Luna Beck M.D. and Associates, PA

17820 SE 109th Ave. Suite 107

Summerfield, FL 34491

Ph: 352-307-7940 Fax: 352-307-7941

PATIENT INFORMATION: Date: ________________

(***ALL INFORMATION ON THIS PAGE IS MANDATORY AND MUST BE FILLED OUT***)

YOUR PERSONAL AND HEALTH INFORMATION ARE STRICTLY PRIVATE AND CONFIDENTIAL

1. Name: ____

(Last Name) (First Name) (Middle Initial)

2. SSN# _______________________ **3**. DOB: _______/_______/_______ (mm/dd/yyyy)

4. Age: ______ **5**. Marital Status: S M D W **6**. Race: ______ **7**. Gender: M/F **8**. Religion: _________

9. Address: ____

City: _____________________________________ State: __________________ Zip: _________________

9. Secondary Address: ____

City: _____________________________________ State: __________________ Zip: _________________

10. Home Phone: ( )___________________________ 11. Cell Phone: ( )______________________

12. Email Address: ____

13. Occupation: _________________________________ 14. Work Phone: ( )____________________

15. Driver's License No. ______________________ 16. Referred by: ________________________________

17. Emergency Contact Name(s): ____

18. Emergency Contact Number(s): ____

19. **PRIMARY INSURANCE:**

Insured Party's Name ____

Insurance Name __________________________ Insurance ID# ______________ Group# __________

20. **SECONDARY INSURANCE:** _______ NONE

Insured Party's Name ____

Insurance Name __________________________ Insurance ID# ______________ Group# __________

21. **ASSIGNMENT AND RELEASE**:

I certify that I, and or my dependents have insurance coverage with ______________ and assign directly to Luna Beck, M.D. PA all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. I authorize the disclosure of my health care information in order to obtain payment or insurance benefit information from the above named insurance company (ies). I hereby authorize medical treatment provided by Luna Beck M.D.

Print Patient's Name/Guardian (if minor) _______________________________ Relationship __________

Patient's/Guardian Signature (if minor) ________________________________ Relationship ___________

Please list other treating physicians:

(Cardiology) Name: ____

(Gastroenterology) Name: ____

(Nephrology) Name: ____

(Neurology) Name: ____

(Ophthalmology) Name: ____

(Urology) Name: ____

(Other) Name: ____

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Patient Record of Disclosure and Consent

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to confidential communications or that a communication of PHI is made by alternate means, such as a correspondence to the individual's office instead of home.

I wish to be contacted in the following manner (check all that apply)

☐ Home Telephone ☐ Work Telephone

☐ OK to leave detailed message ☐ Leave message with call back number only

WRITTEN COMMUNICATION

☐ Ok to mail to home address ☐ Mail to work address ☐ Do not mail any personal info

Please list individuals we can discuss your information with (e.g. treatment, diagnosis, billing, test results, etc.)

Please list their relationship to you and phone number for secure identification.

*** THIS INCLUDES SPOUSES and CHILDREN and GUARDIAN YOU AUTHORIZE ***

Name ______________________________ Relationship _________________ Phone # ____________________

Name ______________________________ Relationship _________________ Phone # ____________________

Name ______________________________ Relationship _________________ Phone # ____________________

Name ______________________________ Relationship _________________ Phone # ____________________

Print Patient's Name: ____

Signature: ____ Date: __________________________

(Parent / Guardian if patient is a minor)

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PLEASE CHECK BOX

FAMILY HISTORY — (PLS SPECIFY WHICH FAMILY MEMBER)

PAST SURGICAL HISTORY

	FAMILY HISTORY		PAST SURGICAL HISTORY
	ALZHEIMER'S DISEASE		ABDOMINAL
	BIPOLAR DISORDER		AMPUTATION
	BLEEDING DISORDER		ANGIOPLASTY
	CANCER OF THE BREAST		ARTIFICIAL JOINT REPLACEMENT
	CANCER OF THE COLON		BACK SURGERY
	CANCER OF THE LUNGS		BLADDER SUSPENSION
	CANCER OF THE PROSTATE		BLOOD TRANSFUSION
	CANCER OF THE UTERUS		BOWEL SURGERY
	CANCER (OTHER PLS SPECIFY)		BREAST SURGERY
	DVT		CABG (CARDIAC BYPASS)
	DIABETES		CARDIAC CATHERIZATION
	HEART PROBLEMS		CARPAL TUNNEL SYNDROME
	HIGH CHOLESTEROL		HEMORRHOID SURGERY
	PULMONARY EMBOLISM		CYST REMOVAL
	STROKE		KNEE SURGERY ____ LEFT ____ RIGHT
	THYROID DISEASE		LAMINECTOMY
	OTHER		LAPAROSCOPY
			LOBECTOMY
	PREVENTATIVE: PLEASE LIST DATES		POLYP REMOVAL
	PAP SMEAR -		PROSTATE SURGERY
	MAMMOGRAM -		OTHER
	COLONOSCOPY -		
	PSA -		
	BONE DENSITY -		
	FLU SHOT -		
	PNEUMONIA SHOT -		
	SHINGLES SHOT -		

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YOUR MEDICAL HISTORY

PLEASE CHECK BOX IF IN PATIENT'S HISTORY

	ACID REFLUX / GERD		HEART DISEASE
	ALLERGIC RHINITIS (ALLERGIES)		INSOMNIA / SLEEP ISSUES
	ALZHEIMER'S DISEASE		LIVER CIRRHOSIS
	ANEMIA		LUNG CANCER
	ANGINA		MENOPAUSE / HOT FLASHES
	ANXIETY DISORDER		MIGRAINES
	ASTHMA		MYOCARDIAL INFARCTION (MI)
	ATRIAL FIBRILATION (AFIB)		NEUROPATHY
	BLOOD CLOTTING PROBLEM		OSTEOARTHRITIS
	BRAIN TUMOR		OSTEOPOROSIS
	CARPAL TUNNEL SYNDROME		CANCER (Specify)
	CATARACTS		PARATHYROID DISORDERS
	CONGESTIVE HEART FAILURE (CHF)		PARKINSON'S DISEASE
	COPD		PERIPHERAL VASCULAR DISEASE
	CORONARY ARTERY DISEASE (CAD)		PNUEMONIA
	DEMENTIA		PULMONARY EMBOLISM (PE)
	DEPRESSION		RESTLESS LEG SYNDROME
	DIABETES		RHEUMATOID ARTHRITIS
	DIVERTICULITIS		RHEUMATIC HEART DISEASE
	EMPHYSEMA		SEIZURE DISORDER
	FATTY LIVER		SHINGLES
	FIBROMYALGIA		SHORTNESS OF BREATH
	FRACTURE HISTORY (Specify)		SKIN CANCER (Specify)
	GALLSTONES		SLEEP APNEA □ **USING CPAP** □ **NO CPAP**
	GASTRIC / PEPTIC ULCER		STROKE / TIA
	GLAUCOMA		TRIGEMINAL NEURALGIA
	GOUT		OTHERS
	HAY FEVER		
	HEADACHES		
	HEART VALVE CONDITION		
	HEPATITUS		
	HERNIA		
	HIGH BLOOD PRESSURE		
	HIGH CHOLESTEROL		

____

____

Patient's Name: ____

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PATIENT MEDICATION LIST

Medication Allergies: ____

DATE	MEDICATION USE	DOSAGE	DIRECTIONS

Patient's Name: ____

Local Pharmacy Name: ____________________________________

Pharmacy Tel#: _____________________________________

Local Pharmacy Name: ____________________________________

Pharmacy Tel#: _____________________________________

PLEASE BRING THE FOLLOWING ON YOUR FIRST VISIT

1. Insurance Cards
2. Drivers License
3. Medication Bottles **(First visit and Every Visit to see Dr. Beck)**
4. Bring copies of labs or tests you recently had.
5. Vitamins and Supplements **(First Visit Only)**
6. Please arrive 30 minutes early or your appointment will be rescheduled

Please call to cancel or reschedule your appointment within 24 hours. If you fail to call the following fee will apply.

- New Patient $50.00
- Established Patient $25.00

Patient's Name: ___________________________________ Date: _________________

Patient's Signature: _________________________________

PROTECTED HEALTH INFORMATION RELEASE AUTHORIZATION

Luna Beck, MD. & Associates PA

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Telephone Number: (352) 307-7940

Fax Number: (352) 307-7941

Full Name: ____ DOB: ______________

This will authorize Dr. ____ to disclose my protected health information to ____ as described for the following purpose ____.

Date of service: ____________________________________ to _________________________________

Check all that apply:

____ Discharge Summary ____ Laboratory Data

____ History & Physical ____ E.R. Records

____ Progress Notes ____ EKG

____ Consultation Note ____ X-Rays, Imaging, etc.

____ Nurse Notes ____ Other

____ All Records

I acknowledge and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV or genetic information. ________ Initials

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This authorization shall expire upon this date: ____

** If I fail to specify an expiration date or event this information will expire six (6) months from the date it was signed.

I understand I have the right to revoke this authorization at any time. I understand that I must do so in writing and deliver the written revocation to _____________________. I understand that the revocation will not apply to information that has already been released to this authorization.

I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and may no longer be protected by federal rules.

____ ______________________________

Signature of Patient / Legal Representative Date

____

Relationship of Representative