Pacita T. Abinales, M.D.
Family Medicine

Benjamin Abinales, M.D.
Internal Medicine

Natasha Blanco, ARNP
Nurse Practitioner

Brittany Yates, ARNP
Nurse Practitioner

IDENTIFYING INFORMATION

Last Name: _________________________ First Name: _____________________ Date of Birth: ___________

Address: ____ Sex: M / F SS#: _______________

City: ___________________State: _____ Zip code: __________

Marital Status: Single / Married / Divorced
Widowed / Partner

Home Phone: (___) ____ - __________

Cell Phone: (___) ____ - __________

EMPLOYMENT INFORMATION

Employer Name: ____ Work Phone: (___) ____ - __________

Address: _______________________________ City: ________________State: ____Zip code: _____________

INSURED PERSON INFORMATION (Please fill in the blanks if insurance is under another person)

Employer Name: ____ Cell Number: (___) ____- __________

Address: _______________________________ City: ________________State: ____Zip code: _____________

INSURANCE INFORMATION

Primary insurance company name: _______________________________Insured ID #____________________

Subscriber's name: ____ Relationship _____________________

Subscriber's address ____ Insurance ID # ___________________

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PATIENT PRIVACY QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical conditions and your diagnosis (Including treatment, payment and health operation)

Name: ____Phone: ________________________

Name: ____Phone: ________________________

2. Please list the family members or significant others, if any, whom we may inform about your medical conditions ONLY IN EMERGENCY.

Name: ____Phone: ________________________

Name: ____Phone: ________________________

3. Please print the address of where you would like your billing statement and/or correspondence from our office to be sent if other than your home.

---

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL." ☐ Yes ☐ No

5. Please print the telephone number where you want to receive calls about your appointment, Labs and Radiology results.

6. Can confidential messages (I.E appointments reminders) be left on your answer machine/voice mail?
☐ Yes ☐ No

PATIENT/GUARDIAN NAME ____ (guardian if under 18 years of age)

PHARMACY INFORMATION

I agree to use ____pharmacy for filling

prescriptions for all of my medications including pain medication.

Address: __________________________________City:__________State:_____Zip code: ____________

Telephone number: (___) ____ - __________ Fax number: (___) ____ - __________.

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The purpose of this agreement is to prevent misunderstanding about certain medications you will be taking for pain management or any potentially addicting neurologic agents. This is to help both you and our practice to comply with the law regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor patient relationship and that my doctor agrees to treat me based on this agreement.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well medicine is helping to relive the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, ect. I will not share, sell or trade with medication with anyone.

I will not attempt to obtain any controlled medications, including opiate pain medicines, controlled stimulants or anxiety medication form anyone, including other physicians.

I WILL SAFEGUARD MY PAIN MEDICATION FROM LOSS OR THEFT. LOST OF STOLEN PAIN MEDICATION WILL NOT REPLACED.

I UNDERSTAND NO REFILS WILL BE AVAILABLE DURING EVENINGS, WEEKENDS OR ON FRIDAYS.

________________________________ ________________________________

PATIENT SIGNATURE **PHYSICIAN SIGNATURE**

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medication.

I AGREE THAT I WILL USE MY MEDICINE AT A RATE NO GREATER THAN THE PRECRIBED RATE AND THAT USE OF MY MEDICINE AT A GREATER RATE WILL RESULT IN BEING WITHOUT MEDICATION FOR A DURATION OF TIME.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to you upon request.

This agreement is entered into my file on this ________day of ___________, ______.

____________________ ________________

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MEDICATIONS: ☐ None

Drug	Dosage	Frequency

ALLERGIES/INTOLERANCE:

List all adverse reactions or allergies you have to medications and symptoms: ☐ None

____

____

____

____

MEDICAL HISTORY: ☐ None

Please check all that apply (please specify, if possible)

☐ Alcohol Abuse

☐ Anemia

☐ Asthma

☐ Bleeding Disorder

☐ Blood Clots

☐ Cancer: ____________________

☐ Chronic Lung Condition

☐ Diabetes

☐ Depression/Anxiety

☐ Drug/Substance Abuse

☐ Eating Disorder

☐ Heart Disease: ____________________

☐ Hepatitis/Jaundice

☐ High Blood Pressure

☐ High Cholesterol

☐ Hypothyroidism

☐ Irritable Bowel Syndrome

☐ Kidney Stones

☐ Lupus/Autoimmune Disorder

☐ Rheumatic Fever

☐ Seizure Disorder

☐ Stomach Ulcers

☐ Stroke

☐ Tuberculosis

☐Other:___________________

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IMMUNIZATIONS:
Tetanus (Td) ☐ (within 10 years) Varicella (Chicken Pox) shot or illness ☐ Pneumovax (pneumonia) ☐ HPV ☐ Influenza (flu shot) ☐ Date: _____________ Hepatitis A ☐ Hepatitis B ☐ Meningitis ☐ Zostavax (shingles) ☐

OTHER PROCEDURES:
Last date of Colonoscopy: ____________ ☐ Refused
Last date of Bone Density Test/DEXA Scan: ____________ ☐ None

GYNECOLOGIC HISTORY: ☐ Not applicable
Last date of period: ____________ ☐ Menopausal ☐ Hysterectomy (Complete/Partial)
Last pap smear date: ____________ Last mammogram date: ____________

OBSTETRIC HISTORY: ☐ Not applicable
Total pregnancies: _______ Total living children: _______Miscarriage(s): _______ Abortion(s): _______
C section(s): _______ Ectopic pregnancies: _______

SURGICAL HISTORY: ☐ None

DATE	SURGERY	HOSPITAL/M.D.

HOSPITALIZATIONS: ☐ None

DATE	REASON	HOSPITAL/M.D.

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FAMILY HISTORY: ☐ Unknown

MEMBER	Still living? (Y/N)	AGE	DIABETES	HIGH BLOOD PRESSURE	HEART DISEASE	MENTAL ILLNESS	CANCER	STROKE
FATHER								
MOTHER								
PATERNAL GRANFATHER								
PATERNAL GRANMOTHER								
MATERNAL GRANDFATHER								
MATERNAL GRANDMOTHER								
SIBLINGS Sister(s):___ Brother(s):___								
CHILDREN Boy(s):___ Girl(s):___								

SOCIAL HISTORY:

Occupation: ______________________________

Exercise Do you exercise regularly? ☐ Yes ☐ No How long (minutes)? _____ How many days a week? _____

Sexual History Are you currently sexually active? ☐ Yes ☐ No

Sexual partner(s) is/are/have been ☐ Male ☐ Female

Have you *travelled* outside the *United States*? ☐ Yes ☐ No

Caffeine Do you drink coffee? ☐ Yes ☐ No How often per week? _______

Pets Do you have any pets? _______

Tobacco Use Have you ever smoked cigarettes? ☐ Yes How many packs per day? _______ / ☐ Former smoker How many years ago? _______ / ☐ Never Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Drug Use Have you used other drugs other than those for medical use in the past 12 months? ☐ Yes ☐ No

Alcohol Use Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? ______

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RELEASE OF INFORMATION

I hereby give my permission to:

____
____
____
____
____
____
____
____

to release my medical records (I.E labs, EKG, radiology, consult notes, hospital documents, etc.).

To: **TAMPA BAY MED**

7500 4th Street North
Saint Petersburg
FL 33702
Ph #727-526-4122
Fax # 727-525-1835

_________________________________ _____________
PRINT NAME **DATE**

_________________________________ _____________
PATIENT or GUARDIAN SIGNATURE **DATE OF BIRTH**

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Statement of financial responsibility

As a courtesy, our office will file your private insurance including your secondary insurance. If payment is not received within 45 days after the claim is submitted to your private insurance the charges will become the patient's responsibility. It will then be the patient's responsibility to contact his/her insurance company to assure payment.

It is the policy of this office to collect payments for services rendered if no valid insurance is available.

I, the undersigned, have read the above statement and accept full financial responsibility for all medical and surgical charges incurred by myself or my dependents, for services rendered by physicians of Tampa Bay Med.

______________________________ ________________

PATIENT SIGNATURE **DATE**

Authorization to release information and assignment to benefits

I authorize the release of any medical information necessary to process this claim, I herby authorize Tampa Bay Med to apply for benefits on my behalf for covered services rendered. I request that payment for my insurance company be made directly to the names above.

I herby authorize any direct payment to Tampa Bay Med for the medical and/or surgical benefit if any, otherwise payable to me under the terms of my insurance.

_____________________ ________________

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PLEASE NOTE:

As most of you know, our schedule is often very full, when a patient fails to keep an appointment, that time cannot be utilized by other patients who are ill and need to see a physician. Due to an increase in the number of wasted appointments through patients failing to attend without informing our office, it has become necessary to implement the following policy:

If you need to cancel and appointment please call our office at least 24 hours in advance of your scheduled appointment time.

Our policy for missed appointment that has not been cancelled at least 24 hours in advance will be charged as follows:

First missed appointment: No charge (we will waive as a courtesy)

Second missed appointment: $25.00 fee

Third missed appointment: $25.00 fee and a possible dismissal from our practice.

______________________ ______________

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ZERO TOLERANCE POLICY

This Practice operates a zero-tolerance policy and will not tolerate violent & abusive behavior both verbal and physical. Therefore, anyone verbally abusing a member of staff or other patients, or using inappropriate language, will be asked to leave the premises and warned in line with the practice policy that this could result in removal from this Practice. This policy includes telephones calls and voicemail messages. Anyone who is violent or causes damage will be removed as a patient of our practice immediately.

We aim to treat our patients courteously at all times and expect our patients to treat our staff in a respectful manner. We take seriously any threatening, abusive, or violent behavior against any of our staff or patients. If a patient is violent or abusive in any way, they will be warned to stop their behavior. If behavior persists, we will exercise our right to act to have them removed, immediately if necessary from our list of patients and advised to seek another practice.

The staff is doing their job when you are asked to verify insurance every time you call to make an appointment. There are no exceptions. They also do their best to accommodate all patients in the day and time the appointment is made.

______________________ ________________

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Patient Consent for Use and Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations, Per HIPPA Regulations

I understand that as part of my healthcare, Tampa Bay Med maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means for communication among healthcare providers who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party can verify that services billed were actually rendered

I have been provided with a *"Notice of Patient Privacy Practices"* that provides a more complete description of information uses and disclosures. I understand that I have the following privileges:

- The right to review the *"Notice of Patient Privacy Practices*" prior to acknowledging this consent
- The right to restrict or revoke the use of disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

By signing this form, I am acknowledging that I have been provided with a copy of the *"Notice of Patient Privacy Practices"* and consenting to the use and disclosure of my personal medical and financial information to conduct business.

___________________________________ ______________________

Patient/Guardian Signature Date

____

Printed Name of Person signing Consent Form

If other than the patient (Patient name) ___________________________ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? Yes No