Office Locations

Mount Dora
P:352-383-1667
F:352-383-9226
Office Hours
Mon – Fri
8 am – 5 pm

Kissimmee
P:407-530-4802
F:407-530-4910
Office Hours
Mon - Fri
8 am – 5 pm

Aegis Medical Group

A Lakeview Internal Medicine Company

Welcome to Aegis Medical Group!

In an effort to decrease your waiting time, we ask that you please complete the enclosed questionnaires.

You can fax in your completed questionnaires to the office your appointment is scheduled in
Or
You can bring in the completed questionnaires to your appointment.
On the day of your appointment, we ask that you bring the following:

- ❖ The completed questionnaires
- ❖ A list of your current medications and strengths (or the actual bottles of medications work as well)
- ❖ Photo ID
- ❖ Your insurance card(s)

If you have any questions or need assistance concerning this paperwork, you can call any one of our offices and we will be more than happy to assist.

On behalf of the AEGIS and Lakeview Internal Medicine team, welcome and we look forward to seeing you soon!

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Appointments

Patients are seen by appointment and on an emergency basis. When you make appointments, please describe your symptoms to our scheduling staff. If you are unable to keep your appointment, please try and give a minimal 24 hours notice.

Telephone Calls

Our staff will take calls during regular business hours for each office. If you are calling to speak to your doctor and he/she is unavailable, our staff with deliver your message. If you call outside our office hours, your call will be taken by our answering service. When necessary, the on-call doctor will be contacted and respond as soon as possible. Emergency calls will be handled promptly 24 hours a day.

Insurance

We participate in many insurance plans. We will bill your charges directly to these plans.

Prescription

Please allow 72 hours to handle all prescription requests. When you are requesting a refill, please provide us with your pharmacy's phone number or location. Per company policy, if a controlled substance is prescribed, the prescription must be signed for and picked up in one of our office locations.

Hospital Affiliations

Our physicians maintain active privileges at The Villages Regional Hospital, Leesburg Regional Medical Center, Florida Hospital Waterman, and Citrus Memorial Hospital.

Records

Your medical records are confidential. If you wish to have copies of your office records released to another physician, we must have written consent. Please inform our office of any changes to you address, telephone number, or insurance.

Office Fees

We believe our professional fees are within the range of usual and customary charges for this region. Our doctors expect payment at the time of check-in. All co pay's, coinsurances, deductibles, and balances are due up front or your appointment will be rescheduled. You will receive a statement for any additional charges deemed patient responsibility by your insurance company.

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NEW PATIENT FORM

Date:_____

S.S#_____-_____-_____

Patient name:_____ Date of Birth_____

Mailing Address:_____ City_____ State _____Zip_____
Is this the address you would like to receive all our billing statement/correspondence to? Yes, if no, please list the alternative address here_____

Correspondences from our office should be sent in a sealed envelope marked "CONFIDENTAL"?
_____ YES _____NO

Phone number:_____ Cell number: _____Other _____
Please circle the one you wish to receive calls about your appointment, lab, x-ray results or other healthcare information.

Can confidential messages be left on your home answering machine or voice mail? ____ Yes ___ No ____ Other option: Please list_____

Sex: M_____ F_____ Marital Status: S____, M____, D____, W____, Other_____

Occupation:_____ Employer:_____

Business address & Phone:_____

Whom may we thank for referring you today?_____

Emergency contact name:_____Phone:_____

Authorization to release information

In an attempt to preserve the confidential nature of the doctor/patient relationship, it is requested that you complete the information listed below regarding appointments and other administrative matters.

Please list all the people whom we may inform about your general medical condition and diagnosis:_____

Please list all the persons that we may inform about your condition in an emergency situation only:_____

I, the undersigned certify that I or my dependent have insurance with_____
and assign directly to Dr. _____, all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorized the use of the signature on ALL insurance submissions.

_____ _____ _____

Responsible Party Signature | Relationship to patient | Date

FAMILY HISTORY-FILL IN HEALTH INFORMATION ABOUT YOUR FAMILY

RELATIONSHIP	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				
Brothers				
Sisters				

Check (x) if your blood relatives had any of the following disease

	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

YEAR	HOSPITAL	REASON FOR HOSPITALIZATION	OUTCOME

PREGNANCY HISTORY

BIRTH YR	SEX OF BIRTH	COMPLICATION IF ANY

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES___ NO___ Dates:_____

Serious Illness/Injuries	Date	Outcome

Health Habits: X all that apply

	Caffeine
	Tobacco
	Drugs
	Other

Occupational Concerns: X if your work exposes you to the following

	Stress
	Hazardous Substances
	Heavy Lifting
	Other
	Your Occupatioin:_____ _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omission that I may have made in the completion of this form:

_____ _____

Patient or Responsible party signature Date

Health History (Confidential)

Patient Name: _____ Todays Date: _____
Age: _____ Birth Date: _____ Sex: _____ Date of last physical examination: _____
What is the reason for your visit? _____
_____

Symptoms: X- all symptoms that you are currently having or have had in the past year

GENERAL		GASTROINTESTINAL		EYE, EAR, NOSE, THROAT		MEN ONLY	
Chills		Appetite poor		Bleeding gums		Breast lump	
Depression		Bloating		Blurred vision		Erection difficulties	
Dizziness		Bowel changes		Crossed eyes		Lump in testicles	
Fainting		Constipation		Difficulty swallowing		Penis discharge	
Fever		Diarrhea		Double vision		Sore on penis	
Forgetfulness		Excessive hunger		Earache		Other	
Headache		Excessive thirst		Ear discharge			
Loss of Sleep		Gas		Hay fever		**WOMEN ONLY**	
Loss of Weight		Hemorrhoids		Hoarseness		Abnormal pap smear	
Nervousness		Indigestion		Loss of hearing		Bleeding between menstruation	
Numbness		Nausea		Nosebleeds		Breast lump	
Sweats		Rectal Bleeding		Persistent cough		Extreme menstrual pain	
		Stomach pain		Ringing in ears		Hot flashes	
MUSCLE, JOINT, BONE		Vomiting		Sinus problems		Nipple discharge	
Pain, weakness, numbness in		Vomiting blood		Vision-Flashes		Painful intercourse	
				Vision-Halos		Vaginal discharge	
Arms	Hips	**CARDIOVASCULAR**				Other	
Back	Legs	Chest pain		**SKIN**		Date of last menstrual period? _____	
Feet	Neck	High blood pressure		Bruise easily			
Hands	Shoulder	Irregular heart beat		Hives		Date of last pap smear? _____	
GENITO-URINARY		Low blood pressure		Itching		Have you had a mammogram? Yes / No	
Blood in urine		Poor circulation		Changes in moles			
Frequent urination		Rapid heart beat		Rash		Are you pregnant? Yes / No	
Lack of bladder control		Swelling of ankles		Scars		Number of children: _____	
Painful urination		Varicose veins		Sore that won't heal			

Conditions: X- all symptoms that you are currently having or have had in the past year

AIDS		Chemical Dependency		High Cholesterol		Prostate problem	
Alcoholism		Chicken Pox		HIV Positive		Psychiatric care	
Anemia		Diabetes		Kidney Disease		Rheumatic fever	
Anorexia		Emphysema		Liver Disease		Scarlet fever	
Appendicitis		Epilepsy		Measles		Stroke	
Arthritis		Glaucoma		Migraine headaches		Suicide attempt	
Asthma		Goiter		Miscarriage		Thyroid problems	
Bleeding disorders		Gonorrhea		Mononucleosis		Tonsillitis	
Breast lump		Gout		Multiple Sclerosis		Tuberculosis	
Bronchitis		Heart Disease		Mumps		Typhoid fever	
Bulimia		Hepatitis		Pacemaker		Ulcers	
Cancer		Hernia		Pneumonia		Vaginal infections	
Cataracts		Herpes		Polio		Venereal disease	

List Medications you are currently taking:
(*use extra sheet of paper if necessary*)
_____
_____
_____
_____
_____
_____
_____

All known Allergies:
_____
_____
_____
_____
_____
_____
Pharmacy: _____
Phone #: _____

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For reporting purposes we ask that you fill out the following information to the best of your ability.

Email Address: _____

- This will be used to gain access to your Lakeview Internal Medicine, P.A. patient portal. You will also receive appointment reminders and updates once your email is provided.

Race:

- American Indian or Alaskan Native
- Asian
- Native Hawaiian or other Pacific Islander
- Black or African American
- White
- Hispanic
- Other Race
- Other Pacific Islander

Ethnicity:

- Hispanic
- Not Hispanic or Latino

Language:

- English
- Spanish
- Other _____

Name:_____ Date:_____

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How likely are you to doze off or fall asleep in the following situations in contrast to feeling just tired? This refers to your usual way of life in recent times. Use the following scale to choose the *most appropriate number* for each situation.

0 = would *never* doze

1 = *slight* chance of dozing

2 = *moderate* chance of dozing

3 = *high* chance of dozing

Chance of Dozing:	**Situation:**
_____	Sitting and reading
_____	Watching TV
_____	Sitting inactive in a public place (e.g., a theater or a meeting)
_____	As a passenger in a car for an hour without a break
_____	As a driver in a car, while stopped in traffic
_____	Lying down to rest in the afternoon when circumstances permit
_____	Sitting and talking to someone
_____	Sitting quietly after a lunch without alcohol

Total: _____

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Patient Consent Form

I consent to the use or disclosure of my protected health information (PHI) by AEGIS Medical Group for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations. I understand that diagnosing or treatment of me by Aegis Medical Group may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Aegis Medical Group is not required to agree to the restrictions that I may request, and may request I seek another Internal Medicine physician. However, if Aegis Medical Group agrees to a restriction that I may request, the restriction is binding on the physician.

I have the right to revoke this consent, in writing, at any time, except to the extent Aegis Medical Group, has taken action in reliance on this consent.

My protected health information (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to Aegis Medical Group's notice of Privacy Practices prior to signing this document. The Aegis Medical Group Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations. This notice of Privacy Practices describes my rights and the Aegis Medical Group duties with respect to my protected health information.

Aegis Medical Group reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of private practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I authorize Aegis Medical Group to view my prescription history via the Prescription Drug Management Program. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

_____ _____

Signature of Patient or Personal Representative Date