Advanced Physical Medicine & Rehab
Gloydian Cruz, MD
2835 Alt 19 Suite B
Palm Harbor, FL 34683
Ph: (727) 748-4742 Fax: (727) 748-4739
Please visit our website at : www.cruzpmr.com

Date of Appt_______________ Age_______

Patient Name______________________________ Date of Birth______________

Address____ City, State, Zip__________________

Phone #______________________ Alt Phone_____________ Social Sec #______________

Sex: M F Marital Status: Single Married Divorced Widowed Partnered

Employer Name (if app)__________________________________ Occupation______________

Email Address______________________________ OK to email appt reminders/billing? YES NO

How did you hear about us (Please circle)? Website Advertisement Friend Doctor

Primary Care Physician____________________ Referring Dr____________________

Do you have health insurance? YES NO Attorney Name (if app) ______________________

Primary Insurance_____________________ ID______________________

Secondary Insurance (if app)_____________________ ID______________________

IN CASE OF EMERGENCY CONTACT_____________________ PH______________________

Is your problem related to:			
	Car / Bike accident	YES NO	Date Occurred____________
	Slip / Fall accident	YES NO	Date Occurred____________
	Job Injury	YES NO	Date Occurred____________

Please state the reason for your visit today & the body part affected as well as date of onset:

____
____
____
____

Please circle the description(s) of your pain:

TINGLING / NUMB (ARMS OR LEGS)   BURNING   STABBING   ACHING   SHOOTING

GNAWING   TENDER   PENETRATING   SHARP   NAGGING

Have you experienced any focal weakness? (i.e. drop foot)   YES NO

Have you experienced bowel/bladder dysfunction other than constipation/incontinence?   YES   NO
If yes, which one? Bladder   Bowel

Are you RT or LT handed? ________

Rate your pain: Least 0__1__2__3__4__5__6__7__8__9__10__ Worst

If you have neck pain, what percentage of your pain is __%Neck __% Arm (Total 100%)

If you have back pain, what percentage of your pain is __%Back __%Leg (Total 100%)

Please circle what makes your pain worse:

WALKING   STANDING   SITTING   LYING DOWN   COUGHING

BOWEL MOVEMENT   SEXUAL ACTIVITY

Please circle what makes your pain better:

WALKING   STANDING   SITTING   LYING DOWN   HEAT / ICE   MASSAGE

Do you need assistance to help walk?   YES NO   If yes, Walker/Cane/Other____________

Do you wear a back or neck brace? YES NO   If yes, what type?____________________

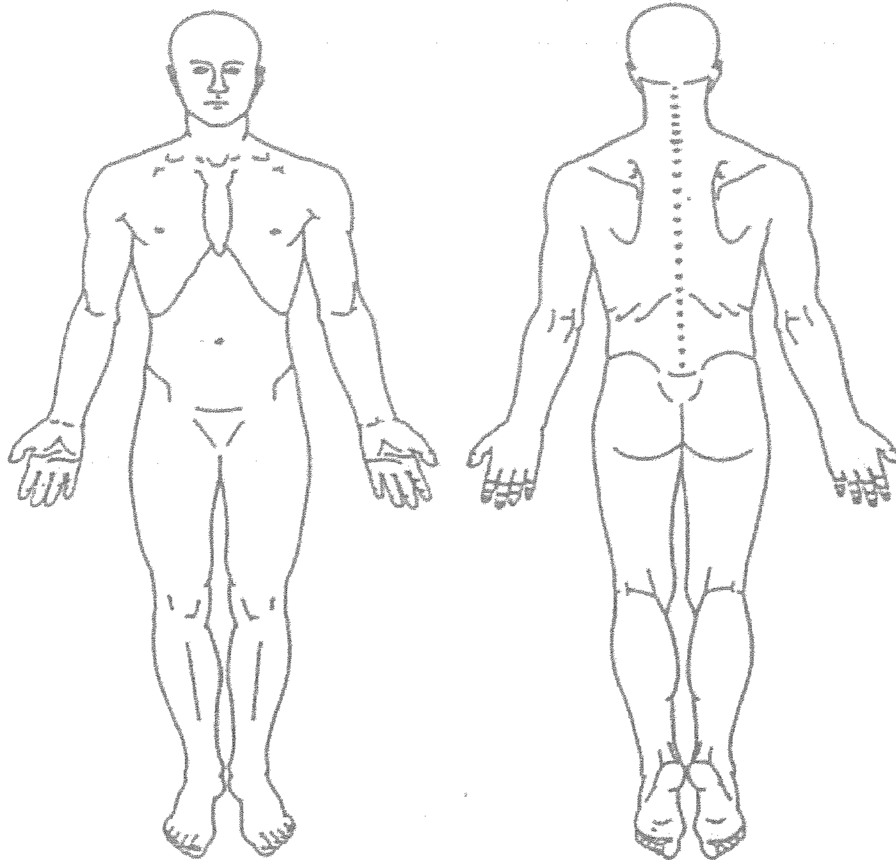
Please list any relevant treatments or injections you have had for this problem:

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

Have you had any of the following diagnostic tests related to this problem:

MRI   CT SCAN   XRAY   BONE SCAN   Date / Facility: ____________________



Using the symbols listed below, please indicate the location of your symptoms on the body diagram above.

*XXXX = PAIN   oooo = Numbness   **** = Pins/needles sensation*

PAST MEDICAL HISTORY:

Please circle if you have experienced any of the following medical conditions:

Other medical condition:_______ ________________ ________________	High blood pressure	Depression / Anxiety	Fibromyalgia / Lupus	Diabetes
Kidney disease	Lung disease	Ulcers	Hepatitis	Seizures
Cancer Type:__________	Psoriasis	Heart disease	Thyroid disease	AIDS / HIV
Stroke	Bleeding disorder Type:__________	Rheumatoid Arthritis	High cholesterol	Serious infection

PAST FAMILY HISTORY:

Father: AGE___ Alive? YES NO If deceased, cause of death_________________________

Mother: AGE___ Alive? YES NO If deceased, cause of death_________________________

Sibling: AGE___ Alive? YES NO If deceased, cause of death_________________________

Sibling: AGE___ Alive? YES NO If deceased, cause of death_________________________

SURGICAL HISTORY:

TYPE OF SURGERY	YEAR OF SURGERY

SOCIAL HISTORY:

Work Status (Please Circle): Employed Full / Part time Unemployed Retired

Are you disabled through social security or have an application pending?

YES NO PENDING

TOBACCO USE: YES NO FORMER

If yes, start year_____ If former, year quit_____

ALCOHOL USE: YES NO

If yes, please indicate: SOCIAL DAILY (IF DAILY, how many drinks per day________)

Do you have a present / past history of recreational drug use? Y N Type of drug: _______________

HAVE YOU EVER BEEN TREATED FOR DRUG / ALCOHOL PROBLEMS? YES NO

ALLERGIES TO MEDICATIONS / FOOD PRODUCTS:

____

____

Please list ALL medications that you are CURRENTLY taking

Name of Drug	Dosage	Frequency	Date started

If you are on ANY blood thinners, who is your PCP/cardiologist? ____________________

List the medications that you have taken <u>FOR PAIN</u> in the <u>PAST</u> that have <u>NOT</u> helped / caused side effects.

____

____

____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME__________________________________ DATE OF BIRTH__________

ADDRESS____

CITY, STATE, ZIP____

RECORDS RELEASED FROM:

DOCTOR/FACILITY NAME____

PHONE____________________________ FAX_________________________________

RECORDS RELEASED TO: *Gloydian Cruz, MD for continuation of medical care*

EXTENT OF INFORMATION TO BE RELEASED:

_X__Medical History	*_X_Lab results*
_X_Office Notes	*_X_Prescription records*
_X_MRI / Xray reports	*_X_Alcohol/Drug test results*

I hereby authorize the disclosure of my identifiable health information as described above. I understand that this authorization is voluntary. This consent shall be valid as long as I am a patient of Advanced Medicine and Rehab plus an additional 7 years. I understand that I may revoke this authorization at any time by notifying APMR in writing, but if I do, the revocation will not have any effect on actions taken before the revocation was received. I also understand that the confidentiality of this information may be protected by federal regulations prohibiting further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

PATIENT SIGNATURE______________________________DATE_____________

REVIEW OF SYSTEMS

Please circle if you have any of the following symptoms.

CONSTITUTIONAL

FEVER	WEIGHT LOSS	WEIGHT GAIN	CHILLS
DIFFICULTY SLEEPING	POOR APPETITE	FATIGUE	NIGHT SWEATS

SKIN

RASH	ITCHING	PIGMENTATION	DRY SKIN

ALLERGIC/IMMUNOLOGIC

CANCER	SEASONAL ALLERGIES	IMMUNE DEFICIENCY

EAR/NOSE/THROAT

TROUBLE HEARING	EARS RINGING	NOSE BLEEDS	SORE THROAT	SINUSITIS
FREQ INFECTIONS	VOICE HOARSE	THYROID MASS	GUMS BLEEDING	STIFF NECK PAIN/TENDER

HEAD/EYES

HEADACHE	HEAD INJURY	VERTIGO	VISION CHANGE
LIGHTHEADEDNESS	DOUBLE VISION	EYES TEARING	EYE PAIN

RESPIRATORY

PAIN WITH BREATHING	COUGHING UP BLOOD	SHORT OF BREATH	RECURRENT INFECTION
WHEEZING	H/O TUBERCULOSIS	PERSISTENT COUGH	

CARDIOVASCULAR

SHORT OF BREATH WITH ACTIVITY	CHEST PAIN	PALPITATIONS
FAINTING	HEART MURMUR	LEG SWELLING

GASTROINTESTINAL

DIFFICULTY SWALLOWING	HEARTBURN	ABDOMINAL PAIN
VOMITING BLOOD	HEMORRHOIDS	JAUNDICE
CONSTIPATION	BLOOD IN STOOL	NAUSEA/VOMITING

GENITOURINARY

RECURRENT INFECTION	KIDNEY STONES	PAINFUL URINATION	BLOOD IN URINE	VAGINAL BLEEDING
FREQUENT URINATION	INCONTINENCE	URINARY RETENTION	VAGINAL DISCHARGE	URINATION URGENCY

ENDOCRINE

EXCESS THIRST	HEAT INTOLERANCE	COLD INTOLERANCE
GOITER	INCREASED URINATION	INCREASED APPETITE

MUSCULOSKELETAL

JOINT STIFFNESS / JOINT PAIN	BACK PAIN / NECK PAIN	LIMITED MOVEMENT
SWELLING	LEG PAIN / ARM PAIN	MUSCLE SPASMS / CRAMPS

NEUROLOGICAL

NUMBNESS	BALANCE PROBLEMS	TREMOR	WEAKNESS
MEMORY LOSS	INCOORDINATION	SEIZURES	PINS/NEEDLES SENSATION

PSYCHIATRIC

DEPRESSION	HALLUCINATIONS	ANXIETY	SUICIDAL THOUGHTS

HEMATOLOGICAL / LYMPHATIC

LYMPHEDEMA	EASY BRUISING	SWOLLEN GLANDS	BLOOD CLOT	BLEEDING PROBLEMS	BLOOD TRANSFUSION

PLEASE READ CAREFULLY AND SIGN BELOW

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Advanced Physical Medicine & Rehab. PLLC for services furnished me by Gloydian Cruz, MD. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Advanced Physical Medicine & Rehab. PLLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **RELEASE OF INFORMATION:** Advanced Physical Medicine & Rehab. PLLC may disclose all or any part of my medical record and or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Advanced Physical Medicine & Rehab for reimbursement for services rendered, and (2) any health care provider for continued patient care. Advanced Physical Medicine & Rehab may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical services, medical education, and medical research, for the collection of statistical data or pursuant to State of Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

3. **NON-COVERED SERVICES:** I understand that Advanced Physical Medicine & Rehab. PLLC contracts with health care service plans (i.e., HMOs, PPOs) relate only to services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefits summary the health care service plan furnishes to the patient; and treatment of tests not authorized by the health care service plan. The undersigned agrees to cooperate with Advanced Physical Medicine and Rehab to obtain necessary health care service plan authorizations.

4. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Advanced Physical Medicine and Rehab I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Advanced Physical Medicine and Rehab for payment. I understand that if my account is delinquent, I may be sent to a Collection's agency. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Advanced Physical Medicine and Rehab. If copayments and or deductibles are designated by my insurance company or health plan, I agree to pay them to Advanced Physical Medicine and Rehab. However, it is understood that the undersigned and or the patient are primarily responsible for the payment of my bill.

5. **CANCELLATIONS**: If you need to cancel your office visit, we ask that you contact us AT LEAST 24 hours prior to your appointment time. We reserve the right to bill you a $25.00 fee to cover our administrative costs for cancellations made within less than 24 hours or not showing up for an appointment without notice. ($50 charge for EMGs and procedures)

6. **HMO AUTHORIZATIONS**: If your policy requires an authorization from your primary care physician we will request authorization in advance for established patients. This is done as a courtesy. However, it still remains the patient's ultimate responsibility to follow up with their PCP to ensure the visit has been authorized.

7. **MEDICAL RECORDS REQUEST**: Request for copies of your medical records must be made in writing on a medical release form. Our office will respond within 15 business days to complete these requests. Records can be faxed to other physicians at no charge. FEE FOR PICKING UP RECORDS YOURSELF: $1.00 for first 10 pages and $0.25 for each page thereafter.

PATIENT SIGNATURE ______________________________ DATE ______________

ADVANCED PM&R SPINE & JOINT CENTER

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.

- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on an your answering machine, mobile voice or text mail, email or with a household family member.

  [ ] Please check here if you do NOT want us to leave messages on your voicemail or with a household member.

  [ ] **Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.**

- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information____

  ____

- You may request a copy of and you have the right to read our "*Notice of Patient Privacy Practices*" prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (please print):____

Signature	Print name of person signing if other than patient	Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [ ] No [ ] RELATIONSHIP____________________________________

FOR OFFICE USE ONLY

Patient refused to sign the form. Reason: ____ Date: ______________