Patient Information

Name: _____ DOB: _____ Sex: _____ Age: _____

Home Address: _____ Apt: _____ City: _____ Zip: _____

Hm Phone (___) _____ Wk Phone: (___) _____ Cellular Phone: (___) _____

Email: _____

Soc. Security No# _____ Marital Status: **Single Married Widow Divorce SEP**

Employer: _____ Patient's Occupation: _____

Primary Language: _____ Translation Needed: **Yes or No**

Spouse's Name _____ Wk Phone: (___) _____

Previous Primary Care Physician: _____ Phone:(___) _____

Whom May we contact in the case of an emergency? _____ Phone:(___) _____

Whom may we thank for referring you to us? _____ Phone:(___) _____

Pharmacy Information: _____ Phone#: _____

Primary Insurance

Insurance Carrier: _____ ID# _____

Named of Insured: _____ Group# _____

SS # Insured: _____ DOB: _____ Sex: _____

Secondary Insurance

Insurance Carrier: _____ ID# _____

Named of Insured: _____ Group# _____

SS # Insured: _____ DOB: _____ Sex: _____

Who is financially Responsible for this bill or Co-payment? _____

Assignment of Benefits- Authnrization to release information- Financial Responsibility and Authorization to Treat.

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. I hereby authorize Primary Care Offices*, to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Primary Care Offices*, (nr to the party who accepts assignment). I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance company or me at any time in writing.

I hereby authorize Drs. Martinez, Gomez, Guvenli and their associated and staff to provide treatment for us.

Signature: _____ Date _____

(Patient, Parent or Guardian)

***Primary Care Offices:** Innovative Care, Innovative Care II, LLC & Tamer Gozleveli DO PA.

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Olga M. Martinez, DO
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Ph. 954-843-7230
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Gokhan Guvenli, MD
12600 Pembroke Rd, Suite 100
Miramar, FL 33027
Ph. 954-432-5400

Gokhan Guvenli, M.D.

Board Certified in Family Medicine

DATE: _____

PATIENT NAME. _____
(NOMBRE DEL PACIENTE)

PHONE NUMBER. _____
(NUMERO DE TELEFONO)

DOB: _____
(FECHA DE NACIMIENTO)

PHARMACY #: _____
(NUMERO DE FARMACIA)

MEDICATION (MEDICAMENTO)	**DOSAGE** (DOSIS)	**FREQUENCY** (FRECUENCIA)	**TIME** (HORA)	**WITH OR WITHOUT MEAL** (CON O SIN COMIDA)	**OTHER** (DIFERNATE USO)	**START DATE** (DIA QUE INICIO)	**USE** (PARA QUE SIRVE)

12600 Pembroke Rd, Suite 100, Miramar, FL 33027

(954) 432-5400 Fax: (954) 433-9873

Comprehensive Patient History Form

Patient Name:_____ Date of Birth:_____ Date:_____

Describe your main problem _____

Where is ynur problem located?_____

Hnw severe is your problem? _____

How long have you had this problem?_____

When does this problem occur?_____

Where were you when this problem started? _____

What other things happen with this problem?_____

_____

Have you ever had the following?		
Diabetes.....	yes	no
Hypertension.....	yes	no
Cancer.....	yes	no
Stroke.....	yes	no
Heart trouble.....	yes	no
Arthritis/gout.....	yes	no
Convulsions.....	yes	no
Bleeding tendency.....	yes	no
Acute infections.....	yes	no
Venereal disease.....	yes	no
Hereditary defects.....	yes	no

List previous hospitalizations/Surgeries/Serious Injuries When?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List Medications you are currently taking

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

9)_____

10)_____

Patient Social History

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Use of alcohol: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily _____

Use of tobacco: ❑ Never ❑ Previously but quit ❑ Current packs per day

_____

Use of Drugs: ❑ Never ❑ Type/Frequency_____

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____
	____	_____	_____
	____	_____	_____
	____	_____	_____
	____	_____	_____

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PLEASE ANSWER ALL QUESTIONS

Have you had any of the following during the past three months?

CONSTITUTIONAL

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

EYES

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

ENT

Hearing loss	No	Yes
Ringing in the ears	No	Yes
Earaches or drainage	No	Yes
Sinus problems	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

CARDIOVASCULAR

Heart trouble	No	Yes
Chest pains	No	Yes
Sudden heart beat changes	No	Yes
Swelling of feet, ankles or hands	No	Yes

RESPIRATORY

Frequent coughing	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Blood in stool	No	Yes
Stomach pain	No	Yes

GENITOURINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change of force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male – testicle pain	No	Yes
Female – pain with periods	No	Yes
Female – irregular periods	No	Yes
Female – vaginal discharge	No	Yes

Female – # pregnancies _____ # miscarriages _____

Female – date of last pap smear _____

Female – findings of last pap smear ❑ Normal ❑ Abnormal

MUSCULOSKELETAL

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

SKIN

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Sleep problems	No	Yes

ENDOCRINE

Grandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Dry skin	No	Yes
Change in hat or glove size	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	No	Yes
Easily bruise or bleed	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reactions to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol or other narcotics	No	Yes
Novocaine or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, methiolate or other antiseptic	No	Yes

Other drugs/medications _____

Known food allergies _____

Patient Signature: _____ Physician Signature: _____

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Questions we sometimes forget or do not have time to discuss

Patient Name: _____ **DOB:** _____

1. **Do you have a Bladder Control Problem?** ☐YES ☐NO

If you do, let's discuss it as there are treatment options I may be able to assist with

2. **Do you regularly do any form of exercise?** ☐YES ☐NO

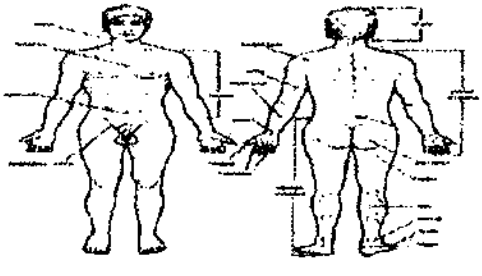
If you don't, we should discuss ways to increase your mobility. If you do, there may still be opportunities to Safely increase what you are doing.

3. **Have you fallen in the last 12 months** ☐YES ☐NO
4. **Do you feel unsafe walking or moving from the bed to the chair?** ☐YES ☐NO
5. **Do you frequently lose your balance or feel dizzy?** ☐YES ☐ NO

If you do, we can discuss things to help you be safe and prevent falls.

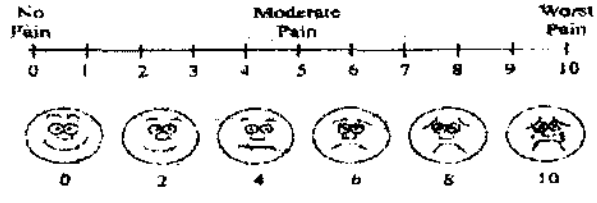
6. **Activities of Daily Living (ADL):**
   Do you need help with: Grooming: ☐YES ☐NO
   Dressing: ☐YES ☐NO Toilet Use: ☐YES ☐NO Feeding: ☐YES ☐NO
   Continence (bowel & bladder): ☐YES ☐NO Housework: ☐YES ☐NO Prepare Meals: ☐YES ☐NO
7. **Advanced Care Planning: Indicate Yes or No to the following:**
   Do you have: Advanced Directive ☐YES ☐NO
   Living Will: ☐YES ☐NO Surrogate decision Letter: ☐YES ☐NO Date discussed: _____
8. **Colorectal Cancer Screening:**
   Did you have a colonoscopy done? ☐YES ☐NO When?_____ With Dr.? _____
   Did you have Focal Occult test done? ☐YES ☐NO When?_____ Where? _____
9. **Did you have a Mammogram done?** ☐YES ☐NO ☐ N/A When?_____ Where? _____
10. **Did you have a Pap smear done?** ☐YES ☐NO ☐ N/A When?_____ Where? _____
11. **Did see an optometrist/Ophthalmologist exam?** ☐YES ☐NO When?_____ Where? _____
12. **How is your Hearing?** ☐Excellent ☐Good ☐Poor ☐Deaf ☐Hearing Aids or Device
13. **Diabetic Patients:** Have you seen a podiatrist this year? ☐YES ☐NO When?_____ Dr.?/Where_____
    Have you seen the optometrist this year? ☐YES ☐NO When?_____ Dr.?/Where_____

Pain Assessment:



Chronic Pain: YES_____NO_____Generalized Location: YES_____NO_____
If pain is localized, please circle at least 3 body parts in the left diagram.

Mark the Level of Pain



Patient Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

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INNOVATIVE CARE INC.
Gokhan Guvenli, M.D.
Board Certified in Family Medicine

www.primarycareoffices.com

LIVING WILL

Declaration made this _____day of _____20____, I _____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

If at anytime I have a terminal condition and if my attending or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provision this declaration:

NAME: _____ DOB: _____

ADDRESS. _____ Relationship to Patient:

_____ _____

PHONE: (_____) _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration:

Additional Instructions (optional)

_____
_____
_____

Signed: _____ Date:_____

Witness: I, _____ _____ _____
Signature Relationship Address

I, _____ _____ _____
Signature Relationship Address

ONE WITNESS SHALL NOT BE A SPOUSE OR BLOOD RELATIVE

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize **Innovative Care Inc, Gokhan Guvenli, MD** to use and/or disclose

Practice Name

certain protected health information (PHI) about me to _____.

Name of entity to receive this information

DOB: _____ Relationship to Patient: _____

This authorization permits **Innovative Care Inc, Gokhan Guvenli, MD** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

Practice Name

_____.

The information will be used or disclosed for the following purpose:

_____. If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____

(Expiration Date or Defined Event).

The Practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Innovative Care Inc, Gokhan Guvenli, MD**

Practice Name

In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Innovative Care Inc
12600 Pembroke Rd Suite 100, Miramar, FL 33027
(954)-432-5400 Fax: (954)433-9873

Address

City State Zip Code

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Patient's Name Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

Innovative Care Inc
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(954)-432-5400 Fax: (954)433-9873

Primary Care Offices
Caring is our priority!

Veronica Gomez, M.D.
Board Certified in Internal Medicine

Olga M. Martinez, D.O.
Board Certified in Family Medicine

Gokhan Guvenli, M.D.
Board Certified in Family Medicine

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CONSENT AND INFORMATION RELEASE

1. MEDICAL CONSENT: I consent to the examination, treatment and procedures which may be performed during this visit; including emergency treatment considered necessary by patient's physician(s).

2. RELEASE OF INFORMATION: I hereby authorize the release to any appropriate Insurance related entity or agency the information needed to process the claims in reference to your medical treatment.

3. INSURANCE ASSIGNMENT OF BENEFITS: I authorize that my insurance benefits Be payable directly to **Primary Care Offices***, on my behalf. I understand that I am responsible for all deductibles, co-insurance, and non-covered charges.

4. FINANCIAL RESPONSIBILITY: I understand that payment is due in full at the time of service and if not, I acknowledge that I am responsible to make the appropriate financial arrangements. Should my account become delinquent and be referred to any third party for collection effort, I agree to pay all reasonable attorney's fees, court costs, and collection expenses.

5. CHANGE OF INSURANCE: I Understand that it is my responsibility to notify the office of any change in my insurance. If not, I realize that I will be responsible for any charges that are not paid.

I release **Primary Care Offices***, in complying with this request of all responsibility for loss of confidentiality by access and/or copies of records released in compliance with this authorization.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, was provided with the Notice of Privacy
Patient Name
Practices of **Primary Care Offices***, to read/review. By signing below, I attest that I am aware and understand his Privacy Policies, Procedures, as well as, my patient rights.

_____ _____
Name of Patient: Date of Birth

_____ _____
Signature of Patient Date

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Authorization for Release of Medical Records

This form is to confirm your authorization to us or disclose your protected health information for a special purpose.

I give my authorization to use or disclose my protected health information as described below.
I give this authorization voluntarily.

Patient Name: _____ DOB: _____
SS #: _____

Describe in detail the protected health information you are authorizing to be used and/or disclosed.

_____

_____

Name the people and/or organizations that you are **authorizing to use** and/or to disclose the protected health information described above.

_____

_____

Name the people and/or organizations that you are **authorizing to receive** and use your protected health information.

_____

_____

I understand that I may revoke this authorization at any time by giving written notice to the privacy officer at you office. I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to consent my claims under the insurance policy.

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorizatinn that permits the use and/or disclosure of my protected health information for research purposes may be a condition f my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan nr my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ Date: _____

If this authorization form is signed by a personal representative for this individual patient:

Personal Representative's Name:

_____ _____
Print Name Signature

_____
Relationship to individual patient

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

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Financial Policy

We are so pleased that you have chosen our practice as your primary care physicians. As your treatment provider, we want to assure you that **Primary Care Offices*** strives to provide optimal patient care in a fiscally responsible manner.

Insurance Policies
We are a participating provider with many insurance carriers, and we will file claims on your behalf if services are a covered benefit. You will be responsible for non-covered services and any services beyond your benefits maximum. If you have dual coverage, and we do not participate with your primary insurance, the practice reserves the right to request that services must be paid in full at the time services are incurred. We will provide the documents you need to file for reimbursement with your insurance company,

You must also advise us when your insurance information changes prior to the time of service. This is important because insurance companies often have time limits for filing claims. Therefore, if you fail to notify us you may lose important benefits because we cannot file claims to your new insurance if it is outside your new insurance company's timely filing limits. Treatment may have to be placed on hold if your insurance changes and we are not advised. If your coverage changes under your new insurance, you will be financially responsible for services rendered that are not covered under your new insurance, even if such services were covered under your prior coverage.

The practice assumes no responsibility for representations made by your insurance company. It is important that patients understand that any coverage provided by insurance is usually designed to reduce patient cost, not eliminate it. While we are here to assist you in working with your insurance company, ultimately you are responsible for the full resolution of the full amount of your bill, regardless of insurance coverage.

Unfortunately, we cannot provide you with a guarantee of coverage. Claims must be submitted and reviewed by the insurance carrier prior to any payment. Any claims denied by your insurance company may become your responsibility for payment. If the insurance company requires additional information from you, and you do not respond to the insurance company within 30 days, you will be responsible for outstanding charges.

Payment Policies
To keep our billing costs down, copayments, co-insurance and deposits are required prior to the time of service. Patients without insurance coverage are required to pay in full prior to services being rendered. For your convenience, we accept the following forms of payment: Cash, Checks, Debit Cards, Visa, MasterCard, Discover, American Express, selected lending institutions and wire transfers. If you pay by check and the check is returned, you will be responsible for a $35 returned check fee and $25 administration fee. Payment will then be required in the form of cash, money order, credit card or certified check.

Account balances can be paid online at www.primarycareoffices.com. Please click the Pay Online button in our home page. If your account is not paid within 120 days, you may be turned over to an outside collection agency. Subject to applicable law, we reserve the right to collect all of our collection expenses, including collection agency fees, attorneys' fees, and court costs incurred to collect amounts due.

By signing below, you authorize the Practice to apply any excess payments from you to any outstanding account balance on either you resulting from prior charges or treatment. Overpayments will be refunded to your account, or at your written direction, after review of the accounts. Any patient requested refund will not be processed until the account is reviewed and all active or patient due balance are paid in full. All overpayments are refunded by check.

Flex sponding cards will only be accepted to pay outstanding account balances.

I /we have read and I/we understand the above financial policy and agree to be financially responsible for services rendered including co-insurance, deductibles, co-pays, non-covered services etc.

I/we hereby assign to **Primary Care Offices*** any and all benefits from any insurance plans where **Primsry Care Offices*** Practice is a participating provider, and I/we authorize and direct such benefits to be paid directly to **Primary Care Offices*** for services rendered.

Patient's Authorized E-mail Address	Patient Signature	Date

***Primary Care Offices:** Innovative Care, Innovative Care II, LLC & Tamer Cozlevli DO PA,

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