IDICULA MEDICAL ASSOCIATES, M.D.
10065 CORTEZ BLVD
BROOKSVILLE, FL 34613
PHONE 352-596-4660 FAX 352-596-4674
www.idiculamedical.com

Requesting Provider ____

Date: _____________________Referred by: ____

Patient name: ____________________________________ Age:___________ D.O.B._____________________
Address ________________________________ City _______________________ State _______ ZIP _________
Phone: Home ____________________________ Work/ Cell ____
Social Security # _____________________________ E-MAIL _______________________________________

I have a living will ____ Yes ____ No Copy to office ____ Yes ____ No
I have received a copy of the patient's rights. ____ Yes ____ No

Closest Living Relative ____ Spouse ______ Other __________
Phone __(____)___________________________ Address ____

Name and phone # to contact in case of emergency **other than listed above**:
Name____ Phone __________________________________
Relationship ____________________________

Authorization to release information and assignment of benefits
I authorize discussion of my medical condition with (____) Spouse,
(____) Children names ____
(____) Other ____
Patients signature ____ Date _______________________

ASSIGNMENT OF MEDICAL BENEFITS TO DOCTOR AND RELEASE OF INFORMATION TO INSURANCE COMPANY

I AUTHORIZE THE ASSIGNMENT OF MEDICAL BENEFITS TO **IDICULA MEDICAL ASSOCIATES, MD**, AND ALLOW ANY OR ALL MEDICAL RECORDS TO BE FORWARDED TO MY INSURANCE COMPANY TO INSURE PAYMENT. I UNDERSTAND THAT I AM LIABLE FOR PAYMENT OF SERVICES RENDERED. I AM ALSO LIABLE FOR ANY DEDUCTIBLE OR CO-INSURANCE MY INSURANCE PLAN REQUIRES.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION AND RX HISTORY TO OTHER PHYSICIANS OR MEDICAL FACILITIES VIA FAX TO EXPEDITE THE TRANSFER OF RECORDS. THIS AUTHORIZATION REMAINS IN EFFECT FOR AS LONG AS I AM UNDER THE CARE OF **IDICULA MEDICAL ASSOCIATES, MD.**

PATIENT SIGNATURE _______________________________________ DATE ________________________

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Authorization for Use or Disclosure of Information for Purposes Requested by Physician's Office

I, ______________________________________, hereby authorize **IDICULA MEDICAL ASSOCIATES, MD,** to use the following protected health information, and/ or disclose the following protected health information for the following purposes:

Medical records ________X_____________ **Billing records** _________X_______________

I authorize Idicula Medical Associates, Inc. to leave messages on my voice mail or answering machine.
____ Yes ____ No

I authorize Idicula Medical Associates, Inc. to leave messages with my spouse. ____ Yes ____ No

I authorize Idicula Medical Associates, Inc. to leave messages with my children. ____ Yes ____ No

Names:____

I authorize Idicula Medical Associates, Inc. to leave messages if my tests are normal. ____ Yes ____ No

I acknowledge that I have received a copy of Idicula Medical Associates, Inc.'s HIPPA privacy notice.
____ Yes ____ No

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **IDICULA MEDICAL ASSOCIATES, MD** at 10065 CORTEZ BLVD BROOKSVILLE, FL 34613. I understand that a revocation is not effective to the extent that **IDICULA MEDICAL ASSOCIATES, MD** has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

IDICULA MEDICAL ASSOCIATES, INC. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
I understand that I have the right to:
1. Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
2. Refuse to sign this authorization.

____ _________________________________
Signature of Patient or Personal Representative **Date**

____ _____________________________________
Name of Patient or Personal Representative **Description of Personal Representative's Authority**

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RX HISTORY CONSENT FORM

I, ____ give my permission
Print patient name

for **Idicula Medical Associates, MD** to e-scribe or fax my prescription to my pharmacy.

______________________________ ______________________
PATIENT SIGNATURE DATE

Primary Pharmacy: ____

Location: ____

Secondary Pharmacy: ____

Location: ____

LIST OF MEDICATIONS, HERBAL SUPPLIMENTS, AND VITAMINS

Medications	Dosage	How many times a day

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

I request and authorize:

(Previous Physicians Name)____

Fax#: ____

to release my medical record which includes my medical history, diagnostic testing, and progress notes concerning any illness and/ or treatment. Please forward the requested medical record(s) to:

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BROOKSVILLE, FL 34613
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______ Agnes Idicula, M.D.
______David Deam, M.D.,
______ Mitchell Halperin, M.D.
______ Jane Block, ARNP
Joseph Idicula, M.D.______
Abdullah Kamara, M.D.______
Lyndon Garcia, M.D.______

Please fax:
____
____

for the purpose of continuous care.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the physician's office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ______________________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient name: ____

D.O.B. ______________________last 4 #'s SS#___________________________

Signature: ______________________________________Date:___________________

Thank you for your attention to this request.

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INSURANCE INFORMATION

Policy Holder:

Name:____
Last Name First Name MI

Date of Birth: _____________Relationship to Patient: ______________

Primary Insurance:

Insurance Carrier Name:_______________________________________

Address:____

Policy#:____

Group#:_____________________ Effective Date:_________________

Secondary Insurance:

Insurance Carrier Name:_______________________________________

Address:____

Policy#:____

Group#:_____________________ Effective Date:_________________

Tertiary Insurance:

Insurance Carrier Name:_______________________________________

Address:____

Policy#:____

Group#:_____________________ Effective Date:_________________

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HEALTH QUESTIONAIRE

Patient Name: ____________________________________ **DOB**: __________________

Please indicate each of your chronic medical problems by putting an "X" next to them.

___ High Blood Pressure
___ Kidney Problems
___ Emphysema/Lung Disease
___ High Cholesterol
___ Other ____

___ Asthma
___ Stroke
___ Diabetes
___ Glaucoma

___ Heart Disease
___ Cancer
___ Thyroid
___ Anemia

Are you allergic to any medications? ___ Yes ___ No If yes, please list them and the reaction they cause.

Drug:__________________________________ Reaction:_________________________

Drug:__________________________________ Reaction:_________________________

Social History:

Tobacco __________ a day

Number of years_____ Years Quit_______

Alcohol __________ drinks per week

Caffeine _______________ cups per day

Street Drugs ___________________

Low Fat Diet _____ Yes _____ No

Exercise __________________type

Times a week __________minutes/session

Water ____ cups a day

Occupation ___________________________

Family History:

___ High Blood Pressure
___ Substance Abuse
___ Emphysema/Lung Disease
___ High Cholesterol

___ Asthma
___ Stroke
___ Diabetes
___ Glaucoma

___ Heart Disease
___ Cancer
___ Thyroid
___ Mental Health

HEALTH QUESTIONAIRE

Patient Name: ___________________________________ **DOB**: __________________

Please list any surgeries/hospitalizations (including the year).

____

____

Are you under the care of any other doctor for any medical problems? _______________
If so, whom and for what medical problems? ____________________________________

Year of last: Tetanus Shot _______Flu shot ________ Pneumonia Vaccine _________

For Women Only: Date of first day of last menstrual period: _____/_____/_____

Number of: Pregnancies__________ Miscarriages __________ Live Births__________
Abortions __________ Contraception Type: ___________________

Date of last: PAP ______ (Abnormal? ________) Osteoporosis Scan _______________
Mammogram ______ (Abnormal? ______) Menopausal Symptoms _____Yes _____No

Have you been the victim of abuse? _______ Yes _______ No

For Men Only:
Date of last Prostate Exam: __________ Last PSA (Prostate Blood Test) ____________

Procedures (list year): Colonoscopy __________ Stress Test __________
Sugar (normal Y/N)____ Cholesterol ___________ EKG ______________

Please place a checkmark next to any symptoms that your are currently having and indicate the year if the symptoms occurred in the past.

General: ______ Fever______Night Sweats ______ Unexplained Weight Loss or Gain _____Fatigue
Skin: ______ Rashes _____ Cancer _____ Change in Hair, Skin, or Nails
Eyes: ______ Glasses _____ Contact Lenses _____ Pain ____ Changing Vision _____ Discharge
Heart: ______ Chest Pain _____ Swelling in Ankles _____ Palpitations _____ Heart Murmur
Lungs: _____ Cough _____ Shortness of Breath _____ Wheeze
Allergy: _____ Hives _____ Hay Fever
Circulation: _____ Leg Swelling _____ Blood Clots
Orthopedic: _____ Painful Joints _____ Muscle Weakness
Neuro / Psych: _____ Seizures _____ Tremor _____ Depression _____ Anxiety _____ Paralysis
Gastrointestinal: _____ Nausea _____ Ulcers _____ Blood in Stool _____ Heartburn
_____ Change in Bowel Movements
Ear, Nose, Throat: _____ Ear Pain _____ Sore Throat _____ Sinus Trouble _____ Change in Voice
_____ Change in Hearing _____ Persistent Runny Nose

Patient Signature____________________________ Date ______________________

Clinician Signature __________________________ Date ______________________