BETHESDA HEALTH
PHYSICIAN GROUP

CHRISTINA A. MICHAEL, M.D.
Cardiovascular Medicine

Patient Contact Information

Patient

Name: ______________________________

Permanent Address: ______________________________

City, State, Zip Code: ______________________________

Social Security Number: ___ - ___ - ___ *Date of Birth:* ___ / ___ / ___

Home Phone: ( ) __________ *Cell Phone:* ( ) __________

Work phone: ( ) __________ *E-mail:* __________

Preferred Contact: Phone __________ *or Email* __________

Race: __________ *Ethnicity:* __________

Religion: __________

Primary Language Spoken: __________ *Secondary Language:* __________

Marital Status: Circle one Single Married Divorced Widowed

Significant Others Name: __________

Do you have a Living Will? Circle one: Yes No (If not, we encourage you to do so)

Do you have a DNR form? Circle one: Yes No

Person authorized to make medical decisions on your behalf including, but not limited to, life prolonging procedures in the event you are medically incapable. (Power of Attorney)

Name: ______________________________

Address: ______________________________

Phone #: ______________________________

Primary Care Physician

Name: __________ Telephone: ( ) __________

Address: ______________________________

______________________________ Fax: ( ) __________

Emergency

In case of Emergency, Please Contact: __________

Telephone: ( ) __________ Cell: ( ) __________

Relationship: __________

Pharmacy Name: __________ Pharmacy Number: __________

Pharmacy Address: ______________________________

How did you hear about us: __________

PATIENT NAME: ____________________

DATE: ____________________

Have you had any recent: *Recientemente, ha tenido*:

Weight gain *aumento de peso*	☐ YES	☐ NO
Fatigue *fatiga*	☐ YES	☐ NO
Night sweats *sudores nocturnos*	☐ YES	☐ NO
Fevers *fiebre*	☐ YES	☐ NO
Chills *Escalofríos*	☐ YES	☐ NO
Weakness *Debilidad*	☐ YES	☐ NO
Seizures *Convulsiones*	☐ YES	☐ NO
Numbness *Entumecimiento*	☐ YES	☐ NO
Trouble walking *Dificultad para caminar*	☐ YES	☐ NO
Falls *Caídas*	☐ YES	☐ NO
Passing-out *Desmayos*	☐ YES	☐ NO
Shortness of breath *Falta de aliento*	☐ YES	☐ NO
Wheezing *Dificultad al respirar*	☐ YES	☐ NO
Cough *Tos*	☐ YES	☐ NO
Coughing up blood *Tos con sangre*	☐ YES	☐ NO
Abdominal pain *Dolor abdominal*	☐ YES	☐ NO
Heartburn *Acidez*	☐ YES	☐ NO
Vomiting *Vómito*	☐ YES	☐ NO
Diarrhea *Diarrea*	☐ YES	☐ NO
Constipation *Estreñimiento*	☐ YES	☐ NO
Change in stool *Cambio en las heces*	☐ YES	☐ NO
Change in bowel frequency *Cambio en la frecuencia de deposiciones*	☐ YES	☐ NO
Painful urination *Dolor al orinar*	☐ YES	☐ NO
Incontinence *Incontenencia*	☐ YES	☐ NO
Blood in urine *Sangre en la orina*	☐ YES	☐ NO
Excessive thirst *Sed excesiva*	☐ YES	☐ NO
Excessive hunger *Hambre excesiva*	☐ YES	☐ NO
Heat or cold intolerance *Intolerancia al Calor o frío*	☐ YES	☐ NO
Mood changes *Cambios de humor*	☐ YES	☐ NO
Depression *Depresión*	☐ YES	☐ NO
Hair loss *Pérdida de cabello*	☐ YES	☐ NO
Skin changes *Cambios en la piel*	☐ YES	☐ NO
Headaches	☐ YES	☐ NO
Dizziness	☐ YES	☐ NO
Pregnancies	☐ YES	☐ NO
If so, diabetes with pregnancy?	☐ YES	☐ NO
High blood pressure with pregnancy?	☐ YES	☐ NO
Any other problems associated with pregnancy?	☐ YES	☐ NO

How many days per week do you exercise? ☐3 ☐5 ☐7
¿Cuántos días a la semana hace usted ejercicio?

How many minutes do you exercise each time? ☐30 ☐45 ☐60
¿Por cuántos minutos hace ejercicio cada vez?

What kind of exercise do you do? ____________________
¿Qué tipo de ejercicio hace?

APPOINTMENT CANCELLATION/ NO SHOW POLICY

Our practice is committed to providing quality health care to our patients. We work diligently to maintain our high level of personalized service and make every effort to accommodate our patients needs for office visits in a timely manner

We understand that emergencies arise as they do for us, however when a patient cancels an appointment without adequate notice or fails to keep an appointment without any notice, we can not use the time to serve the needs of other patients. We respectfully request your understanding to our policy as stated below.

Failure to give 24 hour notice of cancellation or no showing to an appointment will result in a $25 charge. Insurance companies do not cover this fee. It will be billed to your account. You will receive a call the day before to remind you of your appointment.

Please use: 561-244-7720 for your calls. This is the only telephone line that is answered 24 hours a day.

Thank you for your consideration and understanding of our policy.

I have read the cancellation/ no show policy:

________________________________ ______________

Patient Signature Date

BETHESDA HEALTH
PHYSICIAN GROUP

10301 Hagen Ranch Rd., Ste. B5
Boynton Beach, Florida 33437
Telephone: 561-244-7720 Fax: 561-244-7724

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby request that my Medical Records be released from

Physician Name/Clinic:____ Fax ____________________

Address:____

I Hereby Authorize that my Medical Records be released to:

CHRISTINA A. MICHAEL, M.D.
Cardiovascular Medicine

10301 Hagen Ranch Rd. Suite B-5
Boynton Beach, FL 33437
(561) 244-7720 • Fax (561) 244-7724

Information Requested

- For dates of service: From:____________________________ Through:________________________
- Physician notes
- Lab results
- X-ray reports
- Complete record
- Other:____

Purpose for Use or Disclosure of Protected Health Information

- Permanent Transfer
- Referral
- Other: ____

Note: Fee may be assessed for records requested for personal use .

Patient Information

Print Name:_______________________ Date of Birth:______________ SSN#:__________________

ENSITIVE INFORMATION:I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome(AIDS), or infection with the Human Immunodeficiency Virus(HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
REDISCLOSURE: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.
RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I Understand that the revocation will not apply to information already released based on this authorization.
OTHER RIGHTS: 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. I understand that I may inspect or obtain a copy of the information to be used or disclosed.
EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: *(If I do not specify an expiration date, event, or condition, this authorization will expire in twelve (12) months.)*

Signature of patient or legal representative: ______________________________________

If signed by legal representative, relationship to patient: ______________________________

Date:_______________________________