Stephen J. Miller, M.D., P.A.

New Patient Form

Patient's Full Name: _____ Age: _____ Sex: _____

Address: _____

Apt.#: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Social Security Number: _____

Date of Birth: _____ Marital Status: Single Married Divorced Widowed

E-Mail Address : _____

Place of Employment: _____ Phone: _____

Address: _____ Your Position: _____

Name of Spouse/Nearest Relative: _____ Relation: _____

Home Phone: _____ Other #: _____

Emergency Contact: _____ Phone#: _____

Primary Doctor's Name: _____ Phone: _____

Referring Physician: _____ Phone: _____

What is the problem that you are coming to see the doctor for today? (***Please specify right or left side***):

_____

If the problem is related to an injury, please provide the following information:

Date of injury: _____ Type of injury: _____

Did the injury occur at work? YES NO (***If yes, please notify the front desk***)

I have reviewed the information on this form fully and completely, and certify that I am the patient ot duly authorized guardian and that the facts above are true to the best of my knowledge. I understand that even though I may have insurance coverage, I am solely responsible for payment of service.

Signature of Patient or responsible party: _____ Date: _____

PATIENT QUESTIONNAIRE

Date: _____ Patient Name: _____

Reason for today's visit: _____

MEDICAL HISTORY

Y	N	Anemia		Y	N	Heart Surgery/Pacemaker
Y	N	Asthma		Y	N	Hemophilia
Y	N	Blood Transfusion		Y	N	Hepatitis
Y	N	Cancer/Chemotherapy Type/Location: _____		Y	N	High Blood Pressure
Y	N	Congenital Heart Defect		Y	N	Low Blood Pressure
Y	N	Emphysema		Y	N	Epilepsy
Y	N	Heart Attack/ Stroke	Date: _____	Y	N	Arthritis
Y	N	HIV/AIDS	Date: _____	Y	N	Diabetic
Y	N	Mitral Valve Prolapse		Y	N	Insulin Dependent
Y	N	Rheumatic/Scarlet Fever		Y	N	Osteoporosis
Y	N	Ulcers/Colitis		Y	N	Artificial Joints
Y	N	Thyroid		Y	N	Fibromyalgia
Y	N	Gout		Y	N	Tuberculosis
Y	N	Blood Clots		Y	N	Are you Currently Pregnant
Y	N	Other serious medical condition: _____				

FAMILY HISTORY
(Has parents or siblings had?)

							Age:	Alive:	
Y	N	Stroke/headache/ Seizure	Y	N	Emphysema	Mother:	_____	Y	N
Y	N	Cancer	Y	N	Diabetes	Father:	_____	Y	N
Y	N	Heart Condition/Hypertension	Y	N	Thyroid Disorder	Brother:	_____	Y	N
						Sister:	_____	Y	N

MEDICATIONS

List **ALL** medications you are currently taking: _____

_____

SURGERY/HOSPITALIZATION

_____

ALLERGIES

Y	N	Asprin	Y	N	Penicillin
Y	N	Codeine	Y	N	Latex
Y	N	Tetracycline	Y	N	Erythromycin
Y	N	Sulpha	Y	N	Iodine
Y	N	Other: _____			

SOCIAL HISTORY

Y	N	Smoker	Packs per day: _____
Y	N	Drink Alcohol	Daily Average Amount: _____
Y	N	Drug Abuse	_____

Office Use Only:

Height: Weight: B/P: Pulse: _____ Resp: _____

Patient: _____ Date: _____

Review of Systems

Do you now have any problems related to the following systems? Circle Yes or No.

Constitutional Symptoms
Fever Y N
Chills Y N
Headache Y N
Other _____

Eyes
Blurred vision Y N
Double vision Y N
Pain Y N
Other _____

Allergic/Immunologic
Hay Fever Y N
Drug allergies Y N
Other _____

Neurological
Tremors Y N
Dizzy spells Y N
Numbness/tingling Y N
Other _____

Endocrine
Excessive thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other _____

Gastrointestinal
Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/heartburn Y N
Other _____

Cardiovascular
Chest pain Y N
Varicose veins Y N
High blood pressure Y N
Other _____

Integumentary
Skin rash Y N
Boils Y N
Persistent itch Y N
Other _____

Musculoskeletal
Joint pain Y N
Neck pain Y N
Back pain Y N
Other _____

Ear/Nose/Throat/Mouth
Ear infection Y N
Sore throat Y N
Sinus problem Y N
Other _____

Genitourinary
Urine retention Y N
Painful urination Y N
Urinary frequency Y N
Other _____

Respiratory
Wheezing Y N
Frequent cough Y N
Shortness of breath Y N
Other _____

Hematologic/Lymphatic
Swollen glands Y N
Blood clotting problem Y N
Other _____

Psychologic
Are you unhappy with your life? Y N
Do you feel severely depressed? Y N
Have you considered suicide? Y N
Other _____

Stephen J. Miller, M.D., P.A. Financial Policy

Thank you for choosing Dr. Stephen Miller as your health care provider. We are committed to providing you with the best possible care. The following is a statement of our financial policy which we require you to read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

- PAYMENT IS DUE AT THE TIME OF YOUR APPOINTMENT
- WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, AMERICAN EXPRESS OR DISCOVER. THERE IS A $20.00 DOLLAR RETURNED CHECK FEE AND WE WILL NO LONGER ACCEPT CHECKS IF YOURS IS RETURNED.
- PATIENT WITHOUT VALID INSURANCE COVERAGE OR ID WILL BE REQUIRED TO LEAVE A $250.00 DEPOSIT PRIOR TO SEE THE DOCTOR.
- YOU WILL BE BILLED A $25.00 CHARGE FOR APPOINTMENTS THAT ARE MADE FOR YOU AND YOU DO NOT SHOW UP OR CANCEL THE APPOINTMENT.

FINANCIAL AGREEMENT:

As a courtesy to our patients, we accept assignment of insurance benefits, in most cases. However, we do require you to pay your co-payment, deductible or patient responsibility at the time services are rendered. Any deductibles, co-payments, co-percentages and services not covered by your insurance company are your responsibility at the time of your visit. This includes charges for office visits, supplies, and x-rays. Further, if you do not obtain a referral for your visit, you will be responsible for the balance of the entire bill.

The adult accompanying a minor and the parents (or legal guardian of the minor) are responsible for full payment at the time of service.

The medical bills incurred in this office are the sole responsibility of the patient or legal guardian thereof regardless of insurance status. I understand that unpaid accounts will be considered default after 90 days of the date of treatment. In the event legal action is necessary to enforce payment of account, I understand that I am responsible for all attorney's fees, collection proceedings and court costs. Signing below indicates that I understand and agree to this agreement.

X_____ Date: _____
(Signature of Patient or Responsible Party)

ASSIGNMENT OF BENEFITS:

I hereby authorize payment to be made directly to "Stephen J. Miller, M.D., P.A." of benefits due to me from my insurance company. I understand that I am financially responsible for charges not covered by the insurance company. I further understand that if payment is sent to me by my insurance company, I will immediately pay "Stephen J. Miller, M.D., P.A."

X_____ Date: _____
(Signature of Patient or Responsible Party)

I authorize the release of any and all medical information to the proper insurance company.

X_____ Date: _____

I hereby consent to treatment for myself or my child.

X_____ Date: _____

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Effective Date: April 14, 2003

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed under federal and state law. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling phone: 305-668-5636 or by requesting one at this Practice's office.

This consent form allows Stephen J Miller, M.D., P.A. to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations. Stephen J. Miller, M.D., P.A. provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that I have the right to request, now and in the future, how protected health information is used or disclosed to carry out treatment, payment and health care operations. I understand that while Stephen J. Miller, M.D., P.A. is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that Stephen J. Miller, M.D., P.A. may refuse me services if I refuse to sign this consent.

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that the services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information.

_____ _____

Please print name **Date**

_____ _____

Signature of Patient or Personal Representative **Relationship to Patient**

FOR PHYSICIAN USE ONLY:
You must complete this section of the form if not signed and dated by the patient or the patient's representative.

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

Social Security Number:_____ **Phone Number:**_____

Address:_____

The date that you requested the signature and date:_____

The reason that the signature and date were not obtained:_____

_____

STEPHEN J. MILLER, M.D., P.A.
Surgery of the Hand and Upper Extremity
Diplomate, American Board of Orthopaedic Surgery

Date _____

I have been informed that the office of Stephen J. Miller, M.D., P.A., will make every effort to schedule my MRI/Cat Scan/Lab Work. However, I understand that it is ultimately my responsibility to make sure that the test is completed. Further, I understand the importance of returning to Dr. Miller's office for my follow up appointment to discuss the test results.

I have read the above statement and I take full responsibility for my part in this treatment process.

_____ _____

Print Name Patient/Guardian Signature

6280 Sunset Drive, Suite 200 South Miami, Florida 33143
Telephone: 305-668-5636 Fax: 305-668-5621

STEPHEN J. MILLER, M.D., P.A.
Surgery of the Hand and Upper Extremity
Diplomate, American Board of Orthopaedic Surgery

PHARMACY

Pharmacy Name: _____

Address: _____

_____

_____

Telephone: _____

6280 Sunset Drive, Suite 200 South Miami, Florida 33143
Telephone: 305-668-5635 Fax: 305-668-5631