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Phone: 386-445-4700
Fax: 386-446-4407

GOAR DE LAMERENS, M.D.

Patient Information

Name: ____ SSN: ____________________
Last First Middle

Address: _________________________________ City: _________ State: ____ Zip: _________

Mailing Address: ____

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Date of Birth: _________________________ Age: ________ Sex: Male _____ Female _____

Marital Status (please check one): Single _____ Married _____ Widow _____ Divorced _____

Patient's Employer: ________________________________ Employer's Phone: ______________

Employer's Address: ____

Occupation: ____

Email: ______________________________ Ethnicity: ________________________________

Race: ________________ Language1: __________________ Language2: __________________

Spouse or Guardian Name: ____

Relationship to Patient: __________________________ SSN: ___________________________

Date of Birth: _____________________________ Phone: ______________________________

Employer: ____________________________________ Employer Phone: __________________

Emergency Contacts:

Nearest relative not living with you: ____

Home Phone: __________________________ Cell Phone: ______________________________

Whom may we thank for referring you to us? _____________________________________

Financial Policy

All professional Services rendered are charged to the patient/guardian. As a courtesy to the patient, we will collect necessary information to bill your insurance. The patient is responsible for all charges, regardless of insurance coverage. It is the policy of this office to pay for all services at the time services are rendered unless other arrangements have been made in advance with our office. (Not applicable if you have Medicare or Medicaid coverage at the time services are rendered.)

Patient Signature: _________________________ Guardian Signature: _____________________

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Insurance Information

Medicare

Medicare Number: ____________________________ Effective Date: ____________________________

Medicaid

Medicaid Number: ____________________________ Effective Date: ____________________________

Private Insurance Company (please provide a copy of your card)

Primary Insurance Company: ____

Name on Policy: ______________________ Date of Birth: ______________ SSN: ________________

Insurance Company Address: ____

Policy Number: __________________ Group Number: ___________________ Effec. Date: __________

Secondary Insurance Company: ____

Name on Policy: ______________________ Date of Birth: ______________ SSN: ________________

Insurance Company Address: ____

Policy Number: __________________ Group Number: ___________________ Effec. Date: __________

Is this visit regarding an accident?

Date of Injury: ____________ Work Related: Yes ____ No ____ Auto Accident: Yes ____ No _____

Does your insurance company need to be notified of any surgeries or admission? Yes ____ No _____

AUTHORIZATION TO TREAT/INSURANCE PROCESSING AUTHORIZATION/ASSIGNMENT OF BENEFITS

I _________________________ HEREBY AUTHORIZE TREATMENT AND SERVICES AS RENDERED BY *ASSOCIATES IN INTERNAL MEDICINE PA/Dr. Goar deLamerens,* AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMIN, HEALTH CARE ADMIN, THEIR INTERMEDIARIES, OR ANY OTHER INSURANCE CARRIER ANY INFORMATION NEEDED FOR THIS OR ANY MEDICARE INSURANCE CLAIM.

I REQUEST PAYMENT OF ANY MEDICAL INSURANCE BENEFITS OTHERWISE PAYABLE TO MYSELF OR ANOTHER POLICYHOLDER TO *ASSOCIATES IN INTERNAL MEDICINE PA/Dr. Goar deLamerens, M.D.* OR THE PARTY WHO ACCEPTS ASSIGNMENT. I ALSO AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ABOUT ME AS NECESSARY FOR THE PURPOSE OF PATIENT REFERRAL AND OR CONCURRENT CARE. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES CLASSIFIED AS NON-COVERED BY MEDICARE OR SAID INSURANCE COVERAGE WITH OR WITHOUT ADVANCE NOTICE. I UNDERSTAND THAT I WILL BE INFORMED OF ANY SUCH CHARGES ON THE DAY OF SERVICE. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

Patient Signature __________________________________ **Date** ____________________

Guardian Signature__________________________________**Date** ____________________

Relationship to Patient ______________________________

MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it. **Please print and complete all information.**

Case No.	Medicare No.	Medicaid No.	Today's Date	Birthdate
Male ☐ Female ☐	Last Name	First	Middle	Daytime Phone
Home Phone	Address	City	State	Zip
Marital Status	Occupation	Person to notify in emergency	Daytime Phone	
Date of last physical examination	Relationship	Home Phone	By Doctor	Phone
Family or referring doctor	Phone	May I contact either of these doctors for your past medical records? Yes ☐ No ☐		
What are your present medical symptoms?				

Family History *please fill out all that apply*

Relationship	Age	Health *(Circle one)*	Deceased *(Circle one)*	Cause of death
Mother		Good Fair Poor		
Father		Good Fair Poor		
Siblings *(circle one)*				
1. M F		Good Fair Poor	Yes ☐ No ☐	
2. M F		Good Fair Poor	Yes ☐ No ☐	
3. M F		Good Fair Poor	Yes ☐ No ☐	
4. M F		Good Fair Poor	Yes ☐ No ☐	
5. M F		Good Fair Poor	Yes ☐ No ☐	
Spouse (*circle one*)				
H W		Good Fair Poor	Yes ☐ No ☐	
Children *(circle one)*				
1. M F		Good Fair Poor	Yes ☐ No ☐	
2. M F		Good Fair Poor	Yes ☐ No ☐	
3. M F		Good Fair Poor	Yes ☐ No ☐	
4. M F		Good Fair Poor	Yes ☐ No ☐	
5. M F		Good Fair Poor	Yes ☐ No ☐	

Blood relatives who have or have had any of the listed conditions *please check all that apply*

	X	Relationship		X	Relationship		X	Relationship
Asthma			Goiter			Rheumatic Fever		
Arthritis			High Blood Pres.			Stroke		
Allergies			Heart Disease			Suicide		
Anemia			Hay Fever			Stomach Ulcers		
Alcoholism			Insanity			Tuberculosis		
Bleeding Tend.			Kidney Disease					
Cancer			Leukemia					
Colitis			Migraine					
Congenital Heart			Nervous Brkdn.					
Diabetes			Obesity					
Epilepsy			Rheumatism					

Habits

			Daily Consumption
Smoke	Y	N	________ pkgs.
Drink Coffee	Y	N	________ cups
Drink Alcohol	Y	N	________ oz.
Drink Beer	Y	N	________ oz.
Fall asleep easily	Y	N	
Awaken early	Y	N	

Past Operations | **Year**

________ ________
________ ________
________ ________
________ ________

Diseases requiring hospitalization | **Year**

________ ________
________ ________
________ ________
________ ________

Serious illness not requiring hospitalization | **Year**

________ ________
________ ________
________ ________
________ ________

Medications *please check all that apply*

- ☐ Antacids
- ☐ Antibiotics
- ☐ Aspirin, Bufferin, Anacin
- ☐ Barbiturates
- ☐ Birth Control Pills
- ☐ Blood Pressure Pills
- ☐ Blood Thinning Pills
- ☐ Cortisone
- ☐ Cough Medicine
- ☐ Digitalis
- ☐ Dilantin
- ☐ Hormones
- ☐ Insulin, Diabetic Pills
- ☐ Iron or Poor Blood Med.
- ☐ Laxatives
- ☐ Phenobarbital
- ☐ Shots
- ☐ Sleeping Pills
- ☐ Thyroid Med.
- ☐ Tranquilizers
- ☐ Vitamins
- ☐ Drink Beer
- ☐ Water Pills
- ☐ Weight Reducing Pills

☐ Other (*please list*)

____
____
____
____

Allergies to medication

____
____
____
____

Please describe any serious injuries or accidents

____
____
____
____

Women Only

Are you still having regular monthly menstrual periods? ☐ Yes ☐ No

Have you ever had bleeding between your periods? ☐ Yes ☐ No

If yes, when? ________________

How heavy? ________________

Do you have bleeding between periods? ☐ Yes ☐ No

If yes, when? ________________

Do you feel bloated and irritable before your period? ☐ Yes ☐ No

Are you currently taking the birth control pill? ☐ Yes ☐ No

If no, have you ever taken the birth control pill? ☐ Yes ☐ No

If yes when? ________________

Have you ever had a miscarriage? ☐ Yes ☐ No

If yes when? ________________

Have you ever had a discharge from your breasts? ☐ Yes ☐ No

If yes when? ________________

Are you regularly tested for cervical cancer? ☐ Yes ☐ No

If yes, what is the date of your last test? ________

Date of last menstrual period: ________________

How many children born alive? ________

How many stillbirths? ______________

How many premature births? ______________

How many miscarriages? ______________

How many cesarean operations? ______________

Please explain any complications of pregnancy: __________________

____

Men Only

Have you ever had loss of sexual activity? ☐ Yes ☐ No

If yes, for how long? ________________________________

Have you ever had treatment of the genitals (private parts)? ☐ Yes ☐ No

Have you ever had discharge from the penis? ☐ Yes ☐ No

Have you ever had a hernia (rupture)? ☐ Yes ☐ No

Have you ever had prostate trouble? ☐ Yes ☐ No

Men and Women *please check all that apply*

Do you frequently have severe headaches? *If yes, please answer the following* ☐ Yes ☐ No

Do they cause visual trouble? ☐ Yes ☐ No

Do they occur on one side of the head? ☐ Yes ☐ No

Do they awaken you from sleep at night? ☐ Yes ☐ No

Do they feel like a tight hat band? ☐ Yes ☐ No

Do they hurt most in the back of the head and neck? ☐ Yes ☐ No

Does aspirin relieve them? ☐ Yes ☐ No

☐ Yes ☐ No

Have you recently had pain in the stomach that:

Occurs 1-2 hours after a meal? ☐ Yes ☐ No

Is brought on by eating fried or gassy foods? ☐ Yes ☐ No

Awakens you at night? ☐ Yes ☐ No

Is relieved by antacid medications? ☐ Yes ☐ No

Is relieved with milk or eating? ☐ Yes ☐ No

Occurs while eating or immediately after? ☐ Yes ☐ No

Is relieved by a bowel movement? ☐ Yes ☐ No

Causes loss of appetite? ☐ Yes ☐ No

☐ Yes ☐ No

Have you ever:

Fainted? ☐ Yes ☐ No

Had spells of dizziness? ☐ Yes ☐ No

Had spells of weakness in the arms and legs? ☐ Yes ☐ No

Had a convulsion? ☐ Yes ☐ No

Do you have:

Ringing in the ears? ☐ Yes ☐ No

Double vision? ☐ Yes ☐ No

Pains in the ears? ☐ Yes ☐ No

Nosebleeds? ☐ Yes ☐ No

Do you frequently have:

Bleeding gums? ☐ Yes ☐ No

Trouble swallowing? ☐ Yes ☐ No

Hoarseness? ☐ Yes ☐ No

A sore tongue? ☐ Yes ☐ No

Nausea and vomiting? ☐ Yes ☐ No

Have you ever had shortness of breath:

While doing your usual work?	☐ Yes	☐ No
While climbing a flight of stairs?	☐ Yes	☐ No
Which awakens you at night?	☐ Yes	☐ No
Which causes you to cough?	☐ Yes	☐ No
Which is accompanied by wheezing?	☐ Yes	☐ No
Do you have a chronic cough?	☐ Yes	☐ No
Have you ever coughed up blood?	☐ Yes	☐ No
Do you cough up much sputum?	☐ Yes	☐ No

Have you had:

Burning while urinating? ☐ Yes No
When or since when?

Loss of bladder control? ☐ Yes ☐ No
When or since when?

Blood while urinating? ☐ Yes ☐ No
When or since when?

Dark colored urine? ☐ Yes ☐ No
When or since when?

Trouble starting to urinate? ☐ Yes ☐ No
When or since when?

Trouble holding the urine? ☐ Yes ☐ No
When or since when?

To frequently get up at night? ☐ Yes ☐ No
When or since when?

To pass a kidney stone? ☐ Yes ☐ No
When or since when?

Have you recently had:

Pains in calves/legs while walking? ☐ Yes ☐ No
When or since when?

Cramps in legs at night? ☐ Yes ☐ No
When or since when?

Pain in the big toe? ☐ Yes ☐ No
When or since when?

Varicose veins? ☐ Yes ☐ No
When or since when?

Phlebitis or inflamed leg veins? ☐ Yes ☐ No
When or since when?

Swelling in the ankles? ☐ Yes ☐ No
When or since when?

Have you had pain or tightness in the chest that:

Occurs when exerting yourself?	☐ Yes	☐ No
Occurs when walking up against a wind?	☐ Yes	☐ No
Occurs when walking up a hill?	☐ Yes	☐ No
Occurs after a heavy meal?	☐ Yes	☐ No
Occurs when upset or excited?	☐ Yes	☐ No
Causes palpitations?	☐ Yes	☐ No
Radiates down the arm?	☐ Yes	☐ No
Disappears if you rest?	☐ Yes	☐ No
Occurs only at rest?	☐ Yes	☐ No
Occurs when walking fast?	☐ Yes	☐ No
Occurs when walking in cold weather?	☐ Yes	☐ No

Please describe your chest pain or tightness:

Have you had:

A recent change in bowel habit? ☐ Yes ☐ No
When or since when?

If yes, please answer the following:
Do you have:

Cramping pain in the abdomen? ☐ Yes ☐ No
When or since when?

Alternating diarrhea and constipation? ☐ Yes ☐ No
When or since when?

Paint during or after bowel movement? ☐ Yes ☐ No
When or since when?

Mucous in the stool? ☐ Yes ☐ No
When or since when?

Blood in the stool? ☐ Yes ☐ No
When or since when?

Ribbon-like stools? ☐ Yes ☐ No
When or since when?

Black stools? ☐ Yes ☐ No
When or since when?

Do you require the use of strong laxatives or enemas? ☐ Yes ☐ No
When or since when?

Please briefly describe your present medical symptoms and anything else we should know about your health.

ASSOCIATES IN INTERNAL MEDICINE P.A.

ATIM
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GOAR DE LAMERENS, M.D.

Please list **ALL** the medications you are taking and the dose, **OR** bring all the medications in their **original bottles** to your appointment.

Medication:	**Dosage:**	**Frequency:**

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GOAR DE LAMERENS, M.D.

Request for Records

Patient Name: ___________________________________

Date of Birth: ___________________________________

SSN: ___________________________________

Request information from:

Dr's Name: ___________________________________

Address: ___________________________________

____

Phone: ___________________________________

Fax: ___________________________________

Please release all medical records you have obtained for the past year to:
Associates in Internal Medicine, PA
Dr. Goar de Lamerens, M.D.

To the above circled address

Signature of Patient or Guardian ______________________ **Date** ____________

I certify that this information is made freely, voluntarily, and without coercion. I understand that the information to be released may include information regarding drug abuse, alcohol abuse, HIV infection, AIDS or AIDS related conditions, physiological, psychiatric or physical impairments. I understand that the information to be released is protected under State and Federal laws and cannot be disclosed without my further written consent unless otherwise provided for by State and Federal law. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

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GOAR DE LAMERENS, M.D.

Your Right to Medical Information Confidentiality

HIPAA is an acronym that stands for Health Insurance Portability and Accountability Act that was made into law in 1996. By law, if you are 18 years or older, you have the right to strict confidentiality regarding your visits to *Associates in Internal Medicine*. In order to release any information including the date or nature of your visit, *Associates in Internal Medicine* has to have **your signed consent and specific directions about what information you are consenting to be released**. Without written consent, *Associates in Internal Medicine* cannot release or discuss any information about your visit with anyone including your spouse, parents or other medical professionals, who are not directly involved in your health care.

Patient Name: ____

Date of Birth: ______________________ **Date:** ______________________

I have read and understand my right to confidentiality. I give my permission to *Associates in Internal Medicine* to discuss medical information about me with the following instructions: **(List anything that you specifically do NOT want us to discuss or state "Okay to discuss all" if it is okay to discuss any of your medical information.)**

____

____

With the following people listed only:

______________________________ **Relationship:** ____________________

______________________________ **Relationship:** ____________________

______________________________ **Relationship:** ____________________

Signature: ______________________________ **Date:** ________________

AIIM Staff: ______________________________ **Date:** ________________

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GOAR DE LAMERENS, M.D.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. ***The privacy of your health information is important to us.***

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain in the privacy of your health information. We are also required to give you this Notice about our privacy practices and our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notices takes effect and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of our health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures per permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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GOAR DE LAMERENS, M.D.

Privacy Policy Questions and Concerns

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict their use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of the Notice. You also may submit a written complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: ____

Officer: ____

Telephone: (__________)________________________ **Fax:** (__________)__________________________

Email: ____

Address: ____

I understand that it may take a minimum of 3 business days for Associates In Internal Medicine, P.A. to refill my medication requests.

Signature:________________ Date:_________

I,___________________________, understand it is my responsibility to provide Associates in Internal Medicine, P.A. of present and/or changes of insurance coverage, preferred providers, referrals, laboratory company, and/or imaging company, as well as address and telephone.

Name (print):___________________________

Signature:______________________________

Date:____________________