

Medical Associates of Brevard

Dr. Esmat Gayed

Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_

(If from out of town please include a local address and phone number)

Social Security #: \_\_\_\_\_ Birth date: \_\_\_\_\_ Race: \_\_\_\_\_

Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouses Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Parents / Guardian Name (if under 18) \_\_\_\_\_

In case of emergency, notify: \_\_\_\_\_

Name Relationship Phone #

Insurance Subscriber or party responsible for payment if other than self:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_

Employer Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Birth date: \_\_\_\_\_

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

In Order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Fl Statues, please answer the following questions:

- Declaration to Decline Life-Prolonging Procedure ( Living Will )
Health Care Surrogate
Durable Power of Attorney
I have made such a declaration
I have not made such a declaration
I have designated a Health Care Surrogate.
I have not designated a Health Care Surrogate
I have appointed a Durable Power of Atty
I have not appointed a Durable Power of Atty

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**INSURANCE ASSIGNMENTS , AUTHORIZATION TO RELEASE INFORMATION  
and RECEIPT OF PRIVACY PRACTICES**

**1. CONSENT TO MEDICAL and SURGICAL PROCEDURES.** The undersigned consents to the procedures which may be performed on an outpatient basis including emergency treatment or services and which may include but not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patients physician.

**2. ASSIGNMENT of INSURANCE BENEFITS and AUTHORIZATION TO RELEASE INFORMATION:** In consideration services rendered I hereby transfer and assign to Medical Associates of Brevard, all rights, title and interest in any payment due for services described herein as provided in the above mentioned policy or policies of insurance. The clinic may disclose all or any part of the patients record (including psychiatric, alcohol and drug abuse information) to any part person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer or the patient for or part of the clinic's charge, including but not limited to medical service companies, insurance companies, workman's compensation carriers, welfare funds or the patient's employer.

**3. FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration services to be rendered to the patient he/she hereby individually obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collection, the undersigned should pay reasonable attorneys fees and collection expense. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute above and accepts it's terms.

**4. MEDICARE/MEDICAID:** Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for the payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or it's intermediaries or carriers any information needed for this or related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me.

**5.** I permit a copy of these authorizations and assignments to be used in place of the original which is on file at the clinic. This assignment will remain in effect until revoked by me in writing.

**6.** This is an agreement that I was given a copy of the NOTICE OF PRIVACY PRACTICES upon request. I will read the copy given to me at my own discretion. If I have any question about the notice of privacy practice I will ask the appointed HIPAA officer employed by Dr. Esmat Gayed.

**\*\*\*I understand that certain insurance claims may be filed as COURTESY, However, if the claim is denied for any reason, I am responsible for payment\*\*\***

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it is my responsibility to pay for any DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PAYER WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS.

**Patient**  
**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian(if under 18)** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Review Of Systems:

Place an **X** before signs or symptoms which you presently have, or have had frequently.

### 1. EYES

\_\_\_\_\_ eyesight worsening  
\_\_\_\_\_ seeing double  
\_\_\_\_\_ cataracts  
\_\_\_\_\_ date of last eye exam  
\_\_\_\_\_ other

### 2. EARS

\_\_\_\_\_ hearing difficulties  
\_\_\_\_\_ buzzing in ears  
\_\_\_\_\_ other

### 3. MOUTH

\_\_\_\_\_ dental problems  
\_\_\_\_\_ easy bleeding of gums  
\_\_\_\_\_ date of last dental exam  
\_\_\_\_\_ other

### 4. NOSE

\_\_\_\_\_ frequent congestion  
\_\_\_\_\_ frequent nosebleeds  
\_\_\_\_\_ other

### 5. HEAD

\_\_\_\_\_ frequent headaches  
\_\_\_\_\_ painful or tender over sinuses  
\_\_\_\_\_ other

### 6. NECK

\_\_\_\_\_ neck pains  
\_\_\_\_\_ lumps or swelling  
\_\_\_\_\_ stiffness  
\_\_\_\_\_ other

### 7. THROAT

\_\_\_\_\_ hoarse voice  
\_\_\_\_\_ difficulty or pain on swallowing  
\_\_\_\_\_ other

### 8. LUNGS

\_\_\_\_\_ wheezing  
\_\_\_\_\_ shortness of breath  
\_\_\_\_\_ cough which produces sputum  
\_\_\_\_\_ cough which produces no sputum  
\_\_\_\_\_ coughing up blood  
\_\_\_\_\_ pain with breathing  
\_\_\_\_\_ other

### 9. HEART

\_\_\_\_\_ attacks of racing heartbeat  
\_\_\_\_\_ chest pain or heaviness  
\_\_\_\_\_ dizzy spells  
\_\_\_\_\_ swollen feet or ankles  
\_\_\_\_\_ leg cramps produced by walking  
\_\_\_\_\_ history of heart murmur  
\_\_\_\_\_ history of mitral valve prolapse  
\_\_\_\_\_ other

### 10. DIGESTIVE

\_\_\_\_\_ heartburn  
\_\_\_\_\_ stomach pains  
\_\_\_\_\_ vomiting  
\_\_\_\_\_ vomiting of blood/coffee ground color  
\_\_\_\_\_ diarrhea or constipation  
\_\_\_\_\_ blood in or black stools  
\_\_\_\_\_ other

### 11. URINARY TRACT

\_\_\_\_\_ frequent urination  
\_\_\_\_\_ getting up at night to urinate  
\_\_\_\_\_ wetting pants on coughing or straining  
\_\_\_\_\_ burning on urination  
\_\_\_\_\_ history of kidney stones  
\_\_\_\_\_ history of urinary tract infections  
\_\_\_\_\_ other

### 12. MUSCULOSKELETAL

\_\_\_\_\_ painful / swollen joints  
\_\_\_\_\_ back pains  
\_\_\_\_\_ shoulder pains  
\_\_\_\_\_ generalized muscle aches  
\_\_\_\_\_ swollen/painful big toe  
\_\_\_\_\_ morning stiffness of joints  
\_\_\_\_\_ other

### 13. SKIN

\_\_\_\_\_ itching / redness / rash  
\_\_\_\_\_ easy to bruise  
\_\_\_\_\_ other

**Continued on other side**

**Review of Systems continued**

**14. NEUROLOGICAL SYSTEM**

- fainting spells
- lightheadedness
- seizures / convulsions
- tremors
- sudden periodic loss of vision
- loss of memory
- other

**15. GENERAL**

- recent weight loss / gain \_\_\_\_\_ pounds
- recent loss of appetite
- tiring easily
- night sweats
- shaking / chills
- fevers
- excessive thirst
- insomnia
- other

**16. BREASTS**

- pain
- history of lumps
- nipple discharge
- date of last mammogram
- other

**17. MENTAL HEALTH**

- anxiety
- depression
- stress
- other

**18. SPECIAL PROBLEMS OR SYMPTOMS**

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date