Joshua Z. Steiner, D.O., P.A. ***HISTORY AND PHYSICAL***

Patient Name:____________________ DOB:______________ Date:______________

Address:____ Phone:______________

Age:_____ (M S W D) Occupation:____________________ Referred by:______________

ALLERGIES: ____

____

Please list all medications you are taking:

____

____

____

____

____

____

FAMILY HISTORY	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Cancer						
Diabetes						
Blood Pressure						
Stroke						
Cholesterol						
Mental Illness						
Kidney						
Thyroid						

HOSPITALIZATIONS	YEAR	SURGERIES	YEAR

Are you experiencing any of the following?

Y N

- ☐ ☐ Hearing problems
- ☐ ☐ Dizziness
- ☐ ☐ Vision problems
- ☐ ☐ Nose bleeds
- ☐ ☐ Sore throat
- ☐ ☐ Hoarseness
- ☐ ☐ Shortness of breath
- ☐ ☐ Chest Pain
- ☐ ☐ Swelling in the legs
- ☐ ☐ Leg Pain
- ☐ ☐ Appetite changes
- ☐ ☐ Heartburn
- ☐ ☐ Abdominal pain
- ☐ ☐ Diarrhea
- ☐ ☐ Vomiting
- ☐ ☐ Constipation
- ☐ ☐ Urinary problems
- ☐ ☐ Nighttime urination
- ☐ ☐ Weight changes.
- ☐ ☐ Fatigue
- ☐ ☐ Easy bruising
- ☐ ☐ Rash
- ☐ ☐ Depression
- ☐ ☐ Headaches
- ☐ ☐ Sleep problems
- ☐ ☐ Sexual problems

Have you ever been diagnosed with any of the following?

Y N

- ☐ ☐ Allergies
- ☐ ☐ Pneumonia
- ☐ ☐ Bronchitis
- ☐ ☐ Asthma
- ☐ ☐ Anemia
- ☐ ☐ High blood pressure
- ☐ ☐ Heart murmur
- ☐ ☐ Ulcer
- ☐ ☐ Acid reflux
- ☐ ☐ Jaundice
- ☐ ☐ Diverticulosis
- ☐ ☐ Kidney stones
- ☐ ☐ Frequent urine infections
- ☐ ☐ Cancer (Type____________)
- ☐ ☐ Diabetes
- ☐ ☐ Thyroid disease
- ☐ ☐ Arthritis
- ☐ ☐ Gout
- ☐ ☐ Seizures
- ☐ ☐ Depression
- ☐ ☐ Anxiety

Other history

____

____

____

Smoking

How much?______________

How long?______________

When did you quit?__________

Alcohol

How much?______________

What kind?______________

Drug Use

What kind?______________

How often?______________

Exercise

How often?______________

What kind?______________

Coffee/Tea/Colas

How many cups per week?_______

FEMALE PATIENTS

Last period?______________

Last Pap test?______________

Last mammogram?____________

Number of pregnancies?________

Number of children?___________

Joshua Z. Steiner, D.O., P.A.
PATIENT INFORMATION SHEET

Date Completed: ______/_______/_______

NAME:________________________ SEX:_______ REFERRED BY:__________________

SOCIAL SECURITY #: ______________________ BIRTH DATE: ________/________/________

RELIGION:__________________________ MARITAL STATUS: S M W D

ADDRESS:____

CITY________________________ STATE _________ ZIP____________________

HOME PHONE: ______________________ CELL PHONE: ______________________

EMAIL:____

EMPLOYER/SCHOOL:____

TITLE: ________________________ WORK PHONE:_____ ____________________

ADDRESS:______________________ CITY/STATE/ZIP______________________

SPOUSE:__________________________ BIRTH DATE:________/________/________

SPOUSE EMPLOYER/SCHOOL:___________________________________

CITY/STATE: __________________________ WORK PHONE:____________________

ETHNICITY: Hispanic/Latino Other Refuse to Answer PRIMARY LANGUAGE:________________

NATIONALITY: Caucasian African Amer Native Amer. Asian Hispanic Other

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SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY OTHER THAN SOMEONE LIVING WITH YOU:

NAME:________________________ RELATIONSHIP:________________________

ADDRESS:______________________ CITY/STATE/ZIP______________________

HOME PHONE: ____________________ CELL PHONE: ______________________

PRIMARY INSURANCE INFORMATION

INSURANCE CO.:______________________

ADDRESS:___________________________

CITY/STATE/ZIP:______________________

PHONE #:___________________________

ID #:______________________________

GROUP NAME OR #:___________________

INSURED NAME:______________________

INSURED SS #:_______________________

RELATIONSHIP TO INSURED:_____________

(e.g.: SELF – SPOUSE – CHILD – PARENT)

SECONDARY INSURANCE INFORMATION

INSURANCE CO.:______________________

ADDRESS:___________________________

CITY/STATE/ZIP:______________________

PHONE #:___________________________

ID #:______________________________

GROUP NAME OR #:___________________

INSURED NAME:______________________

INSURED SS #:_______________________

RELATIONSHIP TO INSURED:_____________

(e.g.: SELF – SPOUSE – CHILD – PARENT

JOSHUA Z. STEINER, D.O., P.A.

OFFICE FINANCIAL POLICIES

In order to better serve your needs and clarify any questions that you may have regarding your insurance, we have adopted the following financial policies. If you have any questions, please speak with one of our billing or managerial staff, and she will gladly assist you.

We will gladly file your insurance claim. Copayments, deductibles, and co-insurance amounts are collected at the time of service. We will verify your insurance coverage at each visit. All insurance changes must be given to us at the time of service. If your insurance changes and we are not notified, you will be responsible for all charges.

As a courtesy to you, insurance forms for services rendered will be completed by our office with your primary insurance carrier. We will not file the secondary insurance – unless it is secondary to Medicare.

In the event that your health insurance plan determines a service to be "not covered", you will be responsible for the uncovered charge.

All forms and letters that we are asked to complete, including Disability forms, FMLA forms, Leave of Absence forms, jury duty excusals, letters regarding travel, and/or any requested correspondence that is not associated with reimbursement of a claim will incur a $15.00 fee to the patient.

NON-CANCELLATION OF APPOINTMENTS
There is a $25.00 charge to patients for a missed appointment without prior notice. Please call us no later than 9:00 AM on the day of your appointment to notify us of your cancellation.

RETURNED CHECK FEE
There is a charge of $50.00 in the event a check is returned for insufficient funds.

STATEMENT PROCEDURE
We will mail a "statement" to the address you have provided once we receive payment from your insurance carrier. If we do not have payment from you within 90 days, we will make every effort to notify you that the account is being turned over to our collection agency and will impact your credit rating.

MEDICAL RECORDS REQUEST
Any patient requesting records must submit a signed records release form and there will be a clerical fee of $1.00 per page to process.

I AGREE TO MY FINANCIAL RESPONSIBILITIES. I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICIES

______________________________ ______________
Patient Signature Date

____
Patient Name (printed)

Joshua Z. Steiner, D.O., P.A.
4410 Sheridan St., Suite A
Hollywood, FL 33021

I hereby authorize my insurance company to make payments directly to my physician and further permit a copy of this authorization to be used in place of the original. This authorization applies to all claims submitted by my physician. I hereby authorize my physician to release any information required in the course of examination and treatment. I further authorize my physician to release any of medical records to any insurance company that may request them. This includes all information of HIV, drug use, psychiatric treatment, or other problems. I understand that my physician will comply with all applicable HIPAA regulations. There is no time limit on this record release.

I understand that a physical exam, school exam, or pre-employment exam including lab and diagnostic testing may not be a covered benefit under my insurance. I will be held responsible for any payment due. I understand that I should check before any lab work, diagnostic tests, or specialist visit that the provider is still affiliated with my insurance company as these can and do change frequently. My physician will not be held responsible for the fees of any lab, diagnostic facility, or specialist that is not covered by my insurance for any reason. If I find that a service will not be covered, I should call the office for a new referral.

A 1.5% late payment charge may be added to all unpaid balances not paid within 30 days of request. In addition, if this account is delinquent and is forwarded to a collection agency or attorney, I agree to pay any and all costs

I understand the following message from my physician:

To avoid any misunderstanding regarding medical insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and the patient is personally responsible for payment of fees. As a courtesy, we will prepare the necessary forms to help you obtain your benefits from your insurance company. We do not render our services on the basis that insurance companies will pay our fee, except in instances such as with specific PPO/HMO groups. If the insurance company does not cover our fee in full, the balance is due and payable by you.

Please sign below to indicate that you have reviewed the above information and give Joshua Z. Steiner, D.O., P.A. permission to treat you.

Signature____ Date________________

Name____

MEDICARE BENEFICIARIES ONLY

I request that payment of authorized Medicare benefits be made to my treating physician for any services rendered. I authorize any holder of medical information about me to release to the Center for Medicare Services and its agents any information needed to determine these benefits or benefits payable for related services.

Signed____ Date________________

Joshua Z. Steiner, D.O., P.A.

______________________________ ______________________________

Patient Name Date of Birth

ALTERNATIVE COMMUNICATION RELEASE FORM

I authorize Joshua Z. Steiner, D.O., P.A. in regards to my protected health information (PHI):

(check as many as you wish)

____To call me at work

____To call me at home

____To call my cell phone

____To speak with anyone on the Right To Share Information list below

____To speak only with me

____To fax information to me at this secured number ____________________

____Other____

RIGHT TO SHARE INFORMATION WITH FAMILY AND FRIENDS

Joshua Z. Steiner, D.O., P.A. reserves the right to communicate PHI with family or friends when it is deemed in the best interest of the patient as described in the Notice of Privacy.

In order to have your PHI shared in other circumstances with members of your family or friends, please list below those individuals to whom we are authorized to release information.

____

____

____

____

______________________________________ _______________

Signature of Patient Date

Joshua Z. Steiner, D.O., P.A.
4410 Sheridan Street, Suite A
Hollywood, FL 33021

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
* YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT *

I, ______________________________________, have received and read a copy this office's Notice of Privacy Practices. I also give my authorization for this office to disclose any of my personal health information as necessary for treatment, payment, or other healthcare operations as detailed in this office's Notice of Privacy Practices.

I, ______________________________________, give this office permission to leave messages regarding my healthcare with either a family member or on my answering machine when I cannot be reached directly.

I understand that this is the policy of this office. If I disagree, I will seek treatment by another physician.

____________________________ Patient's signature

____________________________ Witness' 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 this form (initial_____)

Communication barriers prohibited obtaining the acknowledgement (initial_____)

An emergency situation prevented us from obtaining the acknowledgement (initial_____)

Joshua Z. Steiner, D.O., P.A.

E-MAIL REQUEST

Please provide us with your email address below:

____ ______/______/______

Name Date of Birth

____@____________________.______

e-mail

☐ Check here if you do not have an e-mail address

For more information, continue reading:

As medical care in the United States rockets into the 21st century, medical provider offices such as ours are increasingly mandated by the government to collect data and communicate with patients in a secure manner. One of the initiatives of the government is to require physician offices to collect email addresses from patients and create ways for patients to communicate electronically with the office.

By providing your email, you are allowing us to send you a request to establish an electronic portal between you and our office. This portal will allow you limited access to the information in your chart and to communicate with the office. Such communication is not to be used for urgent or emergent matters and does not replace a physician encounter for diagnosis and treatment of acute or chronic conditions.

Joshua Z. Steiner, D.O., P.A.
4410 Sheridan Street, Suite A
Hollywood, FL 33021

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I understand that this is the policy of this office. If I disagree, I will seek treatment by another physician.

____________________________	____________________________
Patient's signature	Witness' signature

____
Date

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Dr. Joshua Z. Steiner D.O., P.A.

ANNUAL WELLNESS QUESTIONNAIRE

Patient: ______________________________ **DOB:** ____________

	(Please circle)	
1. During the past month, have you often been bothered by feeling down, depressed or hopeless?	YES	NO
2. During the past month, have you often been bothered by little interest or pleasure in doing things?	YES	NO
3. Have you fallen in the last year?	YES	NO
4. Do you have any complaints of balance problems or difficulty walking?	YES	NO
5. Do you have trouble hearing the television or radio when others do not?	YES	NO
6. Do you have to strain or struggle to hear / understand conversations?	YES	NO
7. Do you need help with preparing meals, transportation, shopping, taking your medicine, managing your finances or other activities of daily living?	YES	NO
8. Do you live alone?	YES	NO
9. Does your home have throw rugs, poor lighting or a Slippery bathtub/shower?	YES	NO
10. Does your home LACK grab bars in bathrooms, Handrails on stairs and steps?	YES	NO
11. Does your home lack functioning smoke alarms?	YES	NO

12. Do you have an Advance Directive (aka Living Will)? YES NO

13. Do you want information on Advance Directive? YES NO

14. What other doctors have you seen in the last year? (Name and Specialty)

____

____

____

____

15. If you use other medical suppliers (Oxygen, CPAP, Home Health etc.)
Please list those below:

____

____

____

PATIENT SIGNATURE:______________________________

DATE:________________________