Medicine for Adults

1862 Mayo Drive - Tavares FL 32778
Ph 352 3430053 Fx 352 3430059

Carlos F. Chang, M.D.

Diplomate of the American Board of Internal Medicine
Board Certified in Geriatric Medicine

Welcome to our practice

Patient Demographic Sheet

Please Print **Date** _____

Name _____ **Date of Birth** _____
(Last) (First) (MI)

Marital Status ☐Married ☐Single ☐Divorced ☐Widowed **SSN** _____

Address _____
(Street) (City) (ST) (Zip)

Home Phone _____ **Cell Phone** _____ **Work** _____

☐ Yes, you may leave a message on my answering machine or cell phone confirming appointments or other information.

E-mail _____

Preferred Pharmacy: ☐**Local** _____ ☐**Mail In** _____

Patient's Employer _____ **Occupation** _____

Person responsible for bill _____ **Relationship** _____

Address _____
(Street) (City) (ST) (Zip)

Referred by _____

INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insured Name:		**Insured Name:**	
DOB:	**Medicare #**	**DOB:**	**Medicare #**
Insurance		**Insurance:**	
ID#:	**Group:**	**ID#:**	**Group:**
Address:			

Reason for Visit _____

Authorization to Release Information and to Pay Benefits

I hereby authorize any physician who has treated or attended me or my dependent to furnish any medical information requested. In consideration of services rendered, I hereby transfer and assign to Dr. Carlos Chang, who has treated me or my dependent, any benefits of insurance that I may have. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature _____ ***Date*** _____

NAME: **DOB:**

Medicine for Adults

1862 Mayo Drive - Tavares FL 32778
Ph 352 3430053 Fx 352 3430059

Carlos F. Chang, M.D.

Diplomate of the American Board of Internal Medicine
Board Certified in Geriatric Medicine

PAYMENT AGREEMENT AND FINANCIAL POLICY – *please read*

Upon check-in, we will collect your deductible, co-pay, uncovered services, or percent of your responsibility. Please be prepared to pay before you are seen by the doctor.

Please be thorough with your insurance information if you expect us to file for you. Bring your card with you and a driver's license without these we will be unable to see you!

CANCELLATION AND NO SHOW FEES/NOTICE: Failure to cancel an appointment within 24 hours will result in a $50.00 no show fee that will be charged directly to you.

FOR PATIENTS WITH INSURANCE: As a courtesy, we will file your insurance. We will bill contracted insurance carriers if proper and correct information is provided. As some time limits are dictated to us, insurance information must fill out corrected initially. If incorrect information is provided, then the patient will be responsible for payment in full. It is your responsibility to make sure we receive prompt payment from them. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying as they should. Any Copayments, Coinsurance, and/or deductibles are due at the time of service.

TO ALL MEDICARE PATIENTS: We will continue to participate as Medicare providers. We will bill Medicare as well as secondary insurance, but if payment is not received from your secondary insurance within 45 days you will be notified and must pay our office the balance due. You must then contact your secondary insurance to pay you for the balance you paid our office. If no secondary insurance information is provided, patients will be responsible for 20% of the Medicare allowable charge at the time of service. Any Copayments, Coinsurance, and/or deductibles are due at the time of service.

BALANCES: All due balances should be paid prior to your next appointment. Accounts that have balances more than 90 days past due may possibly be turned over to a collection agency unless previous arrangements have been made.

COLLECTION PROCEDURES: Collection procedures are started after 3 invoices have been sent to the address in file and personal contact has been attempted. It is requested that you keep your information updated should there be any changes in addresses. In the unfortunate event your account should be sent to collection and you wish to return to the practice (subject to practice discretion), a surcharge of 50% will be added to balance administrative fees.

If your insurance denies payment on your account you will be asked to pay by check, cash, or charge. If you do not pay in a timely fashion, your account may be subject to a monthly finance charge and turned over to collections. If you do not agree with the denial it is your responsibility to pay services and take it up with your insurance.

SELF PAY PATIENTS: This category includes those people with no insurance and patients who have an indemnity plan and wish to file their own insurance. Payment for medical services is expected on the day the services are rendered. We accept Visa, MasterCard, checks, and money orders. If you will not be able to pay for our services in full, you must contact the office to make a payment agreement before coming to see the doctor.

If your insurance is out of state (except PPO insurance), you must pay for your visit at the time of service. 95% of out of state insurance companies pay the patient and will not pay us directly (even if they tell you they will).

_____ _____

Print Patient Name Print Name of Guarantor (if different from Patient Name)

_____ _____

Signature Patient/Guarantor Date

NAME: **DOB:**

Medicine for Adults

1862 Mayo Drive - Tavares FL 32778
Ph 352 3430053 Fx 352 3430059

Carlos F. Chang, M.D.

Diplomate of the American Board of Internal Medicine
Board Certified in Geriatric Medicine

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name _____ **Date of Birth** _____

Previous Name _____ **SSN:** _____

I hereby request and authorize the release of medical information to Dr. Carlos F. Chang, MD, for purposes of review and examination and further authorize you to provide such records thereof as may be requested. The foregoing is subject to such limitation as listed below:

☐ Entire Record ☐ Old record from previous physician ☐ Specific information_____

Source of information: _____

_____

_____

I give special permission to release any information regarding:

☐ Substance Abuse ☐ HIV/ STD information ☐ Psychiatric/ mental information

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES UPON PRESENTATION OF WRITTEN REQUEST.

NAME: **DOB:**

Medicine for Adults

1862 Mayo Drive - Tavares FL 32778
Ph 352 3430053 Fx 352 3430059

Carlos F. Chang, M.D.

Diplomate of the American Board of Internal Medicine
Board Certified in Geriatric Medicine

AUTHORIZATION FOR DISCLOSURE OF IDENTIFIABLE HEALTH INFORMATION

Purpose: This form is used to confirm the direction of an individual that Carlos F. Chang, MD.'s practice uses to disclose protected health information for a particular or general purpose. I understand that the information I authorize a person or entity to receive maybe re-disclosed and no longer protected by federal privacy regulations.

SECTION A: The Individual confirming the authorization: ☐**Self** ☐**Individual's Representative**

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Please list persons/ organizations authorized to receive the information:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

If limits are placed on the extent information is to be disclosed, please specify above.

SIGNATURES(place initials on lines and sign below)

_____ I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

_____ I understand that I may revoke this authorization at any time by notifying Carlos F. Chang, MD., in writing, except to the extent that action has already been taken in reliance on this authorization.

_____ I acknowledge that I have received Carlos F. Chang, MD., PA. Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Notice of Privacy Practices.

_____ I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment.

_____ Unless otherwise revoked, this authorization will expire on the event of departure from the practice.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

NAME: **DOB:**

Medicine for Adults

1862 Mayo Drive - Tavares FL 32778
Ph 352 3430053 Fx 352 3430059

Carlos F. Chang, M.D.

Diplomate of the American Board of Internal Medicine
Board Certified in Geriatric Medicine

HEALTH MAINTENANCE INFORMATION

Last Physical Exam	_____	Prostate exam	_____
Last blood test	_____	Colonoscopy	_____
EKG	_____	Pneumonia shot	_____
Chest X-ray	_____	Prevnar shot	_____
PAP/ pelvic exam	_____	Flu shot	_____
Mammogram	_____	Tetanus shot	_____
Bone density/ DEXA	_____	Shingles vaccine	_____

PERSONAL MEDICAL HISTORY

Arthritis	☐Yes	☐No	Asthma	☐Yes	☐No	Atrial fibrillation	☐Yes	☐No
COPD	☐Yes	☐No	Carotid ds	☐Yes	☐No	Circulation ds	☐Yes	☐No
Coronary ds	☐Yes	☐No	Diabetes	☐Yes	☐No	High blood pressure	☐Yes	☐No
Fibromyalgia	☐Yes	☐No	Hypothyroid	☐Yes	☐No	Hyperthyroidism	☐Yes	☐No
Sleep apnea	☐Yes	☐No	Stomach ulcer	☐Yes	☐No	Valve Heart ds	☐Yes	☐No
Stroke/ TIA	☐Yes	☐No	Reflux ds	☐Yes	☐No	Depression	☐Yes	☐No
Seizures	☐Yes	☐No	Kidney ds	☐Yes	☐No	Anxiety	☐Yes	☐No
High lipids	☐Yes	☐No	Prostate ds	☐Yes	☐No	Low back pain	☐Yes	☐No
Rheumatism	☐Yes	☐No	Schizophrenia	☐Yes	☐No	HIV	☐Yes	☐No
Cancer	☐Yes	☐No	_____					

Other conditions_____

_____

_____

NAME: **DOB:**

Medicine for Adults

1862 Mayo Drive - Tavares FL 32778
Ph 352 3430053 Fx 352 3430059

Carlos F. Chang, M.D.

Diplomate of the American Board of Internal Medicine
Board Certified in Geriatric Medicine

PAST SURGICAL HISTORY (please list all surgeries and dates)

Year/Procedure

_____

_____

_____

_____

Year/Procedure

_____

_____

_____

_____

MEDICATIONS LIST

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY

Marital Status ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed Children? _____

Occupation _____ Retired ☐Yes ☐No

Tobacco Smoking ☐Never ☐Quit _____ ☐Active _____ Chewing ☐Yes ☐No

Alcohol use ☐None ☐Binge drinking ☐1-2 drinks a day ☐3 or more drinks a day

Advanced Directives: Living Will ☐Yes ☐No Health Care Surrogate ☐Yes ☐No POA ☐Yes ☐No

FAMILY HISTORY

Grandparents _____ ☐None

Mother _____ ☐None

Father _____ ☐None

Sisters _____ ☐None

Brothers _____ ☐None

NAME: **DOB:**

Medicine for Adults

1862 Mayo Drive - Tavares FL 32778
Ph 352 3430053 Fx 352 3430059

Carlos F. Chang, M.D.

Diplomate of the American Board of Internal Medicine
Board Certified in Geriatric Medicine

REVIEW OF SYSTEMS

Fever	No	Yes	Vomiting	No	Yes	Anxiety/Panic attacks	No	Yes
Chills	No	Yes	Frequent indigestion	No	Yes	Crying	No	Yes
Malaise	No	Yes	Belching	No	Yes	Sadness	No	Yes
Fatigue	No	Yes	Heartburn	No	Yes	Bad mood swings	No	Yes
Weight loss	No	Yes	Acid reflux	No	Yes	Lack of enjoyment	No	Yes
Weight gain	No	Yes	Constipation	No	Yes	Pessimism	No	Yes
↓ Appetite	No	Yes	Diarrhea	No	Yes	Hallucinations	No	Yes
↑ Appetite	No	Yes	Vomiting blood	No	Yes	Hyperactivity	No	Yes
Insomnia	No	Yes	Black stools	No	Yes			
Fluid retention	No	Yes	Passing blood	No	Yes	Bleeding problems	No	Yes
Cold intolerance	No	Yes	Stool incontinence	No	Yes	Swollen nodes	No	Yes
Sweats	No	Yes	Hemorrhoids	No	Yes	Anemia (low blood)	No	Yes
			Rectal pain	No	Yes	Frequent infections	No	Yes
Blurred vision	No	Yes				Varicose veins	No	Yes
Cataracts	No	Yes	Painful urination	No	Yes			
Eyelid itching	No	Yes	Blood in urine	No	Yes	Skin rashes	No	Yes
Floaters	No	Yes	Frequent urination	No	Yes	Skin itching	No	Yes
Double vision	No	Yes	Urinary urgency	No	Yes	Changing moles	No	Yes
			Incomplete voiding	No	Yes	Skin sores	No	Yes
Nasal congestion	No	Yes	Excessive night			Nail/Hair problems	No	Yes
Runny nose	No	Yes	urination	No	Yes			
Nasal itching	No	Yes	Urinary incontinence	No	Yes			
Nose bleeds	No	Yes				Allergies		
Postnasal drip	No	Yes	Joint pains	No	Yes	Allergy to Penicillin	No	Yes
Sore throat	No	Yes	Joint swelling	No	Yes	Allergy to Sulfas	No	Yes
Ear ringing	No	Yes	Body aches	No	Yes	Allergy to Aspirin	No	Yes
Hearing loss	No	Yes	Chronic back pain	No	Yes	Allergy to Opiates	No	Yes
Ear pain	No	Yes	Weakness	No	Yes	Other allergies	No	Yes
Clogged ears	No	Yes	Muscle pain	No	Yes			
Ear discharge	No	Yes	Tender points	No	Yes	Females Only		
			Leg edema	No	Yes	Vaginal disch/itching	No	Yes
Cough	No	Yes	Leg cramps	No	Yes	Pelvic pain	No	Yes
Wheezing	No	Yes	Chronic neck pain	No	Yes	Abnormal menses	No	Yes
Short of breath	No	Yes	Gait instability	No	Yes	Hot flushes	No	Yes
Coughing blood	No	Yes				Profuse sweats	No	Yes
Painful breathing	No	Yes	Frequent headaches	No	Yes	Decreased sex drive	No	Yes
Stridor	No	Yes	Numbness/ tingling	No	Yes	Breast pain	No	Yes
			Neuropathy	No	Yes	Breast lump	No	Yes
Chest pain/angina	No	Yes	Muscle weakness	No	Yes	Nipple discharge	No	Yes
Breathless with activ.	No	Yes	Convulsion/seizures	No	Yes	Hormonal therapy	No	Yes
Palpitations	No	Yes	Mental state change	No	Yes			
Profuse sweating	No	Yes	Dizziness	No	Yes	Males Only		
Can't lay flat	No	Yes	Vertigo	No	Yes	Difficulty start stream	No	Yes
Wake up gasping	No	Yes	Memory problems	No	Yes	Slow urination	No	Yes
Swelling of feet	No	Yes	Abnormal gait	No	Yes	Testicular masses	No	Yes
Passing out	No	Yes	Tremors	No	Yes	Decreased sex drive	No	Yes
			Fainting spells	No	Yes	Problem erections	No	Yes
Abdominal pain	No	Yes						
Nausea	No	Yes	Depression	No	Yes			

NAME: **DOB:**