OSCEOLA SURGICAL ASSOCIATES
An Affiliate of Osceola Regional Medical Center

Name_____**DOB**_____**DATE**_____

Reason for your visit: _____

Pharmacy Name/address: _____

List of current medications (include aspirin and over the counter meds):_____

_____

_____

List any allergies and reaction: _____

Medical History: Circle Yes or No

HIGH BLOOD PRESSURE___YRS/MO	**YES NO**		**FLU SHOT**	**YES NO**	
DIABETES____YRS/MO	**YES NO**		**PNEUMONIA VACCINE**	**YES NO**	
HEART ATTACK	**YES NO**		**COLONOSCOPY/DATE_____**	**YES NO**	
CANCER/TYPE	**YES NO**		**HEADACHES**	**YES NO**	
EPILEPSY SEIZURES	**YES NO**		**DIZZY SPELLS**	**YES NO**	
PROBLEMS WITH ANESTHESIA	**YES NO**		**CHEST PAIN**	**YES NO**	
GALLBLADDER PROBLEMS	**YES NO**		**SHORTNESS OF BREATH**	**YES NO**	
HERNIAS	**YES NO**		**PRODUCTIVE COUGH**	**YES NO**	
TB, HIV, HEPATITIS, HERPES	**YES NO**		**NAUSEA/VOMITING**	**YES NO**	
PEPTIC ULCER DISEASE	**YES NO**		**DIARRHEA**	**YES NO**	
BLADDER PROBLEMS	**YES NO**		**CONSTIPATION**	**YES NO**	
ARTHRITIS/LOCATION_____	**YES NO**		**RECTAL BLEEDING**	**YES NO**	
PHLEBITIS	**YES NO**		**HEMORRHOIDS**	**YES NO**	
BLOOD CLOTS	**YES NO**		**ANEMIA**	**YES NO**	
VARICOSE VEINS	**YES NO**		**BLEEDING TENDENCIES**	**YES NO**	
THYROID DISEASE LOW/HIGH	**YES NO**		**CRAMPS IN CALVES**	**YES NO**	
ASTHMA	**YES MO**		**WEIGHT**	**GAIN, LOSS, STABLE**	

Other medical problems: _____

List any surgeries/hospitalizations done (<u>Please include dates</u>):

_____When_____

_____When_____

_____When_____

Family History (Do Not Include self):

Cancer **YES NO**, Type & Who: _____

Heart disease **YES NO**: _____

Diabetes **YES NO**: _____

Stroke **YES NO**: _____

Colon Cancer,Polyps,Inflammatory Bowel Disease **YES NO**:_____

Social history:

Do you smoke? **YES NO** or did you quit & when? _____, Packs per day_____# of Years: _____

Alcohol? **YES NO** Occasionally, Regularly

Women:

Number or Pregnancies: ____Number of children: _____Age of first Preg: _____ Breastfeed? _____

Age of first period: _____Age of menopause: _____Breast Lumps: **YES NO** Last Mammogram: _____

Do you have a Living Will or Advance Directive? **YES NO**

Legal Guardian or Power of Attorney? **YES NO** Who: _____

Name of Primary Care Physician: _____

Name of Cardiologist: _____

Name of Pulmonologist: _____

PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-_____-_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐
Responsible party name: (Last)_____(First)_____(MI) _____
Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male
Responsible Party Social Security Number:_____-_____-_____Phone number: _____
Address:_____
City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____
Phone number:_____ Do you have a living will? ☐ Yes ☐ No
Emergency contact relationship to patient:_____ ☐ Guardian
Address_____
City, State:_____ZIP: _____
Home phone:_____Work hone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

OSCEOLA SURGICAL ASSOCIATES
An Affiliate of Osceola Regional Medical Center
Napoleon N. Estrada, M.D., F.A.C.S
Antonio J. Ramirez, D.O.
Fuad H. Shahin, M.D., F.A.C.S.
Phillip Kondylis, M.D.
320 W. Bass Street
Kissimmee, FL 34741
Ph (407)846-3166
Fx (407)846-9115

Email address:

_____

****Email addresses will not be shared. They are required to give electronic access to your medical records, communicate surgery instructions in writing, as well as ask your opinion about how our office is performing. Thank you ☺**

Patient name: _____
Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, OSCEOLA SURGICAL ASSOCIATES may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge OSCEOLA SURGICAL ASSOCIATES may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to OSCEOLA SURGICAL ASSOCIATES any insurance or other third-party benefits available for health care services provided to me. I understand OSCEOLA SURGICAL ASSOCIATES has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to OSCEOLA SURGICAL ASSOCIATES, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to OSCEOLA SURGICAL ASSOCIATES by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for OSCEOLA SURGICAL ASSOCIATES, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that OSCEOLA SURGICAL ASSOCIATES or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or OSCEOLA SURGICAL ASSOCIATES or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ Date: _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) _____

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CONSENT FOR MEDICAL STUDENTS OBSERVATION OF MEDICAL TREATMENT AND INFORMATION

All students will abide with confidentially and our Notice of Privacy Practice in accord with office policies.

I (Name) _____Date of Birth_____
Consent to having medical students present in the exam room with the physicians at the time of my visit or procedure. I understand that my physician may disclose protected health information and treatment in accord with the visit.

I (Name) _____Date of Birth_____
Decline for medical students to be present in the exam room.

_____ _____
Patient Name Date

Right to revoke: You will have the right to revoke this consent at any time, in writing, except to the extent that action has already been taken.