BLOOMINGDALE MEDICAL ASSOCIATES

Internal Medicine - Primary Care

Diplomates American Board of Internal Medicine

13403 Boyette Road
Riverview, Florida 33569
(813) 654-1775 • FAX (813) 651-9082

Dear New Patient:

Welcome! We are pleased you have chosen Bloomingdale Medical Associates for your health care needs. We are a group of four Internal Medicine physicians, one Board Certified Family Practice physician, two certified Physician Assistants and three Advanced Registered Nurse Practitioners who are committed to delivering quality health care to you. We are confident you will be pleased with your decision to choose one of our physicians as your primary care doctor.

Attached please find a patient information registration form, which contains a medical history questionnaire. Please complete this form prior to arriving for our appointment and bring it with you. **Please arrive 30 minutes before your appointment time** so that we may prepare your account and verify your registration information. Also included in your packet is a medical record release form. Please complete this form so we can obtain a copy of your medical records from your previous physician. You may bring the completed form to your first appointment or submit the form to your previous physician to obtain your records prior to your visit.

Please bring your photo ID and insurance card. Without your ID and insurance card, unfortunately we would need to reschedule the appointment. We are providers for Medicare and a number of managed care programs. If you have a managed care plan, we recommend you contact your member services department to verify our participation and your primary care selection. **If your insurance company requires a co-payment, it will be collected when you check in with our Patient Coordinator. We will collect the appropriate percentage or deductible for all other health insurance plans (including Medicare) at the time of service. We do not bill for deductibles and/or co-insurances.** We accept cash, check, Mastercard, Visa and Discover.

Our office hours are 8:00 AM to 5:15 PM Monday through Thursday and to 4:45 on Friday. We also offer Saturday appointment from 9:00 to 1:00 for active illnesses only. If you need to cancel your appointment please contact us as soon as possible.

If you have any further questions, please do not hesitate to call. We have a support staff of over 40 qualified clinical and business employees who are here to help you. It is our goal to exceed your expectations and we look forward to establishing a long and healthy relationship with you!

Sincerely,

Administrator
Enclosures

BLOOMINGDALE MEDICAL ASSOCIATES
PATIENT INFORMATION

Account #: _____

Date: _____

Patient's Name: _____ SS #: _____

Address: _____ City: _____ St: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____ May we use email for medical results? ( ) Yes ( ) No

Northern Address: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Parent or Guardian (If a minor): _____

Parent's Employer: _____ Work Phone #: _____

Spouse's Name: _____ Employer: _____ Work Phone #: _____

Emergency Contact Name: _____ Daytime Phone #: _____ Cell Phone #: _____

Current Local Pharmacy

Name: _____

Address: _____

Phone #: _____

If you are here today as the result of an accident, please briefly explain the nature of the injury.

_____

_____

Date of Accident: _____ ( ) Auto ( ) Other

How were you referred to our office:
( ) Referring Physician: _____
( ) Friend ( ) Yellow Pages ( ) Other

I understand that I am solely responsible for servitces rendered at the time of service. In the event that insurance is filed on my behalf for payment of medical and/or surgical services in the office/hospital, I authorize payment on benefits to BLOOMINGDALE MEDICAL ASSOCIATES. I understand that I am responsible for any amount not covered by my insurance company.

I authorize _____ to receive my medical information.
Family Member / Friend Name

I authorize the release of any medical information necessary for payment to be sent to BLOOMINGDALE MEDICAL ASSOCIATES.

Signature: _____ Date: _____

Today's visit will be paid by: ( ) Cash ( ) Check ( ) Visa / Mastercard / Discover / American Express

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I,_____, have received a copy of
(Print Name)

Bloomingdale Medical Associates Office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

BLOOMINGDALE MEDICAL ASSOCIATES

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

LAST NAME: _____ FIRST NAME: _____ DOB: _____ DATE: _____

Review of Systems

Do you now or have you had any problems related to the following systems?

Circle **Yes** or **No.**

Constitutional Symptoms	NOW	PAST	(Comments)
Weight change	Y N	Y N	
Chills	Y N	Y N	
Sleep Disorder	Y N	Y N	
Other			

Eyes			
Double vision	Y N	Y N	
Glaucoma	Y N	Y N	
Cataracts	Y N	Y N	
Other			

Ear / Nose / Throat / Mouth			
Hearing changes	Y N	Y N	
Sore throat	Y N	Y N	
Sinus problem	Y N	Y N	
Other			

Cardiovascular			
Chest pain	Y N	Y N	
Irregular heartbeat	Y N	Y N	
Swelling in ankles	Y N	Y N	
Other			

Psychologic			
Are you generally happy?	Y N	Y N	
Do you feel depressed?	Y N	Y N	
Do you feel anxious?	Y N	Y N	
Do you feel safe in your home?	Y N	Y N	

Endocrine			
Excessive thirst	Y N	Y N	
Too hot / cold	Y N	Y N	
Tired / sluggish	Y N	Y N	
Other			

Hematologic / Lymphatic			
Swollen glands	Y N	Y N	
Blood clotting problem	Y N	Y N	
Bruising	Y N	Y N	
Other			

Allergic / Immunologic			
Hay Fever	Y N	Y N	
Drug allergies	Y N	Y N	
Food	Y N	Y N	
Other			

Genitourinary	NOW	PAST	(Comments)
Change in stream	Y N	Y N	
Nocturia (getting up at night)	Y N	Y N	
Urinary frequency > 8 times/day	Y N	Y N	
Other			

Musculoskeletal			
Bone pain	Y N	Y N	
Muscle pain	Y N	Y N	
Joint pain	Y N	Y N	
Other			

Integumentary (Skin)			
Rash	Y N	Y N	
Lumps or bumps	Y N	Y N	
Moles, skin tags	Y N	Y N	
Other			

Neurological			
Tremors	Y N	Y N	
Dizzy spells	Y N	Y N	
Numbness/tingling	Y N	Y N	
Other			

Respiratory			
Wheezing	Y N	Y N	
Frequent cough	Y N	Y N	
Shortness of breath	Y N	Y N	
Other			

Gastrointestinal			
Abdominal pain	Y N	Y N	
Nausea/vomiting	Y N	Y N	
Indigestion/heartburn	Y N	Y N	
Other			

Sexual History			
Change in sex drive?	Y N	Y N	
Sexual performance satisfactory?	Y N	Y N	
Other (i.e. sexual trauma)			

Last Exams: Please enter date (mo/yr)

Dental: _____ Eye: _____
Prostate: _____ PSA test: _____
Mammogram: _____ Bone Density: _____
Pelvic: _____
PAP smear: _____

Living Will? ☐ Yes ☐ No Advanced Directive? ☐ Yes ☐ No **Dr / PA / NP / sig:** _____

PATIENT SIGNATURE: _____

OVER →

Medical History

Last Name: First Name:

Medical ☐ None *(High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.)*

Pregnancy History

Year	Sex	Complications

Surgical ☐ None *(Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.* - Please enter year surgery was done if known)

Allergies to medications? ☐ None (If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)

Last Immunizations: FLU ___/___/___ PNEU ___/___/___ Tetanus ___/___/___ Other ___ ___/___/___

Current prescription medicines: ☐ **None**

Name of drug	mg dose	#tablets	#times per day

Additional Current prescription medicines:

Name of drug	mg dose	#tablets	#times per day

Current Non-Prescription Medicine (Aspirin, Tylenol, Ibuprofen, Aleve, vitamins and herbals.)

Family History

Father: ☐ Living - Age: _____ ☐ Deceased, Age at Death _____ (Cause) _____

Mother: ☐ Living - Age _____ ☐ Deceased, Age at Death _____ (Cause) _____

Siblings: Number Living _____ Number deceased _____ (Cause) _____

List other illnesses in your family (Example - Diabetes, heart disease, colon cancer, breast cancer, prostate cancer, etc.)

(Family Member) (Illness) (Family Member) (Illness) (Family Member) (Illness)

_____ = _____ _____ = _____ _____ = _____

Social History

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED **NUMBER OF CHILDREN** _____ ☐ None

Smoke? ☐ Yes ☐ No If yes, how much? _____ # of packs/day _____ # of years When did you stop smoking? _____

Alcohol? ☐ Yes ☐ No If yes, how much? _____

Occupation _____ ☐Retired Significant prior industrial or agricultural exposures? ☐Yes ☐No

Exercise regularly? ☐ Yes ☐ No If yes, what and how frequently?

Bloomingdale Medical Associates

13403 Boyette Road, Riverview, FL 33569
Phone: (813)654-1775

Authorization to Release/Obtain Medical Records

Please allow 7-10 Business days for Bloomingdale Medical Associates to process your request.

hereby authorize the disclosure of information from the health records of:

Patient's First Name	Patient's Last name		
Address	City	State	Zip
Phone Number (with area code)	Last 4 digits of Social Security Number	Date of Birth	

Health Information to disclose:

- ☐ All information
- ☐ Most recent one year History
- ☐ Immunization records
- ☐ Labs & imaging studies
- ☐ Most recent three-year history
- ☐ Other (specify) _____

Method of disclosure:

☐ Release medical records **FROM Bloomingdale Medical Associates to**:

Name: _____
Address: _____
or Fax No.: _____

☐ Release medical records **TO Bloomingdale Medical Associates from**:

Name: _____
Address: _____
or Fax No.: _____

The following Items Must Be Initialed to be Include in the Use and/or Disclosures

_____ HIV/AIDS relate information and/or records HBV, TB, or other Communicable Diseases
_____ Mental Health Information and/or Records
_____ Domestic Violence
_____ Genetic Testing information and/or records
_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how and What kind of information is to be disclosed.) Describe:

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request or on the following requested date: _____.

_____ _____
Print Patient's Name Date

_____
Signature of Patient or Patient's Legal Representative

_____
Print Name of Legal Representative (if applicable)

_____
Relationship to patient

PLEASE DO NOT FAX IF OVER 25 PAGES. Fax number 813-651-9082