY TO THE DOCTOR IF ASSIGNMENT HAS BEEN TAKEN. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT AND FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM TO THE INSURANCE COMPANIES I HAVE LISTED OR IN CASE OF MEDICARE PART B, TO THE SOCIAL SECURITY ADMINISTRATION AND PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY EITHER MYSELF OR THE ABOVE OFFICE AT ANYTIME.

SIGNATURE:_____ DATE:_____

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NAME: _____

AGE: _____ SEX: _____ TODAY'S DATE: _____

PLEASE CHECK BOX IF YOU HAVE OR HAVE HAD EITHER: ❑ DIABETES ❑ THYROID DISEASE

PLEASE MARK SYMPTOMS BELOW:

1. ❑ FATIGUE ❑ TIREDNESS
2. ❑ INTOLERANCE TO HEAT OR COLD
3. ❑ EXCESSIVE SWEATING
4. ❑ INCREASE ❑ DECREASE - IN APPETITE
5. ❑ WEIGHT GAIN ❑ LOSS
6. ❑ FAST HEART RATE
7. ❑ CHEST PAIN
8. ❑ HEART MURMUR
9. ❑ SWELLING OF LEGS
10. ❑ HIGH BLOOD PRESSURE
11. ❑ HEARTBURN
12. ❑ STOMACH OR DUODENAL ULCER
13. ❑ ABDOMINAL PAIN
14. ❑ NAUSEA ❑ VOMITING
15. ❑ DIFFICULTY SWALLOWING
16. ❑ DIARRHEA / CONSTIPATION
17. ❑ BLACK AND TARRY STOOLS
18. ❑ YELLOW JAUNDICE
19. ❑ BLEEDING FROM RECTUM
20. ❑ PAINFUL URINATION
21. ❑ KIDNEY/BLADDER STONE
22. ❑ HAVE TO URINATE AT NIGHT
23. ❑ BLADDER OR KIDNEY INFECTION
24. ❑ DIFFICULT STARTING URINATION
25. ❑ DECREASE IN URINE STREAM
26. ❑ PROSTATE PROBLEMS
27. ❑ SEXUAL IMPOTENCE
28. ❑ LUMPS OR PAINS IN TESTES
29. ❑ CHANGES IN SKIN ❑ DRY
    ❑ COARSE ❑CLAMMY
30. ❑ CHANGES IN HAIR
31. ❑ TREMOR OF HANDS/FINGERS
32. ❑ FREQUENT HEADACHES
33. ❑ MUSCLE WEAKNESS
34. ❑ DIZZY SPELLS
35. ❑ FAINTING OR BLACKOUTS
36. ❑ IRREGULAR PULSE
37. ❑ HEART ATTACK
38. ❑ VISUAL DISTURBANCE ❑ DOUBLE ❑ BLURRED
    ❑ DECREASED
39. ❑ PAINFUL EYES
40. ❑ COUGH
41. ❑ BLOOD IN SPUTUM
42. ❑ ASTHMA / WHEEZING
43. ❑ DECREASED HEARING
44. ❑ RINGING IN THE EARS
45. ❑ VOICE CHANGES
46. ❑ NECK PAIN
47. ❑ SWELLING / LUMPS IN NECK
48. ❑ FEELINGS OF DEPRESSION
49. ❑ FEELINGS OF ANXIETY
50. ❑ MOODINESS
51. ❑ NERVOUSNESS
52. ❑ MEMORY LOSS
53. ❑ MENTAL ILLNESS
54. ❑ PHOBIAS
55. ❑ SLEEP DISTURBANCES
56. ❑ ARTHRITIS / PAIN IN JOINTS
57. ❑ BACK PAIN

FEMALE - MENSTRUAL HISTORY

60. AGE OF ONSET_____
61. MENSTRUAL PERIODS: ❑ REGULAR ❑ HEAVY
    ❑ MODERATE ❑ LIGHT
62. DAYS OF MENSTRUAL FLOW_____
63. LENGTH OF CYCLE _____ DAYS
64. ❑ PAIN / BLEEDING AFTER SEX
65. ❑ HOT FLASHES
66. NUMBER OF PREGNANCIES_____
67. MISCARRIAGES_____
68. DO YOU DO SELF BREAST EXAMS? ❑ YES ❑ NO
69. ❑ BREAST SECRETION ❑ PAIN ❑ LUMPS
70. DO YOU HAVE PMS? ❑ YES ❑ NO
71. FAMILY HISTORY OF OSTEOPOROSIS ❑ YES ❑ NO
72. AT WHAT AGE DID YOU GO INTO MENOPAUSE? _____
73. DID YOU TAKE HORMONES AFTER YOUR MENOPAUSE?
    ❑ NO ❑ YES IF YES, FOR HOW LONG? _____

DIETARY HISTORY

74. ARE YOU ON A SPECIAL DIET? ❑ YES ❑ NO
    IF YES, PLEASE SPECIFY: _____
75. DO YOU TAKE CALCIUM SUPPLEMENTS? ❑ YES ❑ NO
    IF YES, HOW MUCH PER DAY? _____
76. DO YOU TAKE VITAMIN D SUPPLEMENTS? ❑ YES ❑ NO

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NAME: _____

AGE: _____ SEX: _____ TODAY'S DATE: _____

FAMILY HISTORY:

	ALIVE	DECEASED	AGE	ILLNESSES
Father:	_____	_____	_____	_____
Mother:	_____	_____	_____	_____
Brothers/Sisters:				
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

HABITS:

Do you/have you ever smoked? ❑YES ❑NO How many per day? _____
Do you drink alcohol? ❑YES ❑NO How much per week? _____
Do you exercise? ❑YES ❑NO What do you do? _____

Please list any operations or hospitalizations:

1. _____ YEAR: _____ 2. _____ YEAR: _____
3. _____ YEAR: _____ 4. _____ YEAR: _____
5. _____ YEAR: _____ 6. _____ YEAR: _____
7. _____ YEAR: _____ 8. _____ YEAR: _____

Please identify your Race from the following CDC-defined options:

❑ Black or African American
❑ White or Caucasian
❑ American Indian or Native American
❑ Asian or Other Pacific Islander
❑ Unknown/Decline to Answer

Please identify your Ethnicity from the following CDC-defined options:

❑ Hispanic
❑ Non-Hispanic
❑ Unknown/Decline to Answer

Preferred Language: _____

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NAME:_____ **DATE:**_____

Pharmacy Name & Address: _____
Pharmacy phone: _____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS:

_____
_____

LIST ALL CURRENT PRESCRIPTION MEDICATIONS AND DOSAGE:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

PLEASE LIST ALL CURRENT *OVER THE COUNTER* MEDICATIONS AND VITAMINS:

_____
_____

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IF YOU HAVE DIABETES MELLITUS PLEASE ANSWER THE FOLLOWING:

PATIENT NAME: _____ DATE: _____

1. I HAVE HAD DIABETES SINCE_____
2. MY WEIGHT IS _____ LBS. MY HEIGHT IS_____FT. _____IN.
3. I AM ON _____ CALORIES PER DAY.
4. I STAY ON MY DIET MOST OF THE TIME. ❑YES ❑NO
5. I EXERCISE ☐REGULARLY ☐OCCASIONALLY ☐NEVER
6. I MONITOR THE CONTROL OF MY DIABETES WITH:
   ☐HOME BLOOD SUGARS ~ NAME OF METER _____
7. HAVE YOU EVER HAD DIABETIC KETOACIDOSIS? ❑YES ❑NO
8. DO YOU KNOW THE SYMPTOMS OF HYPOGLYCEMIA? ❑YES ❑NO
9. DO YOU CARRY SUGAR TABLETS OR HARD CANDY TO USE IN CASE OF HYPOGLYCEMIA? ❑YES ❑NO
10. WERE YOU EVER HOSPITALIZED BECAUSE OF DIABETES? ❑YES ❑NO
    IF YES, EXPLAIN WHY _____
11. DO YOU HAVE ANY OF THE LONG TERM COMPLICATIONS OF DIABETES? ❑YES ❑NO
12. DO YOU SEE YOUR EYE DR. ONCE A YEAR? ❑YES ❑NO
    DATE OF LAST EXAM _____
13. DO YOU SEE YOUR FOOT DR. REGULARLY? ❑YES ❑NO
    DATE OF LAST EXAM _____
14. MY DIABETES WORSENS WHEN: ❑I DO NOT EAT PROPERLY
    ❑I AM UNDER STRESS ❑I DO NOT TAKE MEDICATIONS PROPERLY
    ❑OTHER_____
15. WHEN MY BLOOD SUGAR GOES UP, I HAVE THE FOLLOWING SYMPTOMS:
    ❑BLURRED VISION ❑THIRST ❑WEAKNESS ❑WEIGHT LOSS
    ❑INCREASED URINATION ❑NAUSEA ❑VOMITING
    ❑VAGINAL ITCHING ❑OTHER _____
16. DO YOU KNOW WHAT HEMOGLOBIN A1C IS? ❑YES ❑NO
    IF YES, DO YOU KNOW WHEN THE LAST ONE WAS DONE? _____ THE RESULT? _____
17. DID YOU EVER ATTEND CLASSES ABOUT DIABETES? ❑YES ❑NO
    WHEN? _____ WHERE? _____
18. DOES DIABETES COMPLICATE YOUR HOME OR WORK SITUATION IN ANY WAY? ❑YES ❑NO
    IF YES, EXPLAIN
    _____
    _____
    _____

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THESE QUESTIONS PERTAIN TO HOW YOUR MEDICAL INFORMATION MAY BE DISCLOSED.
PLEASE REVIEW CAREFULLY AND SIGN BELOW.

DO WE HAVE YOUR PERMISSION TO MAIL OR FAX YOUR PROGRESS NOTES AND LABORATORY RESULTS TO YOUR HOME? ____**YES** ____ **NO** FAX NUMBER: _____

MAY WE CALL APPOINTMENT REMINDERS TO YOUR HOME PHONE?	**YES**	**NO**
DO WE HAVE PERMISSION TO LEAVE THE FOLLOWING INFORMATION ON YOUR HOME ANWERING/VOICE MAIL:		
TEST RESULTS / MEDICAL INFORMATION	**YES**	**NO**
APPOINTMENT INFORMATION	**YES**	**NO**
BILLING INFORMATION	**YES**	**NO**
MAY WE CONTACT YOU AT YOUR E-MAIL ADDRESS WITH TEST RESULTS, MEDICAL, BILLING, INSURANCE OR APPOINTMENT INFORMATION?	**YES**	**NO**

E-MAIL:_____@_____

I AUTHORIZE JOSE R. ANTUNES, M.D., P.A. TO SHARE MY MEDICAL, BILLING AND APPOINTMENT INFORMATION WITH THE FOLLOWING INDIVIDUALS:

_____

_____ (INITIALS). I AGREE TO PAY ANY "NO SHOW" FEES IF I FAIL TO CANCEL ANY APPOINTMENTS WITHOUT GIVING 24 HOURS NOTICE.

I HEREBY AUTHORIZE THE OFFICE OF JOSE R. ANTUNES, M.D., TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED. I REQUEST PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO JOSE R. ANTUNES, M.D., P.A. IF ASSIGNMENT HAS BEEN TAKEN. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS **CORRECT** AND FURTHER **AUTHORIZE THE RELEASE OF ANY NECESSARY MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM** TO THE INSURANCE COMPANY I HAVE LISTED OR IN THE CASE OF MEDICARE PART B TO THE SOCIAL SECURITY ADMINISTRATION AND PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY ME OR THE ABOVE OFFICE AT ANYTIME. **I UNDERSTAND THAT I AM RESPONSIBLE TO PAY ANY AMOUNT NOT COVERED BY INSURANCE.**

PRINT NAME_____

SIGNATURE_____ DATE: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Jose R. Antunes, M.D., P.A. may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to Jose R. Antunes, M.D., P.A.'s Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Jose R. Antunes, M.D., P.A. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager / Privacy Officer at 2400 Fruitville Road, Sarasota, FL 34237. With my consent, Jose R. Antunes, M.D., P.A. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. With my consent, Jose R. Antunes, M.D., P.A. may mail OR e-mail my appointment reminders, test results and patient statements to my home.

I have the right to request that Jose R. Antunes, M.D., P.A restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I request the following restrictions:

_____

_____

With my consent, Jose R. Antunes, M.D., P.A. may fax to the designated Medical Doctor as noted on the front of my chart all progress notes and laboratory reports.

By signing this form, I am consenting to Jose R. Antunes, M.D., P.A.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Jose R. Antunes, M.D., P.A. may decline to provide treatment to me.

_____ _____
Patient's Name Date

_____ _____
Signature of patient or legal guardian Name of legal guardian, if applicable