Matthew G. Smith, M.D. P.A. & Jennifer Freedman, A.R.N.P.
530 Tyrone Blvd N St. Petersburg FL 33710
P: 727-823-3022 F: 727-343-6775

GENERAL INFORMATION:

______________________ ______________________ ______ ___/___/___
Patient Last Name First Name MI DOB

(______)______________________ (______)______________________
Home # Cell Phone #

____
Home Address City State Zip

SS#: _________ - ________ -__________ Male_/ Female (Please Circle) Single Married Divorced Widowed (Please Circle One)

How did you hear about our practice? ______________________________

Emergency Contact Information:

Name: ______________________ Phone #: ______________________ Relationship:__________________

Insurance Information:

Primary Insurance:______________ Member ID: _______________ Group#:__________ RX Bin:________

Secondary Insurance:________________ ID: ________________

Prescription Insurance: ________________________ ID: ______________

*******PLEASE BRING ALL INSURANCE CARDS TO OFFICE VISIT INCLUDING SECONDARY AND PRESCRIPTION. *******

"I understand that I am financially responsible for all charges, whether or not paid by said insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services.
By signing this form, I give Matthew G. Smith, MDPA consent to perform medical treatment."

Signature: ____ Date: ___________________

Matthew G. Smith, M.D, P.A. & Jennifer Freedman, A.R.N.P.

Last Name: ________________ **First Name:** ____________________

Please list each medication; dosage and how often you take it.

Medication	Dosage	How Often
☐ VITAMIN D		
☐ ASPIRIN		
☐ VITAMIN B 12		
☐ FISH OIL		

Are you allergic to any medications? YES/NO (Please Circle) If Yes, Please List:

MEDICATION	REACTION

Pharmacy: ______________________ **Telephone#:**____________________

Matthew G. Smith, M.D, P.A. & Jennifer Freedman, A.R.N.P.

Last Name: ________________ First Name: ___________________

Patient Medical History:

Please check any of the following illnesses that are applicable to your personal history:

- ☐ AMPUTATION
- ☐ DIABETES
- ☐ KIDNEY DISEASE
- ☐ GOUT
- ☐ THYROID DISEASE
- ☐ HIGH CHOLESTEROL
- ☐ LIVER DISEASE
- ☐ STOMACH ULCERS
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ INCONTINENCE: FECAL/URINE
- ☐ GALL BLADDER DISEASE
- ☐ OSTOMIES
- ☐ CIRRHOSIS
- ☐ COPD
- ☐ EMPHYSEMA
- ☐ ASTHMA
- ☐ CHRONIC PAIN
- ☐ FALLS
- ☐ ARTHRITIS
- ☐ STROKE
- ☐ T.I.A. (MINI STROKE)
- ☐ SEIZURES
- ☐ PARALYSIS
- ☐ MIGRAINES
- ☐ ALCOHOL ABUSE
- ☐ BIPOLAR
- ☐ SCHIZOPHRENIA
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ BLEEDING DISORDER
- ☐ SICKLE CELL ANEMIA
- ☐ ANEMIA
- ☐ CANCER:________
- ☐ LEUKEMIA
- ☐ HIV/AIDS
- ☐ HEPATITIS A,B,C
- ☐ CARDIAC ARRHYTHMIAS
- ☐ ATRIAL FIBRILLATION (AFIB)
- ☐ CONGESTIVE HEART FAILURE (CHF)
- ☐ CORONARY ARTERY DISEASE/CARDIAC STENTS
- ☐ HEART ATTACK
- ☐ HIGH BLOOD PRESSURE
- ☐ VASCULAR DISEASE (ARTERIAL)
- ☐ DVT (CLOTS)
- ☐ VARICOSE VEINS

Personal Habits:

Have you ever smoked? Yes or No Are you currently smoking? Yes or No

How many packs a day? ______ For how many years? ____________

If you quit, how long ago? _______

Do you use or have used chewing tobacco? Yes or No

If yes, how long? _________ When did you quit? _________

Do you drink alcohol? Yes or No If yes, How much and how often:_________________

Have you ever used the following: __Marijuana __LSD __Heroin __Cocaine __ Speed __Crack

Do you exercise? Yes or No If yes, how often? _____________ What type: _______________

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Last Name: _______________ First: _______________
Previous Primary Care Doctor: ____________________

Please list and indicate approximate year of the following:

Operations:

_______________ **Year:** ____ _______________ **Year:** ____

_______________ **Year:** ____ _______________ **Year:** ____

_______________ **Year:** ____ _______________ **Year:** ____

Hospitalization:

Hospital and Approximate Date: **Reason:**

____________________ ____________________

____________________ ____________________

Have you had any of the following immunizations? If yes please indicate month and year:

- ☐ **FLU** ___/____
- ☐ **PNEUMOCOCCAL** ___/____
- ☐ **SHINGLES** ___/____
- ☐ **HEPATITIS** ___/____
- ☐ **TETANUS**____/____

Have you had any of the following screening exams? If yes, please indicate approximate year:

- ☐ **EYE EXAM** _____
- ☐ **COLONOSCOPY** _____
- ☐ **PAP SMEAR** _____
- ☐ **MAMMOGRAM** _____
- ☐ **RECENT MRI OR CT:**____________

Do you see any specialists? If so please list doctor and condition being treated:

DOCTOR	**CONDITION**
Dr.____________________	____________________
Dr.____________________	____________________
Dr.____________________	____________________

Matthew G. Smith, M.D, P.A. & Jennifer Freedman, A.R.N.P.

Last Name: ________________ **First Name:** _____________

Family History:

	CIRCLE SEX	AGE	HEALTH	AGE AT DEATH	CAUSE
FATHER					
MOTHER					
BROTHERS/SISTERS	M F				
	M F				
	M F				
SONS/DAUGHTERS	M F				
	M F				

***CHECK IF ANY BLOOD RELATED RELATIVE HAS OR HAD ANY OF THE FOLLOWING AND RELATIONSHIP TO YOU:**

- ☐ LUNG DISEASE______________
- ☐ MENTAL ILLNESS _____________
- ☐ CANCER ______________
- ☐ STROKE _______________
- ☐ GALL BLADDER DISEASE____________
- ☐ THYROID DISEASE___________
- ☐ DIABETES_____________
- ☐ HYPERTENSION _____________
- ☐ HIGH CHOLESTEROL _____________
- ☐ CLOTTING DISORDER ______________
- ☐ KIDNEY DISEASE___________
- ☐ ALCOHOL OR DRUG ABUSE _________________
- ☐ CORONARY ARTERY DISEASE ________________

Matthew G. Smith, M.D, P.A. & Jennifer Freedman, A.R.N.P

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize the following healthcare provider(s) and its physicians, employees, and agents to release or disclose to **Matthew G. Smith, MD PA** and its representatives all of my medical records including records pertaining to treatment, prognosis and diagnosis, including any specially protected or listed records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection. Please list at least one healthcare provider?

Dr.(s): ______________________________

Telephone #: ____________________ Fax#: ____________________

Address: ______________________________

I further authorize you to provide to and discuss with Matthew g. Smith MD PA and its representatives any confidential information with respect to my medical condition or treatment, wither formally or informally.

Release Medical Records To:
Matthew G. Smith, MD PA
530 Tyrone Blvd N
St. Petersburg, FL 33710
P: 727-823-3022 F: 727-343-6775

Patient's Name: ______________________________
SSN: ______________________________
Date of Birth: ______________________________
Which Records?
All Medical Records, Psychiatric, Psychological diagnosis and treatment Hospital Records Pathology Lab Results Imaging
Purpose of Disclosure: New PCP and/or established patient outside facility record request
I understand that if the organization authorized to receive the information is not a health plan or healthcare provider; the release information may no longer be protected by Federal Privacy Regulations. I understand that I am not required to sign this Authorization to ensure treatment and I mat inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidential rule.

Patient or Authorized Representative's Signature: ____________________

Relationship to Patient: ____________________ **Date:** ____________

Matthew G. Smith, MD PA & Jennifer Freedman, ARNP

Advance Directives

What are advance directives?

"Advance Directive" is a general term that refers to your oral or written instructions about your future medical care in the event you become unable to speak for yourself.

What is a living will?

A living will is a type of advance directive in which you put in writing your wishes about medical treatment should you be unable to communicate your wishes.

What is a medical power of attorney?

A medical power of attorney is a document that lets you appoint someone you trust make decisions about your medical care if cannot make those decisions yourself.

Why do I need an advance directive?

Advance directives give you a voice in decisions about your medical care when you are unconscious or too ill to communicate. As long as you are able to express your own decisions your advance directives will not be used and you can accept or refuse any medical treatment. But if you become seriously ill, you may lose the ability to participate in decisions about your own treatment.

What happens if I don't have an advance directive?

In the event that you cannot speak for yourself, health and medical decisions may be made by someone not of your choosing or by the court.

Once I make an advance directive, can I cancel it?

Yes, your advance directive can be canceled or revoked by you at any time.

Who I should I talk to about an advance directive?

Your Primary Care Physician is the best person to answer your questions. Your doctor has the knowledge and cares about you to put your concerns at ease. All necessary paperwork and information is available at our office. Ask your doctor or see the receptionist.

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In order to comply with Omnius Budget Reconciliation Act (OBRA) of 1990 and Chapter 765 of the Florida Statues, please answer the following questions:

Declaration to Decline Life –Prolonging Procedure (Living Will)

__I have made such a declaration.

__I have **NOT** made such a declaration.

Do Not Resuscitate (DNR)

__ I have a DNR.

__ I **DO NOT** have a DNR.

Health Care Surrogate

__I have designated a Health Care Surrogate.

__I have **NOT** designated a Health Care Surrogate.

Durable Power of Attorney

__I have appointed a Durable Power of Attorney for Health Care decisions.

__I have **NOT** appointed a Durable Power of Attorney for Health Care decisions.

I have been provided information regarding the PATIENT SELF DETERMINATION ACT:

______________________________ _____-____-_____

Please Print Full Name **Social Security Number**

Signature: ______________________________ **Date:**____________

Patient or patient representative

Relationship of Patient Representative (if applicable): _________________