



CONSENT TO RELEASE MEDICAL, PSYCHIATRIC, AIDS/ARC/HIV TESTING, ALCOHOL OR DRUG ABUSE PATIENT RECORDS

1. I hereby authorize my physician at Holy Cross Medical Group:

- To RELEASE copies of my medical records to:
To RECEIVE copies of my medical records from:

2. I understand that my records may contain information pertaining to my diagnosis or treatment of my medical, psychiatric, AIDS/ARC/HIV testing, alcohol or drug abuse condition. I also understand that any topic discussed during my medical treatment was documented, and therefore, will be released:

Signature Date

3. Information to be released/requested: (please circle)

OFFICE NOTES LAB X-RAYS EKG HOLTER ECHO
D/C SUMMARY OP NOTE H&P BILLING INFO DX ALL

Date of service(s):

4. I understand that this release can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. To revoke this consent, written notice must be given.

5. This consent expires in 90 days.

6. Holy Cross Medical Group is released from any legal responsibility of liability; for the release of the above information to the extent indicated and authorized herein.

Signed: Date:

Print Patient Name: Witness:

Patient SS#: Date of Birth:

Patient Address:

Print name of person signing for the patient and their relationship to the patient:

Name: Date:

Please send requested information to:

Phone #: (954) Fax #: (954)



PATIENT INFORMATION RECORD

Age: _____

Allergies: _____

Patient's Legal Name: _____ Today's Date: _____
First M.I. Last

Address: _____
Street City State Zip

Phone #'s - Daytime: _____ Evening: _____ Emergency: _____ Cell: _____

Where do you prefer to receive calls?: Home Number Work Number Cell Number In Writing
 OK leave message with detailed info Leave message with call-back number only

Patient's Date of Birth: _____ Sex: Male Female

Marital Status: Single Married Widowed Divorced Partner Religion: _____ Primary Language: _____

Ethnicity: _____ Race: _____

Social Security No.: _____ - _____ - _____ Referred By: _____

Email Address: _____

Responsible Party: _____ Telephone: (____)-_____
First M.I. Last

Address: _____
Street City State Zip

Responsible Party Social Security No.: _____ - _____ - _____ Date of Birth: _____

Employer: _____ Telephone: (____)-_____

Address: _____
Street City State Zip

Next of Kin: _____ Relationship: _____ Telephone: Res:(____)-_____ Work:(____)-_____

I. INSURANCE INFORMATION:

Is Your Insurance a: PPO HMO Medicare Medicaid Other: _____

II. IS PATIENT'S CONDITION RELATED TO:

Employment (Current or Previous): Yes No Auto Accident: Yes No Other Accident: Yes No

PRIMARY	INSURANCE COMPANY NAME: _____
	Address: _____ Street City State Zip
	Group Number: _____ Medicare/Policy Number: _____
	Name of Insured: _____ Insured's Date of Birth: _____
	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Student over 18 Other (Please describe): _____
SECONDARY	INSURANCE COMPANY NAME: _____
	Address: _____ Street City State Zip
	Group Number: _____ Medicare/Policy Number: _____
	Name of Insured: _____ Insured's Date of Birth: _____
	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Student over 18 Other (Please describe): _____

**** FOR OFFICE USE ONLY ****

Identification Presented: Passport Driver's License State I.D. Insurance Card

➔ **TURN OVER AND COMPLETE** FORM #0828 Front Rev-16 10/22/2014 HCH Printing Services



MEDICARE AND MEDICAID SIGNATURE AUTHORIZATION

Medicare and Medicaid patient certification - patient certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII and/or TITLE XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services. I request that this authorization apply to all claims, present and future. I understand that I am responsible for my health insurance deductible and coinsurance. I authorize the Hospital and all of its employees, independent contractors, business associates, agents and/or affiliates of same (collectively "Hospital") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods or otherwise even if I am charged for the call. I expressly consent to such automated calls and with such consent, I specifically waive any objection or claim I may have against the Hospital, for making such calls, including any claim under the Telephone Consumer Protection Act and any similar law and regulations as amended. This consent may not be orally revoked or modified but may be withdrawn at any time in writing.v

Date: _____

Print Patient's/Beneficiary's Name: _____

Patient's/Beneficiary's Signature: _____

**COMMERCIAL INSURANCE, MANAGED CARE MEMBERS
AND SECONDARY PAYOR AUTHORIZATION**

I authorize the release of any medical information necessary to process my insurance claim(s). I request that the payment authorized be made on my behalf. I assign the benefits payable for physician services to the HOLY CROSS MEDICAL GROUP / HOLY CROSS HOSPITAL. I request that this authorization apply to all insurance claims, present and future. I understand that I am responsible for payment of any balance not paid by my insurance company. I authorize the Hospital and all of its employees, independent contractors, business associates, agents and/or affiliates of same (collectively "Hospital") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods or otherwise even if I am charged for the call. I expressly consent to such automated calls and with such consent, I specifically waive any objection or claim I may have against the Hospital, for making such calls, including any claim under the Telephone Consumer Protection Act and any similar law and regulations as amended. This consent may not be orally revoked or modified but may be withdrawn at any time in writing.

Date: _____

Print Patient's/Insured's Name (Parent's Signature if child): _____

Signature of Insured: _____

Patient's/Insured's Signature: _____



PATIENT ACKNOWLEDGEMENT

I have been given a copy of the Holy Cross Hospital, Inc. Notice of Privacy Practices, version effective September 23, 2013.

Signature of Patient or Representative: _____ Date: _____

Print Name of Patient or Representative: _____

Relationship of Representative to Patient: _____

Test Results may be left on my answering machine: YES NO

When calling my phone, results can also be left with – Name: _____

IN EMERGENCY SITUATIONS ONLY:

PLEASE CHECK ONE BOX:

DO NOT RELEASE ANY OF MY MEDICAL INFORMATION TO A FAMILY MEMBER OR FRIEND

PLEASE RELEASE MY MEDICAL INFORMATION IF NEEDED TO:

Relationship: _____ Phone: _____

FOR HOLY CROSS HOSPITAL, INC. USE ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the Patient or the Patient’s Representative, please explain your efforts to obtain their acknowledgement and the reason you could not obtain it: _____

Patient's Name: _____ **Date:** _____

It is helpful to gather information about your medical history for the physician to use in your examination. Please complete this form completely for the physician's review.

1. CONSTITUTIONAL SYMPTOMS

- Good general health lately No Yes
- Recent weight change..... No Yes
- Fever..... No Yes
- Fatigue..... No Yes
- Headaches..... No Yes

2. INTEGUMENTARY (Skin, Breast)

- Rash or itching No Yes
- Change in skin color..... No Yes
- Change in hair or nails..... No Yes
- Varicose veins..... No Yes
- Breast pain..... No Yes
- Breast lump..... No Yes
- Breast discharge..... No Yes

3. NEUROLOGICAL

- Frequent or recurring headaches No Yes
- Lightheaded or dizzy No Yes
- Convulsions or seizures No Yes
- Numbness or tingling sensations No Yes
- Tremors..... No Yes
- Paralysis No Yes
- Stroke..... No Yes
- Head injury..... No Yes

4. HEMATOLOGIC / LYMPHATIC

- Slow to heal after cuts..... No Yes
- Bleeding or bruising tendency No Yes
- Anemia..... No Yes
- Phlebitis..... No Yes
- Past transfusion No Yes
- Enlarged glands..... No Yes

5. PSYCHIATRIC

- Memory loss or confusion No Yes
- Nervousness No Yes
- Depression..... No Yes
- Insomnia No Yes

6. ENDOCRINE

- Glandular or hormone problem No Yes
- Thyroid disease No Yes
- Diabetes No Yes
(Insulin or Non-Insulin – Circle one)
- Excessive thirst or urination..... No Yes
- Heat or cold intolerance No Yes
- Skin becoming dryer No Yes
- Change in hat or glove size No Yes

7. EYES, EARS, NOSE MOUTH

- Hearing loss or ringing No Yes
- Earaches or drainage..... No Yes
- Chronic sinus problem or rhinitis No Yes
- Nose bleeds No Yes
- Mouth sores No Yes
- Bleeding gums No Yes
- Sore throat or voice change No Yes
- Swollen glands in neck..... No Yes

8. CARDIOVASCULAR

- Heart trouble..... No Yes
- Chest pain or angina pectoris No Yes
- Palpitation No Yes
- Shortness of breath with walking No Yes
- Swelling of feet, ankles or hands No Yes

9. RESPIRATORY

- Chronic or frequent coughs No Yes
- Spitting up blood..... No Yes
- Shortness of breath No Yes
- Asthma or wheezing No Yes

10. MUSCULOSKELETAL

- Joint pain No Yes
- Joint stiffness or swelling..... No Yes
- Weakness of muscles or joints No Yes
- Muscle pain or cramps..... No Yes
- Back pain No Yes
- Cold extremities..... No Yes
- Difficulty in walking..... No Yes
- Use ambulatory assistive device Walker Cane
..... Crutches Wheelchair
..... Prosthetic Limb Hold person's arm
- Sports injury No Yes

11. GASTROINTESTINAL

- Loss of appetite..... No Yes
- Change in bowel movements..... No Yes
- Nausea or vomiting No Yes
- Frequent diarrhea No Yes
- Constipation No Yes
- Rectal bleeding or blood in stool No Yes
- Abdominal pain No Yes
- Peptic ulcer (stomach or duodenal)..... No Yes

ALLERGIC / IMMUNOLOGIC

- History of reaction to:
Medication..... No Yes
List: _____
- Other No Yes
List: _____



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PATIENT NAME: _____

DATE: _____

Cell Phone Number: _____

Email Address: _____

PRIMARY CARE PHYSICIAN:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP : _____

PHONE: _____

FAX: _____

OTHER PHYSICIAN:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP : _____

PHONE: _____

FAX: _____

PHARMACY:

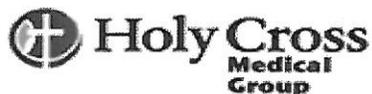
NAME: _____

ADDRESS: _____

CITY/STATE/ZIP : _____

PHONE: _____

FAX: _____



Date: _____ Patient Name _____ DOB _____

Holy Cross Hospital is now collecting information from patients during their office visit as part of the Meaningful Use healthcare initiatives put in place by the Federal Government. Listed below is the information that we are gathering to comply with the new program. If you would please take a moment to answer the following questions then hand this paper back to the front desk.

We thank you in advance for your time.

Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity

This classification provides a minimum standard for maintaining, collecting and presenting data on race and ethnicity for all Federal reporting purposes. The categories in this classification are social political constructs and should not be interpreted as being scientific or anthropological in nature. They are not to be used as determinants of eligibility for participation in any Federal program. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity by Federal agencies. (<http://www.whitehouse.gov/omb/inforeg/statpolicy/#dr>).

1. Which of the following do you consider yourself?

___ Hispanic or Latino ___ Not Hispanic or Non-Latino ___ Decline ___ Unknown ___ Other

2. Which category best describes your race?

___ Black, African American ___ American Indian, Alaska Native ___ Asian
___ Native Hawaiian, Other Pacific Islander ___ Pacific Islander ___ White
___ Chinese ___ Filipino ___ Hispanic ___ Japanese ___ Other ___ Declined ___ Unknown

3. Which language do you prefer to use to communicate?

___ English ___ French ___ Creole ___ Spanish ___ Russian
___ Portuguese ___ Other

4. What communication method would you prefer the office to use when conveying medical information?

Home Phone ___ - ___ - _____ Cell Phone ___ - ___ - _____
Work Phone ___ - ___ - _____ Postal Service (mailing) ___ PO Box

5. How did you hear about us?

___ Health Screening ___ Insurance Company ___ Ad/TV/Internet
___ Word of mouth ___ another patient ___ Physician referral