Henry Calas MD PA

Ver 1.1 8/2018

827 SE 5th Street Stuart, FL 34994
772-223-5525

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____

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

Primary Phone: _____ Alternate Phone: _____

E-mail Address: _____ Social Security #: _____

Race: ☐ African American/Black ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Multiracial

☐ Other: _____ Ethnicity: _____ ☐ Decline

Language: _____ Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name (if applicable): _____ Phone: _____

Caregiver's Name (if applicable): _____ Phone: _____

Emergency Contact: _____ Phone: _____

Referring Provider: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Work Status: ☐ Not Employed ☐ Full-Time ☐ Part-Time ☐ Disabled ☐ Retired

Patient Employer: _____ Occupation: _____

Name of Primary Insurance: _____ Policy Holder: _____

Subscriber or Contract Number: _____ Insured Date of Birth: _____

Name of Secondary Insurance: _____ Policy Holder: _____

Subscriber or Contract Number: _____ Insured Date of Birth: _____

Pharmacy: _____ Location: _____ Phone: _____

CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

I understand that as a part of the electronic health record Henry Calas MD will transmit my prescriptions electronically, as per-mitted, to the pharmacy that I designate as my primary pharmacy provider. Additionally, Henry Calas MD will obtain the history of all my past prescriptions dating back two years from pharmacy benefit managers and I understand that those prescriptions will become a part of my electronic health record. By signing below I hereby give consent to the above actions.

Signature of Patient or Legal Representative: _____ Date: _____

RECORD RELEASE & ASSIGNMENT OF INSURANCE

I hereby authorize Henry Calas, MD to release all medical information that has been previously requested from any physician, hospital or clinic where I have been treated. I also understand that this authorization to release medical information shall only be valid for the purposes of second opinions or referral for additional specialist evaluation. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, at the time of service, unless other arrangements are made in advance. I hereby authorize the payment of benefits of my insurance policy, if any, to be paid directly to Henry Calas MD for services rendered. I understand I am responsible for charges not covered by insurance including any deductible and co-payments or co-insurance. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for any charges incurred in the collection of this account, should I default on payment. Such changes include, but are not limited to legal fees, interest charges or late charges.

Signature of Patient or Legal Representative: _____ Date: _____

Henry Calas MD PA

827 SE 5th Street Stuart, FL 34994

Ver 1.1 8/2018

Date: _____

Name: _____

Reason for your visit: _____

Past Medical History: Please check (✓) if you have or have had any of the following:

- ☐ Anemia/Bleeding Disorder
- ☐ Asthma/Emphysema
- ☐ Bronchitis
- ☐ Cancer (Type) _____
- ☐ Diabetes
- ☐ Tumor (Type) _____
- ☐ Heart Attack/Disease
- ☐ Blood Transfusion
- ☐ Hepatitis: A,B or C
- ☐ Headaches/Migraines
- ☐ Peptic Ulcer Disease
- ☐ High Blood Preasure
- ☐ Pneumonia or TB
- ☐ Polio
- ☐ Seizures
- ☐ Rheumatic Fever
- ☐ Stroke/TIA
- ☐ Sinus Disorder
- ☐ Thyroid/Gladular Disease
- ☐ Colitis
- ☐ Gastrointestinal Bleeding
- ☐ HIV+ or AIDS
- ☐ Pacemaker

Past surgical history: _____

List All Medication: Which are you currently taking? Include dosage and frequency.

Are you allergic to any medications or environmental substances? If so, please list:

Ver 1.1 8/2018

Have you ever had an allergic reaction to iodine, contrast dye or shellfish? _____

Approximate daily use of the following:

Alcohol: _____ Tobacco: _____ Caffeine: _____

Family History: Please indicate any history of diseases in your family such as

1) Cancer 2) Heart Condition 3)Diabetes 4) Seizures 5) Stroke 6) High Blood Pressure 7) Headaches 8) Memory Problems 9) Muscle Disorders

Parents:

Mother: _____

Father: _____

Grandparents: _____

_____

Brothers, Sisters: _____

_____

Aunts, Uncles, Cousins _____

_____

Children: _____

_____

Review of Systems: Please indicate by a check (✓) any of the following symptoms:

- ☐ Blurry Vision
- ☐ Constipation
- ☐ Drainage from Eyes / Ears / Nose
- ☐ Leg / Ankle Swelling
- ☐ Loss of Bowel / Bladder Function
- ☐ Shortness of Breath
- ☐ Bloody, Painful Urination
- ☐ Chest Pain
- ☐ Diarrhea
- ☐ Memory Problems
- ☐ Palpitations
- ☐ Rectal Bleeding
- ☐ Coughing Blood
- ☐ Vomiting Blood

Henry Calas MD PA

827 SE 5th Street Stuart, FL 34994
772-223-5525

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPPA)

Dear Patient:

Please complete the information below in order to insure that all requests regarding release of your medical information is processed properly and abide by Florida Health Care Medical Records Law and HIPP A regulations.

Completion of this authorization form permits Henry Calas, M.D. to release specific medical information to your designated personal representative.

I hereby authorize Henry Calas, M.D. to disclose all of my health information (e.g. test results, medications, appointments and any other medical information) to:

Name	Relationship
Name	Relationship
Name	Relationship

I hereby give my consent for Henry Calas, M.D. to use and disclose protected health information (PHI) to carry out treatment, payment and healthcare operations known as (TPO).

With this consent Henry Calas, M.D. may call my home or other alternative location to leave messages or in person, may mail to my home or other alternative location in reference to any items that assist the office in carrying out (TPO) such as appointment reminders, insurance items and/or test results that pertain to my clinical care.

Signature of Patient/Guardian	Date

This authorization will remain in effect unless withdrawn by patient in writing

Henry Calas MD PA

827 SE 5th Street Stuart, FL 34994

AUTHORIZATION FOR THE REQUEST OF PATIENT'S HEALTH INFORMATION

ATTENTION PATIENTS

Please sign below that you acknowledge that our office does not honor Advanced Directives or DNRs. In the case if an emergency, we will call 911.

Print Name: _____

Signature: _____

Date: _____