Doctor4UClinic Urgent Care and Primary Care
5318 34th ST W
Bradenton, FL 34210
Phone 941-758-0205
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Dr. Lihini Dalzell, DO **Dr. Manellema Fernando, MD**

Please Print and Complete

Today's Date: _____ Reason for Visit:_____

Primary Care Physician:_____ Pharmacy for today's visit:_____

Patient Information:

First Name: _____ MI:_____ Last Name:_____

Nick Name or Preferred Name:_____

Date of Birth:_____/_____/_____ Age:_____Social Security #:_____-_____-_____Sex:_____Marital Status:_____

Address:_____

Apt#_____ City:_____ State:_____ Zip:_____

Mailing Address (If Different):_____

Home Phone:_____Cell Phone:_____ Email:_____

Consent for email, text message, voice appointment reminders: Yes to all No to all Yes only to_____

Responsible Party Information: ***(For patients under 18 and other dependent patients)***

Name:_____Date of Birth_____/_____/_____ Sex:_____

Address:_____Apt#:_____City:_____State:_____Zip:_____

Phone:_____Relationship to patient:_____

Consent for Treatment of Minors:

I give consent for my child (17 and under) to be treated at Doctor4UClinic.

I understand that I must be present at each appointment for any child age 17 or younger.

X_____ _____
Signature of Parent or Guardian Date

Emergency Contact: **Can we share information with this contact?**

Name_____Number_____Relationship_____ Yes No

Name_____Number_____Relationship_____ Yes No

Shareable Information: ☐ Results ☐ Office Notes/Plan ☐ Referral
Results regarding sexually transmitted diseases, whether positive or negative, will only be given to the patient.

How did you hear about us? (circle) Google Friend or Family Physician/Provider Referral Insurance Other

Signature:_____ Date:_____

*Created 06/28/23

Financial Policy

It is our goal to provide our valuable patients with the best quality of care and service as possible. The following financial policy outlines your financial responsibility for services rendered to you.

This office files insurance claims on behalf of our insured patients comma both as a courtesy and as a part of our provider agreements with certain insurance carriers. We require photo identification and an insurance card in order to file insurance claims on your behalf.

Under these agreements, patients are responsible for payment of insurance deductibles and copayments at the time the service is rendered. In addition, patients are responsible for payment and full for services that are considered to be "non-covered" by your insurance carrier for any reason. If we cannot verify your insurance eligibility with the information you provide, payment in full is expected at the time of your visit. Any outstanding balance from deductibles, co-insurance, etc. are due in full upon receipt of your statement.

We offer services for non-insured patients. Any additional charges resulting from additional testing or procedures will be discussed with you before they are performed so you as the patient are aware of price charges before they are performed. All charges are payable and expected at the time services are rendered.

Our office accepts cash, debit/ATM cards and credit cars (Visa, Master Card, Discovery and American Express).

Thank you for allowing us to participate in your healthcare plan and for your compliance with our policies.

Signature:_____ Date:_____

Consent For Use And Disclosure Of Health Information

This notice describes how medical information about you may be used and disclosed, your rights as a patient and the ways for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (HIPPA privacy act.) We have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

we may release of disclose your health information:

- For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our office that are taking part in your care.
- For billing and collection purposes, we may release records of your health care and information that you have provided to your insurance carrier or other financially responsible parties.
- For operational purposes within our office for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorized the release of any information pertinent to your case to any insurance company, adjustor, attorney involved in the case for the purpose of obtaining payment on your health claims.

We will use your personal address, email address and or telephone number to contact you regarding your appointments, to send your information about our office, office events or to share treatment options. We will not disclose information about you to anyone outside of our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health related information should be provided to the front desk in writing.

We normally provide information about your health to you in person at the time of your visit with us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like this information in a different form, please advise in writing as to your preferences.

Information that we use or disclose on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your complaint in writing to "Mark Dalzell, General Office Manager" at Mark@doctor4uclinic.com.

Signature:_____ Date:_____

General Consent to Treat and Patient Acknowledgements

The following are the conditions for services provided by Doctor4UClic for the patient whose name appears at the bottom of the page.

Consent for Medical Treatment:

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Doctor4UClinic and associated physicians, clinicians and other personnel. I /we consent to the testing for infectious disease, such as, but not limited to syphilis, AIDS, Hepatitis and testing for drugs if deemed advisable by the physician. I /we are aware that the practice of medicine and surgery is not an exact science and I /we acknowledge that no guarantees have been made as to the result of treatments or examinations.

Assignment Of Insurance Benefits:

I /we guarantee payment of all charges made for or on account of the patient and I /we assign our rights in any insurance benefits or other funding to the physician and Doctor4UClinic. I /we understand that I /we am/are responsible for any charges not covered by insurance or other forms of benefits. I /we understand that Doctor4UClinic can obtain my/our credit report for review in collection of this debit. In the event that this account is placed with a collection agency or attorney for collection, I /we shall pay all collection fees and costs, including reasonable attorney fees. For Medicare beneficiaries, I /we provide all necessary information for proper assignment of Medicare benefits.

Name:_____ Signature:_____ Date:_____

Patient Medical History

Date:_____ Name:_____ D.O.B:_____

Medical History ☐ No Ongoing Medical History

Cardiology
☐ Arrhythmia ☐ Atrial Fibrillation
☐ CHF ☐ Heart Disease
☐ High Cholesterol
☐ High Blood Pressure
☐ MI/ Heart Attack ☐Valve Disease

Endo
☐ Diabetes 1 ☐ Diabetes 2
☐ Hypothyroid ☐ Hyperthyroid

GI
☐ Barrett's Esophagus
☐ Cholecystitis/Gallstone
☐ Cirrhosis ☐ GERD
☐ Irritable Bowel Syndrome
☐ Crohn's/Ulcerative Colitis
☐ Hepatitis C ☐ Hepatitis B

Genito-Urinary
☐ BPH (Enlarged Prostate)
☐ Kidney Disease ☐ Kidney Failure
☐ Kidney Stones ☐ HPV

Lymph/Heme
☐ Clotting disorder
☐ Sickle Cell ☐ Anemia

Ortho
☐ Arthritis ☐ Spinal Stenosis
☐ Degenerative Joint Disease
☐ Osteoporosis

Neuro
☐ Alzheimer's ☐ Dementia
☐ Autism ☐ CVA/Stroke
☐ Developmental Delay
☐ Parkinson's ☐ Seizure Disorder
☐ Concussion ☐ Headache

Ophtho
☐ Blindness ☐ Macular Degeneration
☐ Cataracts ☐ Glaucoma
☐ Detached Retina

GYN
☐ Irregular Periods ☐ Ovarian Cyst

Psych
☐ Anxiety ☐ Bipolar ☐ Depression
☐ PTSD ☐ Schizophrenia
☐ Alcohol/ Substance Abuse

Pulm
☐ Asthma ☐ Emphysema ☐ COPD
☐ Sleep Apnea ☐ Snoring
☐ Pulmonary Embolism

Rheum
☐ Auto-immune Disorder
☐ Lupus ☐ Sjogrens
☐ Rheumatoid Arthritis ☐ Scleroderma

Vascular
☐ Peripheral Artery Disease
☐ Carotid Artery Stenosis
☐ Abdominal Aortic Aneurysm

Other
☐ Seasonal Allergies ☐ HIV
☐ Cancer Type/ Location _____

Surgical History ☐ No Surgical History

☐ Appendectomy ☐ Lung Removal
☐ Kidney Stone Removal
☐ Bariatric Surgery
☐ Gallbladder removal
☐ Hernia Repair ☐ Colon Resection
☐ Splenectomy ☐Tonsillectomy
☐ Lumpectomy: Left Right Bilateral
☐ Mastectomy: Left Right Bilateral
☐ Heart Valve Replacement
☐ Heart CABG
☐ Cardiac Stent ☐ Heart Pacemaker
☐ Joint Replacement
☐ Neck Surgery ☐ Back Surgery
☐ Vasectomy ☐ Prostate Surgery
☐ Cataracts ☐ Glaucoma
☐ Melanoma ☐ MOHS
☐ Squamous Cell ☐ Basal Cell
☐ Kidney Transplant ☐ Kidney Removal
☐ Carotid Endarterectomy
☐ Vascular Procedure
☐ Other:_____

Social History ☐ None Apply

☐ Current Everyday Smoker ☐ Some Day Smoker: **(Circle)** Cigarettes E-Cigarettes Vape Cigar Pipe
Number Of Packs Per Day?_____ Total Years Smoked? _____
☐ Former Smoker: Quit Date? _____ ☐ Never Smoked ☐ Chewing Tobacco
Alcohol Use: ☐ Yes ☐ No Drinks per day? _____ Drinks per week? _____
Medical Marijuana Use? ☐ Yes ☐ No Drug Use? ☐ Yes ☐ No

Family History ☐ No Known Medical History

Diabetes, Who?_____ High Blood Pressure, Who? _____
Bleeding Disorder, Who?_____ Cancer, Who/What Kind?_____

Females

Date of Last Menstrual Period? _____ ☐ No Longer Having Menstrual Periods
Sexually Active? ☐Yes ☐ No Method of Contraception? _____
Pregnant? ☐Yes ☐No Trying To Get Pregnant? ☐ Yes ☐ No Breast Feeding? ☐ Yes ☐ No
☐ Irregular Periods ☐ Tubal Ligation ☐ Cesarean Section ☐ Hysterectomy ☐ Partial or ☐ Total ☐ Mastectomy

Tetanus Shot ☐ Less Than 5 Years Ago ☐ Less Than 10 Years Ago ☐ Unknown
Children Immunizations Up To Date? ☐ Yes ☐ No

Medications (Name, Strength and Frequency) ☐ ***Not Taking Any Medications***

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Allergies To Medications/ Reaction To Medication ☐ ***No Known Allergies To Medications***

1. _____ 3. _____ 5 . _____
2. _____ 4. _____ 6. _____

Signature:_____ Date:_____

*Created 06/28/23