AEGIS MEDICAL GROUP

Patient Name: _____ DOB: _____

Demographic Information

Please type or Print Clearly

Prefix: ____ Last name: _____ First Name: _____ MI: _____ Suffix: _____

Address 1: _____ City: _____
Address 2: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email: _____
Race: _____ Ethnicity: _____ Language: _____ Translator needed: Y / N

Release of Information signed: Y /N Med List: Y / N

Primary Care Provider (for office use only) _____
Date of Birth: ___/___/_____ Gender: M / F SSN: _____
Marital Status: M / S / D / W

Emergency contact: Name: _____ Phone: _____ Email:_____
Emergency Contact Relation: _____

Insurance: _____

Dr. Office to leave a message: _____

Pharmacy Name: _____ City: _____ Phone Number _____

I authorize Aegis Medical Group to release to any insurance company/Medicare or its carriers any information needed to process and pay my claims. I permit a copy of this to be used for that purpose and to request payment of medical insurance and medical benefits to be made directly to Aegis Medical Group. I understand that it is mandatory to inform the healthcare provider of any other party who may be responsible for paying any deductible amount, co-pay, or any percentage fees not paid by the insurance company of third party within a reasonable time which is not to exceed 60 days. I also authorize payment of my insurance/ Medicare benefits to be paid directly to Aegis Medical Group for my treatment. I also understand that it is my responsibility to pay any unpaid amounts not paid by the insurance company and Medicare.

Insurance regulations suggest that if we inform you in advance if we believe a service may not be covered or fully reimbursed by your insurance company. In the Dr's professional judgement certain services are needed to give high quality healthcare and to help provide a diagnosis, but some services may not be reimbursed by them. The services may include but are not limited to and EKG, Labs, biopsy, etc. Aegis Medical Group with only preform theses services when required and the results will help us provide you with quality healthcare.

Patient agreement: I certify that I have read and fully understand the information. I understand that I will be responsible for any payment, or any medically necessary services should they be denied by my insurance company. I understand that I have the right to accept and refuse medical treatment.

_____ _____ _____/ _____/ 20____
Signature Patient Name Date

AEGIS MEDICAL GROUP

Patient Name: _____ DOB: _____

Advance Directive/ Living Will/ Power of Attorney/ DNR

I understand that I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. An Advance Directive refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes.

Please check the following statements that apply: We would like a copy for our records.

_____I have executed an Advanced Directive.

_____I have NOT executed an Advance Directive.

Check the one(s) you have and can provide copies of them to our office:

_____Living Will

_____Durable Medical Power of Attorney

_____Do Not Resuscitate (DNR)

_____ _____ _____/ _____/ 20____

Signature Patient Name Date

AEGIS MEDICAL GROUP

Patient Name: _____ DOB: _____

Prescription Order Pick-up (if our system is down and receiving a handwritten prescription)

There may be times when you need a friend or family member to pick up a prescription order (script) from your physician's office. For us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

Please check only one box below.

☐ ***I do not want*** to designate anyone to pick-up my prescription order (script)

☐ ***I wish*** to designate the following individual to pick up a prescription order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

_____ _____

Patient/Parent/Guardian/Patient Representative Signature Date

Patient/Parent/Guardian/Patient Representative Name (Printed): _____

Primary Pharmacy: _____ Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

_____ _____ _____/ _____/ 20____

Signature Patient Name Date

AEGIS MEDICAL GROUP

Patient Name: _____ DOB: _____

HIPAA Privacy Authorization Form
Authorization for Use or Disclosure of Protected Health Information

I authorize Aegis Medical Group to use and disclose my protected health information as described below:

1. Extent of Information to be released.
   a. I authorize the release of my COMPLETE health record (including records relating to my mental health as well as treatment of alcohol and/ or drug abuse **initials:** _____
   b. I authorize the release of my COMPLETE health record with the **EXCEPTION** of the following information: (please initial next to the records to exclude)
      1. _____ Mental Health records
      2. _____ Alcohol/ drug abuse treatment
      3. _____ Other: (please specify): _____
2. This medical information may be used by the entity I authorize to receive this information for medical treatment, consultation, billing/ claims, payments, or other purposes as I may direct.
3. This authorization shall be in force and effective until
   a. _____ (list date)
   b. Twelve months from date this form is signed **initials:** _____
4. I understand that I have the right to revoke this authorization at any time. I further understand that to revoke I must submit a request in writing. I understand that the revocation is not effective to the extent that any person/entity has already acted in reliance on my authorization of if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim.
5. I understand that my treatment, payment, enrollment, and/or eligibility for benefits will not be conditioned on whether I sign this authorization.
6. I understand the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state laws.
7. I authorize the release of information to include diagnoses, records, exams rendered to me, and claims data to the following individuals:
   a. Spouse: Name: _____
   b. Child(ren): Name(s)_____
   _____
   c. Other (please indicate relationship) _____
8. Messages regarding my healthcare may:

   a._____ (initial) be left on any one of my messaging systems using the numbers I have provided

   b._____ (initial) NOT be left on any messaging system. I would like a message to return the provider's call instead.

Patient/Authorized Representative Signature: _____ Date: _____

Printed Name of Representative (if applicable):_____ Relationship: _____

If signed by representative, reason patient is unable to sign:_____

_____ _____ _____/ _____/ 20____

Signature Patient Name Date

AEGIS MEDICAL GROUP

Patient Name: _____ DOB: _____

Consent to Release Confidential Information

__ STAT Please __Urgent (2-3 business days) __ Routine

Please type or print clearly:

Last Name: _____ First Name: _____

Last 4 of SSN: _____ Date of Birth: DD/MM/YYYY - _____/____/_____

I hereby authorize a copy of my medical records be released to the following facility:

Aegis Medical Group: Phone: Fax:

___ Last 2 Years ___Last Hospital Visit ___Last ER Visit ___ Complete Record

___ PFTs __ECHO __LABS __CT __CXR __US __EKG

For Office use only:

Records to be released from: Phone: _____ Fax: _____

Dr: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Please initial next to your Preference:

____ This release is to cover ALL records contained in my medical chart to include Mental Health, drug or alcohol treatment.

____ This release is to cover ALL records contained in my medical chart EXCEPT:

_____ Psychiatric records / treatment _____ Drug related records / treatment

_____ Alcohol related drugs / treatment

I understand the purpose of record release is for continuity of my medical care. The information contained in my medical record(s) may include diagnoses, evaluation and/or treatment of any mental of emotional condition(s). This may also include alcohol and/or drug related conditions and treatments. Information regarding HIV infection with any probable causative agent of AIDS is also considered to be part of my medical record. The expiration of this release is one year from the date of signature. I may revoke this authorization at any time by notifying in writing to Aegis Medical Group. The written revocation will be effective on the date received by the Aegis Medical Group office. Any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal Privacy Regulations. By authorizing the use or disclosure of information there will be no conditions placed on my healthcare or payment of my healthcare. I have a right to receive a copy of this form after I have signed it. In compliance with Florida State Law, I may be required to pay a fee for any retrieval and photocopying of records and/or supervising inspection of medical records.

_____ _____ _____/ _____/ 20____

Signature Patient Name Date

AEGIS MEDICAL GROUP

Patient Name: _____ DOB: _____

Patient Responsibility Form

1. The patient is responsible for providing Aegis Medical Group with the most correct, active, and up to date information about their insurance prior to each visit.
2. Aegis Medical Group will bill to the insurance most recently provided by the patient. If information given by the patient is inaccurate and the insurance denies the claim, the patient will be responsible for the balance of the visit. Please be aware that with some insurance companies there are timely filing deadlines and providing correct information at tine time of service is critical. Timely filing means the patient's insurance plan may not pay the claim after a certain amount of time after the service.
3. Patients are responsible for the payment of co-pays at the time of service.
4. Patients are responsible for paying any applicable co-insurance, deductibles and all other procedures or treatment not covered by their insurance plan.
5. Aegis Medical Group is not responsible for knowing what each individual insurance plan does or does not cover. If the patient has questions about their plan and what services are covered, they should contact their health insurance company.
6. In the event a patient's health plan determines a service to be *"not payable",* the patient will be responsible for the complete charge and agree to pay the costs of all services provided.
7. Patients have the right to check with their insurance about coverage before receiving any service provided Aegis Medical Group
8. The patient's health insurance policy is a contract between the patient and their Health Insurance Company or employer. It is the patient's responsibility to know if their insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations, and limits on outpatient charges regardless of whether our physicians participate.
9. The patient is responsible for knowing if our doctor is in-network with their insurance plan and if the services are covered. Any balances applied to an out of network rate will be the responsibility of the patient to pay.
10. If the patient is uninsured, the patient agrees to pay for the medical services rendered to them at the time of service.
11. Medicare may not cover some of the services that the patient's doctor recommends. The patient will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help the patient decide whether they want to receive services, knowing they may be responsible for payment. Patients should read the ABN carefully.
12. The patient agrees that in return for the services provided to them by Aegis Medical Group, they will pay their account at the time service is rendered or upon insurance claim processing- If a payment plan is necessary, the patient understands that the agreement is for past due balances only, and that all future co-payments, co-insurances and/or deductibles, are due at the time of service. If copayments, co-insurances and/or deductibles are assigned by the patient's insurance company or health plan, they agree to pay them to Aegis Medical Group.

Worker's Compensation and Automobile Claims

Aegis Medical Group ***does not*** accept and/or file workers comp or auto claims.

I have read the above and understand the contents of this form. I have been given the opportunity to ask any questions and I am satisfied with my current knowledge regarding Aegis Medical Group policies regarding patient responsibilities.

_____ _____ _____/ _____/ 20____

Signature Patient Name Date

Patient Name: _____ DOB: _____

Consent to Treat Form

1. I _____(patient name) give permission for **Aegis Medical Group** to give me medical treatment.
2. I allow **Aegis Medical Group** to file for insurance benefits to pay for the care I receive.

3 I understand that:

- **Aegis Medical Group** will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay, or I do not have insurance.

4. I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

_____ _____ _____/ _____/ 20____

Signature Patient Name Date

AEGIS MEDICAL GROUP

Patient Name: _____ DOB: _____

What brings you to see me today?

Do YOU have any drug allergies: □ Penicillin □ Sulfa □ Tetracycline □ _____

Family Health History

This pertains to **YOUR BLOOD (genetic) relatives ONLY**

Relative Type	Living (L) or Deceased (D)	Current age/age @ death	Cause of death	Health condition you wish me to know about
Father				
Mother				
Brother (s)				
Sister (s)				
Mother's Father				
Mother's Mother				
Father's Father				
Father's Mother				
Child(ren)				
□ I was adopted				

Your Chronic Medical Condition(s)

Chronic Condition	Year Diagnosed	Chronic Condition	Year Diagnosed
Diabetes		Hypertension	
□COPD □ Bronchitis □ Asthma		High cholesterol	
□ CAD □ Heart attack		Hypothyroidism	
CHF (heart failure)		Depression (anytime throughout life)	
□ Pacemaker □ Defibrillator		Acid Reflux (GERD)	
□ Atrial Fib □ Heart Arrhythmia		□ Cirrhosis □ Hepatitis A B C	
Peripheral Vascular Disease		□ Gout □Osteoarthritis	
□ DVT □ PE (blood clot)		Erectile Dysfunction	
Stable Chest Pain (angina)		Sleep Apnea	
□ Seizures □ Epilepsy		□ Cataracts □ Glaucoma	
□ Stroke □ TIA		Parkinson's	
□ Dementia □Alzheimer Disease		Valve: □Mechanical □Pig □Cow	
Rheumatoid Arthritis		Cancer:	

_____ _____ _____/ _____/ 20____

Signature Patient Name Date

AEGIS MEDICAL GROUP

Patient Name: _____ DOB: _____

□ HIV □AIDS		□Chemo Tx □Radiation	
Neuropathy □hand/arm(s) □feet/leg(s)		Dependency □drug □alcohol	
Migraines		Amputation: where?	

Review of Systems

Please circle all that you have experienced within the **past 6 months**

Fever / Chills	Dizziness/ spinning	Fainting	Forgetfulness	Headache
Sweating	Weakness	Weight loss/ gain	Numbness	Nervousness
Loud snoring	↑ Daytime sleepiness	Trouble sleeping	Imbalance	Hives/ rash
Diarrhea	Indigestion/ heartburn	Constipation	Nausea	Vomiting
Rectal bleeding	Dark colored stools	Abdominal pain	↑ Urination	Blood in urine
Painful urination	Incontinence (leakage)	Trouble swallowing	Bruising	Itching
Change in skin	Non- healing sores	Vision changes	Earaches	Loss of hearing
Discharge of ear	Hoarseness	Ringing in ears	Nosebleeds	Sore throat
Sinus issues	Teeth / gum concerns	Congestion	Cough	Shortness of breath
Palpitations	Chest pain/ discomfort	Leg swelling	Varicose veins	Pain in legs with walking
↑ Thirst	↑ Hunger	Cold/ burning feet	Joint pain	Breast / nipple discharge
Vaginal discharge	Breast lump	Penial discharge	Testicle lump	Painful intercourse

Smoking History: ☐I was NEVER a smoker ☐CURRENT smoker ☐FORMER smoker

I currently smoke: ____ (number of packs daily) for ____ (number of years)

I did smoke: ___ (number of packs daily) for ___(number of years) & quit in _____(enter year)

Alcohol History: ☐I have never ☐I am a current drinker ☐I drank but now do not

I currently drink____ (number of alcoholic beverages) ☐Daily ☐Weekly ☐Monthly

Previously I drank ___ (number of alcoholic beverages) ☐Daily ☐Weekly ☐Monthly

I quit in _____ (enter year). I have attended AA in past ____ NO ___ YES

_____ _____ _____/ _____/ 20____

Signature Patient Name Date

AEGIS MEDICAL GROUP

Patient Name: _____ DOB: _____

Illicit Drug History: I have used illicit drugs: ☐ NEVER ☐CURRENTLY ☐ IN PAST

Type of drug: ☐Marijuana ☐Cocaine ☐Methamphetamine ☐Heroin

☐Other: _____

Prevention & Maintenance of your Health

Please provide date of the **MOST RECENT** injection/ procedure

Type	MM/DD/YYYY	Type	MM/DD/YYYY	Type	MM/DD/YYYY
Flu Vaccine		Mammogram		Heart Cath	
Covid Vaccine		Endoscopy (EGD) Barrett's Y N		Prostate Exam/ PSA	
Pneumonia Vaccine		Pap Smear Last Menses: Hysterectomy: Y N		ECHO (ultrasound of heart)	
Shingles		Bone Density (DEXA)		Stress test	
Hep B series		Colonoscopy Polyps: Y N		Chest Xray	
Eye Exam		Herpes Zoster			

Blood Transfusion (s)

Please list dates & reason for transfusion (s)

Date (s)	Reason

Hospitalizations in the past 1 year

Reason for hospitalization	Date

Surgical History (All major surgeries)

Procedure Type	Date

_____ _____ _____/ _____/ 20____

Signature Patient Name Date

Patient Name: _____ DOB: _____

Fractures

Type/ Bone	Date

Please list all medications in the following tables. Please pay attention to table headings.

OVER THE COUNTER MEDICATION (S)

Name of medication	Dose	How many times a day
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed

PHYSICIAN PRESCRIBED MEDICATION(S)

Name of medication	Dose	How many times a day
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed

_____ _____ _____/ _____/ 20____

Signature Patient Name Date

AEGIS MEDICAL GROUP

Patient Name: _____ DOB: _____

		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed

Other Providers Participating in My Healthcare

Type	Name of Doctor	Phone number
Cardiologist		
Dermatologist		
ENT ear/nose/throat)		
Gastroenterologist		
GYN		
Nephrologist		
Oncologist		
Ophthalmologist		
Orthopedist		
Psych (counselor)		
Pulmonologist		
Rheumatologist		
Urologist		

_____ _____ _____/ _____/ 20____

Signature Patient Name Date

AEGIS MEDICAL GROUP

Patient Name: _____ DOB: _____

My last Primary Care Doctor was:

Name:_____

Phone Number:_____

Sleep Scale

Date this form was completed: _____

Over the past **SIX (6) months**,
how likely are you to doze off or fall asleep in the following situations?

Please use the following scale to select your most appropriate number for each listed situation.

0= would never doze

1= slight chance of dozing

2= moderate chance of dozing

3= high chance of dozing

Situation	**Chance of dozing (select # from above)**
Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (theater/meeting)	_____
As a passenger in a care x 1 hour without a break	_____
As a driver in a car, while stopped in traffic	_____

_____ _____ _____/ _____/ 20____
Signature Patient Name Date

Patient Name: _____ DOB: _____

Lying down to rest in the afternoon _____

Sitting and chatting with a friend _____

Sitting quietly after lunch without alcohol _____

TOTAL: _____

_____ _____ _____/ _____/ 20____

Signature Patient Name Date