

Welcome

PATIENT INFORMATION

Tell us how were you referred? (Insurance carrier, Commercials, friend, doctor's name, etc.)

First Name _____ Middle Initial _____ Last Name _____

Address _____ Apt / Suite # _____

City _____ State _____ Zip Code _____

SSN _____ -- _____ -- _____ Birth Date ____/____/____ Age _____

____ Male ____ Female Driver's License Number _____ State _____

Marital Status Single Married Widowed Divorced Separated

Spouse/Significant Other _____ Ages of Children _____, _____, _____, _____, _____, _____

Home Phone (____) _____ -- _____ Work Phone (____) _____ -- _____ Cell Phone (____) _____ -- _____

E-mail _____

Emergency Contact Name _____ Relationship _____ Phone (____) _____ -- _____

Your Occupation _____ Employer _____ Length of Employment _____

Business Address _____ City _____ State _____

Referred by: Physician Name _____ Referred by: Patient Name _____

Insurance / Responsibility

Primary Insurance _____ Secondary Insurance _____

Person Responsible for Account _____ Relation to Patient _____

First Initial Last

If different than patient:

Birthdate _____ SSN _____ Home phone _____

Address _____ City _____ State _____ Zip _____

HISTORY (Chief complaint)

Why are you here to see the doctor today? _____

Approx Height: _____ Approx Weight: _____ Age: _____ When was your last physical exam? _____

AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any information to any insurance company or third party payor for the purpose of obtaining payment for services rendered by Randall C. Latorre, M.D. I also hereby authorize the release of information acquired in the course of my treatment to any other physician(s) involved in my care. **Medicare Authorization:** I understand that this is a lifetime signature authorization. **Assignment of Benefits:** I authorize my insurance company to pay Randall C. Latorre, M.D., PA directly for all surgical and/or medical benefits. I understand that I am financially responsible for all services received, including any balances not covered by my insurance carrier(s).

Please list anyone our office is allowed to discuss your medical issues. We will **ONLY** speak to you or the person that you list here in reference to your medical care:

1. _____ 2. _____

Signature: _____ Date _____

Patient Name: _____

LIST ALL MEDICAL PROBLEMS AND ALL SURGERY YOU HAVE UNDERGONE WITH DATES

How did you tolerate the anesthesia? _____

Were you satisfied with the results? ____ Yes ____ No If not, why not? _____

ALLERGY ARE YOU ALLERGIC TO ANY MEDICINES? WHICH ONES? & *what is your reaction?*

Are you taking any medications? Include BIRTH CONTROL PILLS, VITAMINS, HERBALS, SUPPLEMENTS, DOSAGE AND FREQUENCY. Include over-the-counter medicines. (i.e.) Tylenol 325mg every 4 hours

Name of Family Physician/Pediatrician: _____ Address/Phone: _____

Name of Internist/Cardiologist: _____ Address/Phone: _____

Name of Pulmonologist: _____ Address/Phone: _____

Name of OB/GYN or Dermatologist: _____ Address/Phone: _____

NO YES May we contact him/her for any medical issues that may arise?
NO YES Do you exercise on a regularly? What type of activity & how often? _____

SOCIAL HISTORY

No Yes Do you smoke cigarettes and/or cigars? How many cigarettes/cigars per day? _____ If you have quit, When _____

No Yes Do you drink coffee? Caffeinated Decaf If so, how many cups a day? _____

No Yes Are you a singer, amateur or professional? How often? _____

No Yes Do you consume Beer Liquor How many a day or weekend? (Quantity) _____

Are you on one of these medications? Viagra Cialis Levitra Coumidin (warfarin) Plavix Aspirin Fish oil Vitamin E

Father: Age____ Alive ____ Deceased____ If deceased, cause of death _____

Mother: Age____ Alive ____ Deceased____ If deceased, cause of death _____

Spouse: Age____ Alive ____ Deceased____ If deceased, cause of death _____

Siblings: Age____ Alive ____ Deceased____ If deceased, cause of death _____

Siblings: Age____ Alive ____ Deceased____ If deceased, cause of death _____

Siblings: Age____ Alive ____ Deceased____ If deceased, cause of death _____

Siblings: Age____ Alive ____ Deceased____ If deceased, cause of death _____

Signature: _____

Date _____

Patient Name: _____

Do You or any family members have (Indicate you or particular family member)

Heart problems_____	Asthma_____	Sleep apnea_____
Tuberculosis_____	High blood pressure_____	Excessive bruising_____
Excessive scarring_____	Diabetes_____	Thyroid problems_____
Bleeding problems_____	Hearing loss_____	Hepatitis_____
Do you take antibiotics prior to dental procedures? YES NO		OTHER:_____

Review of Systems: Circle every issue that you experience.

General/Constitutional- SLEEP APNEA. Snoring, weight loss or gain, fatigue, fever, night sweats, chills, decreased strength, difficulty conducting usual activities, exercise intolerance.

Skin/Breast - Rash, itching, pigmentation, moisture or dryness, texture changes, changes in hair growth or loss, nail changes. Breast lumps, tenderness, swelling, nipple discharge

Eyes/Ears/Nose/Mouth/Throat- Headaches, spinning sensation, lightheadedness, injury, double vision, tearing, blind spots. Nose bleeding, colds, discharge. Gum bleeding, dentures, Neck stiffness, pain, tenderness, masses in thyroid.

Cardiovascular- Chest pain, palpitations, fainting, shortness of breath on exertion or laying flat, hypertension, heart murmurs, varicose veins with pain, calf pain at rest.

Respiratory - Pain, shortness of breath, wheezing, stridor, cough, coughing blood, respiratory infections, tuberculosis (or exposure to tuberculosis).

Gastrointestinal - Poor appetite, foreign body sensation in your throat, difficulty swallowing, indigestion, food allergy, abdominal pain, heartburn, nausea, vomiting, vomiting blood, jaundice, constipation, or diarrhea, abnormal stools (clay-colored, tarry, bloody, greasy), increased flatulence, hemorrhoids, recent changes in bowel habits

Genitourinary- Urgency, frequency, pain, night time frequency, blood in urine, , unusual (or change in) color of urine, stones, infections, kidney pain, hesitancy, change in size of stream, dribbling, incontinence, change in libido, potency, genital stores, discharge, venereal disease. **(Female)-** irregularity, last period, menstrual pain, abnormal bleeding, skipped periods, vaginal discharge, post-menopausal bleeding, intercourse pain.

Musculoskeletal- Pain, swelling, redness or heat of muscles or joints, limitation of motion, pain with normal movements, muscular weakness, atrophy, cramps.

Neurologic/Psychiatric- Convulsions, paralyses, tremor, incoordination, numbness, difficulties with memory of speech, sensory or motor disturbances. Nervousness , emotional problems, anxiety, depression, previous psychiatric care, unusual perceptions, hallucinations.

Allergic/Immunologic/Lymphatic/Endocrine- Reactions to drugs, food, insects, skin rashes, trouble breathing. Anemia, bleeding tendency, previous transfusions and reactions. Lymph node enlargement or tenderness, hormone therapy, growth, secondary sexual development, intolerance to heat or cold.

For Women only

NO YES Have you taken hormones (estrogens, progesterones, BCP) or thyroid medication? (Circle all that apply) _____

NO YES Is there a possibility of pregnancy at this time? Tested by Home pregnancy test or Gynecologist? (Circle appropriate answer)

NO YES Do you have a history of gynecological problems now or previously? Explain _____

When was your last menstrual period? Date: _____

Number of Pregnancies: _____ Miscarriages _____ Abortions: _____

“Thank you for providing the essential information in this comprehensive evaluation. Your cooperation is appreciated. Write down any questions you may have so that we may discuss them in detail during your visit.”

Signature: _____

Date _____

Patient Name: _____

NOTICE OF PRIVACY PRACTICES FOR RANDALL C LATORRE, MD

Dr. Latorre is committed to preserving the privacy of your health information. **In fact, we are required by law to provide you with a Notice describing how information about you may be used and disclosed and how you can get access to this information.**

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Inspect and copy your protected health information.
- Request a restriction of your protected health information.
- Request to receive confidential communications from us by alternative means or at an alternative location.
- Have your protected health information corrected or amended.
- Receive an accounting of certain disclosures we have made, if any, of your protected health information.
- Obtain a paper copy of the Notice of Privacy Practices from our office.

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of patient care. In addition, we may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

We have available a detailed Notice of Privacy Practices which fully explains your rights, uses of your health information, and our obligations under the law. If you would like a copy of this detailed notice, please request a copy at the front desk.

The Notice of Privacy Practices may be revised from time to time and you may request a copy of a revised notice at any time. The effective date at the bottom of this page indicates the date of the most current Notice in effect.

If you have any questions about the Notice and its content, or if you believe your privacy rights have been violated, you can file a complaint with our Office Manager or with the Secretary of Health & Human Services. There will be no retaliation for filing a complaint.

Office Manager
Randall C. Latorre, MD
16622 N Dale Mabry Highway
Tampa, Florida 33618
Phone: 813-908-8585

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

By signing below, you acknowledge that you understand the Notice of Privacy Practices fully and the rights that you have regarding the above information as a patient of our office.

Effective Date: April 30, 2003

Signature: _____

Date _____