

WELCOME

NILE R. LESTRANGE, M.D.
1600 South Federal Highway, Tenth Floor
Pompano Beach, FL 33062
Telephone: (954) 788-9000 Fax: (954) 788-9307

TODAY'S DATE: _____

PATIENT INFORMATION All information is kept strictly confidential.

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

HOME PHONE #: _____ CELL PHONE #: _____ WORK PHONE #: _____

SOCIAL SECURITY #: _____ - _____ - _____ DATE OF BIRTH: _____ AGE: _____

SEX: (circle) **MALE** **FEMALE**

MARITAL STATUS: (circle) **MARRIED** **DIVORCED** **SINGLE** **WIDOWED** **MINOR**

EMPLOYER/SCHOOL: _____ OCCUPATION/LEVEL: _____

EMERGENCY CONTACT: _____
(Name) (Phone) (Relationship)

Whom may we thank for referring you to our office? _____

ACCOUNT COVERAGE AND PAYMENT Complete one section only.

INSURANCE COVERAGE:

Primary Insurance Company: _____ ID #: _____ Group #: _____

Is policy in your name? **YES** **NO** If NO, Subscriber's Name: _____ Date of Birth: _____

Secondary Insurance Company: _____ ID #: _____ Group #: _____

MOTOR VEHICLE ACCIDENT/SLIP & FALL:

Insurance Carrier: _____ Policy #: _____ Phone #: _____

Name of Insured: _____

Attorney Name: _____ Phone #: _____ Fax #: _____

Date of Accident: _____ Claim #: _____

WORKERS' COMPENSATION COVERAGE:

Insurance Carrier: _____ ID #: _____ Group #: _____

Adjuster Name: _____ Adjuster Phone #: _____ Ext: _____

Date of Accident: _____ Claim #: _____

FAMILY HISTORY

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
DECEASED	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
CHILDREN	# ALIVE	AGES & HEALTH	# DECEASED	CAUSE OF DEATH		

SIGNATURE

To the best of my knowledge, the above information is complete and correct.

Signature of Patient, Parent, Guardian or Personal Representative

Date

PERSONAL HEALTH INFORMATION All information is kept strictly confidential.

AGE: _____ HEIGHT: _____ WEIGHT: _____ Referring Doctor: _____
(Name) (Phone #)

Pain/Concerns today: _____

Circle any symptoms you currently have or have had in the past:

WOMEN only – Are you pregnant? **YES NO**

GENERAL

Change in weight
Exposure to MRSA
Recent Illness
Decrease in exercise tolerance
Chills
Fever
Forgetfulness

ENDOCRINE/GLANDS

Heat intolerance
Cold intolerance
Diabetes
Excessive thirst
Frequent urination
Thyroid problems
Excessive sweating

HEAD, EYE, EAR, NOSE, THROAT

Change in vision
Change in hearing
Ringing in ears
Recent upper respiratory infections
Headaches
Dizziness
Lightheadedness
Double vision
Blind spots
Masses in the neck
Nosebleeds

RESPIRATORY

Difficulty breathing
Shortness of breath
Coughing up blood
Wheezing/Asthma
Tuberculosis
Night sweats
COPD
Emphysema
Lung Cancer
Persistent cough

DIGESTIVE

Abdominal pain
Constipation
Vomiting
Bloating
Diarrhea
Acid reflux
Difficulty swallowing
Change in appetite
Gastritis
Ulcers
Change in bowel habits

NERVOUS SYSTEM

Loss of consciousness
Seizures
Blackouts
Numbness/Tingling
Radiating pain
Change in speech
Change in coordination
Loss of muscle tone
Tremors
Paralysis
Shooting pain
Burning pain
Stroke or TIA

BLOOD/LYMPH

Anemia
Bleeding disorders
Previous transfusions
Rh incompatibility
Lymph node enlargement
Lymph node tenderness

CARDIOVASCULAR

Chest pain
Palpitations
Murmur
Abnormal rate/rhythm
High blood pressure
High cholesterol
Heart Disease
History of Aneurysm

GENITO-URINARY

Excessive urination
Frequent urination
Urgency while urinating
Painful urination
Blood in urine
Kidney stones
Sexually Transmitted Disease
Renal issues
Bladder issues

MUSCULOSKELETAL

Broken bones
Muscle weakness
Sprains
Strains
Other injuries

EMOTIONAL STATUS

Mood changes
Depression
Change in memory
Anxiety
Tension
Bipolar disorder

List all surgeries you have had: _____

Circle any conditions you have or have had in the past:

AIDS/HIV Cancer Gallbladder Disease Kidney Disease Stroke/TIA
Alcohol Dependency Cataracts Glaucoma Liver Disease STD
Appendicitis Chemical Dependency Gout Multiple Sclerosis Thyroid Disease
Arthritis Diabetes Heart Disease Osteoporosis Ulcers
Bleeding Disorder Epilepsy/Seizures Hepatitis Pneumonia Varicose Veins
Broken Bones Other serious illnesses: _____

Check illnesses which have occurred in any of your **BLOOD RELATIVES**:

- Diabetes Cancer Bleeding Disorder High Cholesterol
- Heart Disease Stroke High Blood Pressure Psychiatric Illness
- Other serious illnesses: _____

MEDICATIONS/ALLERGIES

List medications you are currently taking: _____

List allergies to medications or substances: _____

HEALTH HABITS

Do you use? How much?
Tobacco _____
Alcohol _____
Illicit Drugs _____

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Printed Name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

NILE R. LESTRANGE, M.D.
1600 South Federal Highway, Tenth Floor
Pompano Beach, Florida 33062
Telephone: (954) 788-9000 Fax: (954) 788-9307

CONSENT FOR TREATMENT

I, the undersigned, voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician.

The undersigned patient and guarantor, if any, hereby agree to pay all charges from Dr. Nile R. Lestrangle to Dr. Nile R. Lestrangle in accordance with the regular rates and terms of Dr. Nile R. Lestrangle and agree to pay for any charges not covered by any third party payer. Dr. Nile R. Lestrangle files insurance as a courtesy to the patient, but the patient is ultimately responsible for payment of the total incurred charges. The undersigned agree that if this account is turned over to a collection agency or attorney, that the undersigned patient and guarantor, if any, shall be obligated to pay the outstanding balance plus all costs of collection including reasonable attorney fees. The undersigned agree that any overpayments collected on this account may be applied to any delinquent account for which the undersigned patient is legally responsible. The undersigned patient and guarantor, if any, hereby agree that they are jointly and severally liable to pay the entire balance due and that Dr. Nile R. Lestrangle is relying upon the undersigned(s) promise to pay in treating the patient.

RELEASE OF MEDICAL RECORDS AUTHORIZATION

I, the undersigned, hereby authorize and request the release of my medical records to:

DR. NILE R. LESTRANGE
1600 SOUTH FEDERAL HIGHWAY, TENTH FLOOR, POMPANO BEACH, FLORIDA 33062

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Dr. Nile R. Lestrangle and assign to him any and all rights and benefits that I or the patient may have under any policy of insurance including Medical, Automobile, Personal Injury Protection, Workers' Compensation, or any other coverage and further direct any such insurance company to make payment of benefits directly to Dr. Nile R. Lestrangle. I understand I am financially responsible to Dr. Nile R. Lestrangle for charges not covered by this assignment.

SIGNATURE AUTHORIZATION

I hereby authorize Dr. Nile R. Lestrangle to furnish to my insurance company of their representative, or Social Security Administration or the Center for Medicare and Medicaid, or Medigap or its intermediaries or to the billing agent of Dr. Nile R. Lestrangle any information needed for this claim or related claims. I permit a copy of this authorization to be used in place of the original.

HIPAA INFORMATION AND CONSENT FORM

I request the following restrictions to use or disclosure of my health information: _____

My signature signifies consent and acknowledgement to the terms in the HIPAA Information and Consent Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

NOTICE OF PRIVACY PRACTICES

I have been provided information regarding the privacy practices used by Dr. Nile R. Lestrangle.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Printed Name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

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INFORMATION ACCURACY

I, the undersigned, acknowledge that any attempt to defraud, deceive and or mislead this office will result in their medial bill being solely his/her responsibility; furthermore any paperwork containing false or incomplete information will result in the same. The undersigned affirms that all information is true and his/her injuries are not in any way related to a motor vehicle accident, slip and fall accident, product liability accident, or anything other than indicated on my initial intake forms.

Signature of Patient

Date

ACKNOWLEDGEMENT OF NON-COVERED SERVICES

I, the undersigned, am aware that _____ is potentially a non-covered service by my insurance company. I have been given the option to receive a prescription to obtain this supply at an approved durable medical supply company and I have opted to receive this supply in this office and pay for the supply or service myself. I fully understand that my insurance company will not reimburse me for the supply or service rendered.

Signature of Patient

Date

Signature of the Physician

Date