LA Medical

Primary Care

Dr. Ravi Pandey	Internal Medicine
Dr. Michael Sinclair	Family Medicine
Dr. Laurence Ehrlich	Internal Medicine
Dr. Anna Abel	Internal Medicine

Karina Solis-Ruelas, FNP-C
Sheena Urdaz, PA-C
Deisy Franco, PA-C

Podiatric Medicine & Surgery

Dr. Lori Lane
Dr. Daniel Heck
Dr. Dina Hansen
Dr. Khoa Pham
Dr. Areeba Ahmed
Dr. Derek Pawich

Locations

Boynton Beach
West Palm Beach
Loxahatchee
Palm Beach Gardens
Wellington
Palm Springs

Information

561-433-5577
info@lamedicalpb.com
myLAmed.com
Mon – Fri: 7:30am to 6:30pm

Last Name: _____ **First Name:** _____

Date of Birth: _____ **Age:** _____ **Occupation:** _____

Sex: ☐ Male ☐ Female Weight: _____ Height: _____

Do you need a translator? ☐ Yes ☐ No Married? ☐ Yes ☐ No

Phone Number: _____

Email Address: _____

Mailing Address: _____

Ethnicity: ☐ White ☐ Hispanic ☐ African American ☐ Asian

☐ Not Listed _____

Emergency Contact and Relationship: _____

Emergency Contact Number: _____

Social Security Number: _____

Select The Type of Care Visit You are Here For

Primary Care ☐ Podiatric Medicine ☐

Healthcare Provider (Facility or Physician):

_____

Their Phone Number: _____

Primary Health Insurance: _____

Primary Policy Number: _____

Secondary Health Insurance: _____

Secondary Policy Number: _____

Are you currently employed? ☐ Yes ☐ No

Is today's encounter the result of a work injury? ☐ Yes ☐ No

Is today's visit the result of an auto-accident? ☐ Yes ☐ No

Company Name: _____

Workers Comp. or Auto Accident Carrier: _____ Claim Number: _____ Date of Accident: _____

Name of Adjuster: _____ Their Phone Number: _____

How did you hear about us?

Google ☐ Friend or Family ☐ ZocDoc ☐ Bus Ad. ☐ Previous Doctor: _____ ☐ Radio ☐ Hospital ☐ Insurance ☐ Social Media ☐ Other: _____

PATIENT CONSENT FOR EXTENDED AUTHORIZATION AND TREATMENT

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 a fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company.

IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT OUR FEES FOR OFFICE VISITS BE PAID AT THE TIME OF EACH VISIT.

If the account is assigned to an attorney for collection and/or suit, LA Medical Associates shall be entitled to reasonable attorney's fees and collection costs.

By signing this information form, you are agreeing to the following:

- The payment of authorized benefits will be made on your behalf. - That the benefits to which you are entitled, including Medicare, private insurance, and other health plans, will be payable to LA Medical Associates.

- That the assignment will remain in effect until revoked by you in writing. A photocopy of this assignment will be considered as valid as the original.

- That you are financially responsible for all charges, regardless of whether it is paid by your insurance company.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if they so choose) and understood the notice.

✘ _____ _____

Signature (parent if patient is a minor) *Date*

Medical Information Release Form

Name: _____ Date of Birth: _____

RELEASE OF INFORMATION

☐ **I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:**

☐ **Spouse**_____

☐ **Children**_____

☐ **Other**_____

☐ **Information is not to be released to anyone.**

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell number:_____

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day)_____ between(time)_____

Signed:_____ **Date:**_____

Witness:_____ **Date:**_____

LA Medical Associates

I hereby acknowledge and understand that phone calls with LA Medical Associates are recorded for training purposes.

Initials: _____

Authorization for Disclosure of Medical Record Information

2326 S. Congress Ave., West Palm Beach, FL 33406 – Phone: 561-433-5577 Fax: 561-275-2696

Patient Information:

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Release Information: I hereby authorize LA Medical Associates to release my Medical Records Information to

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Transfer/Reason: _____ ☐ Other: _____

Please Release the following Medical Records Information:

☐ A two year abstract of my medical records. ☐ Private Insurance claim for the date/dates of service: _____

☐ All records for all dates of service in: ☐ Primary Care ☐ Podiatric Care ☐ MedSpa

☐ Work Comp claim for date/dates: _____ ☐ Auto Accident claim for date/dates: _____

Authorization to Release Protected Information:

Required – Please completed the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records. **Initial each line below to confirm your choices.**

I ☐ DO ☐ DO NOT want **Psychiatric Treatment** Notes released. _____

I ☐ DO ☐ DO NOT want information about **Mental Health** released. _____

I ☐ DO ☐ DO NOT want information about **HIV Tests & Related Information** released. _____

I ☐ DO ☐ DO NOT want information about **Alcohol and/or Substance Abuse** released. _____

I ☐ DO ☐ DO NOT want information about _____ released. _____

Other Sensitive Information?

_____ _____

Patient Signature Date

_____ _____

Parent/Legally Recognized Representative Signature Date

*By my signature, I attest that I am the legally recognized representative of the above mentioned patient.
The information release pursuant to this authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to.

LA Medical Associates

Authorization to Request Medical Record Information

2326 S. Congress Ave., West Palm Beach, FL 33406 – Phone: 561-433-5577 Fax: 561-275-2696

Patient Information:

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Requesting Records from:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Requesting the Release of the following Medical Records to LA Medical Associates:

I hereby authorize LA Medical Associates to receive the following Medical Records Information

☐ Private Insurance claim for the date/dates of service: _____

☐ All my Medical Records for all dates of service.

☐ Specific Diagnostic Imaging / Testing Done: _____

☐ Other: _____

Authorization to Release Protected Information to LA Medical Associates:

Required – Please completed the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records. **Initial each line below to confirm your choices.**

I ☐ DO ☐ DO NOT want **Psychiatric Treatment** Notes released to LA Medical. _____

I ☐ DO ☐ DO NOT want information about **Mental Health** released to LA Medical. _____

I ☐ DO ☐ DO NOT want information about **HIV Tests & Related Information** released to LA Medical. _____

I ☐ DO ☐ DO NOT want information about **Alcohol and/or Substance Abuse** released to LA Medical. _____

I ☐ DO ☐ DO NOT want information about _____ released to LA Medical. _____

Other Sensitive Information?

_____ _____

Patient Signature Date

_____ _____

Parent/Legally Recognized Representative Signature Date

*By my signature, I attest that I am the legally recognized representative of the above mentioned patient.
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(First Name-----Initial--------Last Name)

Reason For Visit:

_____

Medical History

To the best of your ability – Mark all that apply to you, **if ongoing OR previously occurred to you.**

Cardiovascular

- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Heart Attack
- ☐ Arrhythmia (Irregular Heart Rate)
- ☐ Stroke
- ☐ Congestive Heart Failure (CHF)
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever

☐ Other: _____

Inflammatory

- ☐ Rheumatoid Arthritis
- ☐ Poor Immune Function (infections)
- ☐ Severe Infectious Disease
- ☐ Herpes or Genital Warts
- ☐ Autoimmune Disease
- ☐ Lupus
- ☐ Chronic Fatigue Syndrome

☐ Other: _____

Metabolic/Endocrine

- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Endocrine Problems
- ☐ Polycystic Ovarian Syndrome
- ☐ Recent Weight Loss
- ☐ Recent Weight Gain

☐ Other: _____

Skin (Integumentary)

- ☐ Chronic Skin Infection
- ☐ Dryness/Cracking
- ☐ Eczema
- ☐ Hives
- ☐ Keloid (Thick Scars)
- ☐ Melanoma
- ☐ Moles
- ☐ Shingles
- ☐ Psoriasis

☐ Other: _____

Respiratory

- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Lung Disease
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Trouble Breathing
- ☐ Tuberculosis (TB)

☐ Other: _____

Neurological

- ☐ ADD/ADHD
- ☐ ALS
- ☐ Anxiety
- ☐ Autism
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Schizophrenia
- ☐ Headaches/Migraines
- ☐ Memory Problems
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Seizures

☐ Other: _____

Cancers

- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer

☐ Other: _____

Musculoskeletal Pain

- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Chronic Pain

☐ Other: _____

Gastrointestinal

- ☐ Celiac Disease
- ☐ Crohn's Disease
- ☐ Gastritis/Peptic Ulcer Disease
- ☐ GERD (reflux)
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Inflammatory Bowel Disease (IBD)
- ☐ Ulcerative Colitis

☐ Other: _____

Do you currently engage in Illicit drug use? ☐ Yes ☐ No

If yes, which ones? (please list all that apply)_____

If yes, how often? _____

Do you have a history of frequent Illicit Drug usage? ☐ Yes ☐ No

If yes, which ones? (please list all that apply) _____

If yes, for how long? _____

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_____

Medical History

To the best of your ability – Mark all that apply to you, **if ongoing OR has previously occurred.**

Foot, Ankle, and Lower Extremity

- ☐ Ankle Fracture
- ☐ Arch Pain
- ☐ Athlete's Foot
- ☐ Broken Foot or Toes
- ☐ Childhood Foot Problems
- ☐ Cramps Foot/Calf
- ☐ Flat Feet
- ☐ Foot Numbness
- ☐ Gait (walking Problems)
- ☐ Hammer/Mallet Toes
- ☐ In-Toeing
- ☐ Ulcers on Legs or Feet
- ☐ Neuroma
- ☐ Painful Corns/Calluses/Bunions
- ☐ Poor Circulation in Lower Limb
- ☐ Swollen Ankles/Feet
- ☐ Tendinitis
- ☐ Varicose Veins
- ☐ Warts
- ☐ Pain in Feet

☐ Other: _____

_____

_____

_____

Nail Conditions

- ☐ Brittle Nails
- ☐ Curved Up
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Nail Pitting
- ☐ Nail Thickening
- ☐ Ingrown Nail
- ☐ White Spots/Lines

Have you ever used:

Shoe Inserts?

☐ Yes ☐ No

Custom Orthotics?

☐ Yes ☐ No

If yes to either, did they help?

☐ Yes ☐ No

Are you currently under the care of a pain management doctor?

☐ Yes ☐ No

If yes, name and phone number of physician or facility:

_____

Any Additional Symptoms? --- Please identify all that apply to you.

- ☐ Joint Pain
- ☐ Chronic Pain
- ☐ Weakness
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Difficulty Sleeping
- ☐ Chest Pain
- ☐ Changes in Vision
- ☐ Changes in Hearing
- ☐ Vomiting
- ☐ Fevers, Chills, Sweats
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Feeling Sad
- ☐ Changes in Urination Frequency
- ☐ Muscle Spasms
- ☐ Headaches/Migraines
- ☐ Wheezing
- ☐ Hair Loss
- ☐ Others: _____
- ☐ Anxious
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing

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Medications

Please list your current medications, their dosage, and how often you take it.

Current Medication Name	Dosage	How Often Per Day	Start Date (month/year)

Allergies

Do you have any drug allergies?

☐ Yes ☐ No

If yes, please indicate all that apply below:

☐ Penicillin ☐ Novocain ☐ Band-Aid
☐ Aspirin ☐ Latex ☐ Tape
☐ Sulfa Drugs ☐ Demerol
☐ Advil/Aleve ☐ Corticosteroids _____
☐ Aspirin ☐ Motrin _____
☐ Codeine ☐ Tylenol _____
☐ Morphine ☐ Iodine ☐ Others: _____

Pharmacy Information

Name of Your Pharmacy: _____

Pharmacy Phone Number: _____

Address Of Pharmacy:

_____

Do you frequently use antibiotics?

☐ Yes ☐ No

If yes, long term use?

☐ Yes ☐ No

Alcohol Usage

☐ I never drink alcohol
☐ I infrequently drink alcohol (socially)
☐ I drink alcohol frequently
☐ I have a history of alcohol abuse
☐ I quit drinking in _____ (year)

On average, I have _____ alcoholic drinks per week.

Tobacco Usage

☐ I do not use any tobacco products
☐ I currently chew tobacco. I chew _____ times per day.
☐ I currently smoke. I smoke _____ times per day.
☐ I currently vape. I vape _____ times per day.
☐ I quit vaping in _____ (year)
☐ I quit smoking in _____ (year)

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Screenings and Test Information

Please fill out the following information to the best of your ability.

Test Name	Provider/Facility	Date Received
Bone Density		
Cardiac Stress Test		
Colonoscopy		
Cologuard		
CT Scan		
EKG		
Mammogram		
MRI Scan		
Pap Smear		
Rectal/PSA		
Eye Examinations		
X-Rays		

Hospitalization and Surgical History

Date	Reason and Hospital Name

Vaccination History

☐ Received Typical Childhood Vaccinations ☐ Never Vaccinated

☐ **I have** been vaccinated for the Flu ☐ **I have NOT** been vaccinated for the Flu

☐ **I have** been vaccinated for Covid-19 ☐ **I have NOT** been vaccinated for Covid-19

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Family History

(Please mark all family members that may apply)

Condition	Mother	Father	Brother	Sister	Children	Grandfather	Grandmother	Aunt	Uncle
ALS or Motor Neuron Disease									
Asthma									
Autism									
Autoimmune Disease (Ex: Lupus)									
Bipolar Disorder									
Breast/Ovarian Cancer									
Colon Cancer									
Lung Cancer									
Dementia									
Depression									
Diabetes									
Eczema/Psoriasis									
Heart Disease									
Hypertension									
Inflammatory Arthritis									
Multiple Sclerosis									
Obesity									
Parkinson's									
Schizophrenia									
Stroke									
Substance Abuse									

Unspecified Condition: _____ **Family Member Affected:** _____

For any affected family members, please write their age.

Mother _____ Father _____ Brother _____ Sister _____ Children _____ Grandfather_____ Grandmother _____ Aunt _____ Uncle_____

For Deceased Family Members, please write their age at death _____

[family member(s) name followed by age at death]

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Patient Privacy Act (HIPPA), requires that our office obtains authorization to leave messages at your home with family members or on voice mail, email, etc. **I hereby give my consent for LA Medical Associates, doctors and staff to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) as follows:**

1. LA Medical Associates, doctors and staff's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by writing to LA Podiatry Group at 2326 South Congress Avenue, Suite 1A, West Palm Beach, FL 33406. My protected health information means health information including, but not limited to my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or health clearing house, this protected health information relates to my past, present and future physical and mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

2. **PHONE CALLS:** LA Medical Associates, doctors and staff may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

3. **MAIL:** LA Medical Associates, doctors and staff may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

4. **E-MAIL**: LA Medical Associates, doctors and staff may E-mail any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

5. I have the right to request that LA Medical Associates, doctors and staff restrict how they use or disclose my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

6. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, LA Medical Associates, doctors and staff may decline to provide treatment for me. LA Medical Associates and doctors reserves the right to change its privacy practices that are disclosed

✘_____ _____

Signature (parent, if patient is a minor) ***Date***

_____ _____

Print Patients Name ***If applicable, Print Name of Legal Guardian***