Gary S. Lehr, MD, FACS • Randy S. Kimmelman, DO • Camil N. Sader, MD, FACS
Ronald L. Stricoff, MD, FACS • Hibbut-ur-Rauf "Heba" N. Schiller, MD

General Surgery • Robotic & Laparoscopic Surgery • Bariatric Surgery • Surgical Oncology • Board Certified

Phone: 954-574-0252 • Fax: 954-429-1759 • 3467 W. Hillsboro Blvd., Suite B, Deerfield Beach, FL 33442

PLEASE PRINT PATIENT INFORMATION

Primary/Family Physician: _____ **Phone#:** _____

Referring Physician: _____ **Phone #:** _____
(If different from Primary/Family Physician)

Patient Name:

_____
Last *First* *Middle Initial*

Address:

_____
Street *City* *State* *Zip*

Social Security #: _____ /_____ / _____ **Date of Birth:** _____ / _____ / _____

Cell Phone #: _____ **Alternate Phone #:** _____

Mobile Carrier: ☐ AT&T ☐ Sprint ☐ T-Mobile ☐ Verizon ☐ Other _____

E-Mail: _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact:

_____
Name *Relationship* *Phone #*

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy address and / or cross streets: _____

Pharmacy zip code: _____

Due to new Federal Guidelines, we are required to obtain the following information from all of our patients. This information is Protected Health Information (PHI) under the HIPAA Privacy Rule.

Please note that these are the only options recognized under the new Federal Guidelines and one option under each category must be selected.

Thank you for your cooperation.

Race:

- ☐ African American
- ☐ Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ Hispanic – African Descent
- ☐ Native American/Eskimo/Aluet
- ☐ Native Hawaiian
- ☐ Other
- ☐ White
- ☐ White Hispanic
- ☐ Refuse to Report

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Refuse to Report

Primary Language: _____ **Secondary Language:** _____

Patient or Representative Signature: _____ **Date:** _____

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PLEASE NOTE: Your insurance is a contract between *you* and *your insurance company.* Possession of an Insurance Card, Insurance Authorization, or an Insurance Referral form issued by your Insurance Company ***is not*** a guarantee of payment for your service.

If you require surgery, any co-payments, deductibles, or co-insurance will be collected prior to your procedure. Payment for professional service is expected at the time service is rendered.

Please be advised if you miss your appointment or cancel with less than 24 hours notice, our practice reserves the right to bill you a $25 fee for each no-show and late cancellation.

PATIENT AUTHORIZATIONS

I authorize payment of benefits to be made to the above-named physicians on my behalf for any authorized services provided to me.

I Authorize any holder of Medical and other information about me to be released to Medicare and its agents, any Private or Commercial Insurance Company, Third Payer, State or Governmental Assistance agency, or Private Payer responsible for paying such benefits for determination and responsibility of reimbursement for all services rendered to me.

I understand that I am financially responsible for any deemed non-covered services by my Insurance Company for services provided to me by the above-named Physicians.

I am fully aware that co-payments are to be paid at the time of service and all "Patient Responsibility" balances are to be paid in full within 90 days or my account will be subject to collections.

********THERE WILL BE A $25.00 CHARGE FOR ALL RETURNED CHECKS********

I certify that I have read and fully understand the above office policies and agree to make payment in full or arrange a payment plan prior to services being rendered. A copy of this authorization may be used in place of the Original.

PATIENT FORMS/LETTERS

Based on "Current Industry Standards", there is a fee for dictation of certain letters and completion of forms that are either brought to the office by the patient or that are sent directly to the office via fax or mail.

You will be informed of the exact charge and the fee is to be paid by cash or credit card prior to the form/letter being completed.

FEE		FORM / LETTER
$50.00	→	FMLA Form (Family Medical Leave Act)
$50.00	→	Disability Form or Letter
$30.00	→	Letter of Medical Necessity
$30.00	→	Jury Duty Letter of Medical Explanation
$50.00	→	Travel Insurance Form and/or Letter of Medical Explanation

**Charges for forms and letters that are not listed above will be between $30-$50. You will be notified of the amount prior to the forms or letters being completed.

Copies of Medical Records: Per Florida Law: $1.00 per page for the first 25 pages, then $.25 for each additional page.

PLEASE NOTE:
** The above fees may be assessed for each occurrence of filling out forms, dictating letters, and/or copying medical records.*
** Once payment has been received, forms, letters, and/or records requests will be completed within 5-7 business days.*

I certify that I have read and fully understand all of the above information.

Patient Name: _____ **Date of Birth:** _____

Patient or Representative Signature: _____ **Date:** _____

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MEDICAL MALPRACTICE NOTICE

Your Physician/Osteopathic Physician has decided not to carry Medical Malpractice insurance.

I, *(please print patient's name)* _____, and/or my representatives agree not to bring a frivolous (meritless) medical malpractice case or cause of action against Drs. Lehr, Kimmelman, Sader, Stricoff and Schiller or any legal entity providing care on their behalf. Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I and/or my representative(s) agree to use a(n) expert medical witness(es) who adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine who would typically have the background and experience to give an opinion on such a case. The expert(s) must be Certified by the American Board of Surgery or the American Osteopathic Board of Surgery, currently be in full-time active practice in the community, and be licensed to practice Medicine in Florida.

In consideration for this, Drs. Lehr, Kimmelman, Sader, Stricoff and Schiller agree to this same stipulation.

I certify that I have read and fully understand all of the above information.

Patient Name: _____ **Date of Birth:** _____

Patient or Representative Signature: _____ **Date:** _____

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CONSENT TO TREAT

In the course of your treatment with our practice, it may be necessary to contact you regarding your appointments, surgery, or medical condition. Please list family members or friends that you authorize us to speak with if we are unable to contact you. Without this authorization, we are prohibited by law to answer any questions regarding your appointments, surgery, or medical condition. This rule applies to spouses, children, parents and any other immediate family members.

I, *(please print patient's name)* _____, hereby authorize the office of Drs. Lehr, Kimmelman, Sader, Stricoff and Schiller to contact the person(s) listed below and/or to leave a message at my home, office or cell phone.

Authorized contact(s):

Name	*Relationship*	*Phone #*

List any exceptions to the above.

_____

_____

_____

This authorization will last indefinitely, unless this office is notified in writing regarding any changes.

Patient Name: _____ **Date of Birth:** _____

Patient or Representative Signature: _____ **Date:** _____

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Welcome to the FollowMyHealth Patient Portal

The Doctors and Staff would like to welcome you to the Patient Portal with FollowMyHealth.

Through the Patient Portal you will be able to access and manage your personal health information from any computer, smartphone or tablet. The portal will also offer another method of communication between the office and the patient. Please be aware that this is a non-critical means of communication.

Do not use the FollowMyHealth Patient Portal to communicate with the office if there is an emergency or an urgent need.
In the event of an EMERGENCY or an URGENT NEED please call 911 or the office immediately.

You will receive an invitation via e-mail to activate your secure account. Click the link provided in the e-mail then follow the steps to create your account. Step 3 will ask for your 4-digit **Invite Code**. This code will be the year you were born.

Didn't receive an e-mail invitation? Just call our office and we will assist with creating/logging into your account.

With the portal you can send messages to the office regarding:

- confirming or canceling office appointments
- updates to your information
- other non-urgent/routine questions

Due to the high volume of calls that we receive daily we know that you will enjoy this extra feature as it will decrease the amount of time you are placed on hold and will offer a more convenient way for you to communicate with the office.

Patient's Name: ***(please print)*** _____

Date of birth: _____

E-mail: _____

☐ **Check this box if you are not interested in signing up for the patient portal** ***(you must still fill in your name, date of birth, and sign this page)***

Patient or Representative Signature: _____ **Date:** _____

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ACKNOWLEDGEMENT OF RECEIPT OF THE PRACTICE'S NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the Practice's Notice of Privacy Practices (located at the front desk and on our website). You may refuse to sign this acknowledgement.

Name: (Please Print) _____

Patient or Representative Signature: _____ **Date:** _____

--- --- --- --- ***THIS SECTION BELOW IS TO BE COMPLETED BY THE OFFICE*** --- --- --- ---

The Practice Use Only _____

Date acknowledgement received: _____

Individual refused to sign: _____ *(check if applicable)*

An Emergency situation prevented the Practice from obtaining acknowledgement: _____ *(check if applicable)*

Other reason acknowledgement was not obtained: _____

_____

Practice Employee:

Print Name: _____

Signature: _____ *Date:* _____

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PATIENT NAME: _____ **DOB:** _____

MEDICAL HISTORY – *Please list all medical problems*: _____

_____

_____

PAST SURGICAL HISTORY – *Please list surgeries with dates (year)*: _____

_____

_____

FAMILY HISTORY – *Please list all known medical problems for family members*:

Mother: _____

Father: _____

Brother: _____

Sister: _____

Other: _____

MEDICATIONS – *Please list all prescriptions, over-the-counters & vitamins with dosage*: _____

_____

_____

_____

☐ **Ozempic or similar medication (oral or injection):** _____

ALLERGY TO MEDICATION: _____

TOBACCO USE:

- ☐ Never Smoker
- ☐ Current smoker (including vape) – every day
- ☐ Current smoker (including vape) – some days
- ☐ Former smoker
- ☐ Smokeless tobacco use – every day
- ☐ Smokeless tobacco use – some days

ALCOHOL USE:

- ☐ Never drinks alcohol
- ☐ Drinks alcohol – every day
- ☐ Drinks alcohol – some days

IMMUNIZATIONS:

Influenza immunization? ☐ Yes ☐ No If yes, when? (month / year) _____

Pneumonia vaccination? ☐ Yes ☐ No If yes, when? (month / year) _____

SCREENING – *Please provide the most recent dates (mm/yyyy) & the results for the following tests if they apply to you*:

COLONOSCOPY – *Date*: _____ RESULTS: ☐ Normal ☐ Other: _____

MAMMOGRAM – *Date*: _____ RESULTS: ☐ Normal ☐ Other: _____

PAP SMEAR – *Date*: _____ RESULTS: ☐ Normal ☐ Other: _____

PATIENT SIGNATURE: _____ **Date:** _____

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PATIENT NAME: _____ **DOB:** _____

☑ **Please select the symptoms that you are <u>currently</u> experiencing:**

- ☐ Appetite change (increase / decrease)
- ☐ Bleeding (intestinal)
- ☐ Chest pain
- ☐ Chills
- ☐ Constipation
- ☐ Cough
- ☐ Decreased memory
- ☐ Depression
- ☐ Diarrhea
- ☐ Discharge (penile/vaginal)
- ☐ Dizziness
- ☐ Dyspepsia (heartburn)
- ☐ Dysphagia (difficulty swallowing)
- ☐ Dysuria (urinary burning)
- ☐ Edema (swelling)
- ☐ Enlarged lymph nodes
- ☐ Fatigue
- ☐ Fever
- ☐ Frequency (urinating)
- ☐ Headache
- ☐ Hematemesis (bloody vomit)
- ☐ Hematuria (bloody urine)
- ☐ Hemoptysis (bloody cough)
- ☐ Joint pain
- ☐ MI (heart attack)
- ☐ Muscle cramps
- ☐ Nausea
- ☐ Palpitations
- ☐ Polydipsia (excessive drinking)
- ☐ Polyuria (excessive urinating)
- ☐ Prolonged bleeding
- ☐ Rectal bleeding
- ☐ Seizures
- ☐ Sexual dysfunction
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Sweats
- ☐ Syncope (faintness)
- ☐ Unexpected weight change
- ☐ Urine retention
- ☐ Vomiting
- ☐ Wheezing

PATIENT SIGNATURE: _____ **Date:** _____

--- --- --- --- --- ***THIS SECTION BELOW IS TO BE COMPLETED BY THE OFFICE*** --- --- --- --- ---

HEIGHT: _____ *WEIGHT:* _____ *TEMP:* _____ *BP:* _____

_____
_____
_____
_____
_____
_____
_____