

**Surgical Associates of Central FL, PA**  
**1181 Orange Avenue**  
**Winter Park, FL 32789**  
**407-647-1331**

Today's Date \_\_\_\_\_  
Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Email \_\_\_\_\_

**Please Circle One:**

**Ethnicity:** Hispanic or Latino  
Not Hispanic or Latino

**Race:** White, Native American,  
Black or African American, Asian  
Other: \_\_\_\_\_

**Preferred Language:** English  
Spanish

Other: \_\_\_\_\_

**Smoking Status:**

• Current every day Smoker  
How many per day: \_\_\_\_\_

• Never Smoker

• Former Smoker

**\*PLEASE NOTE: we will use the below to  
communicate to with our patients.**

- Home Phone
- Mobile Phone
- Email via the secure patient portal
- Mailed Letter

**Preferred Pharmacy List: WE NEED THE  
TELEPHONE NUMBER**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

\*Advanced Directive Yes / No

\* Living Will Yes/No

**Consent for Treatment, Payment and  
Healthcare Operations**

I consent to the use or disclosure of my protected health information by Surgical Associates of Central Florida, P.A. (hereafter referred to as Surgical Associates) for the purpose of diagnosing, providing treatment to me, discussing financial issues, obtaining payment for my health care bills or to conduct healthcare operations. I understand that diagnosis or treatment of me by the doctors of Surgical Associates may be rendered based on upon my consent, as evidenced by my signature below.

I \_\_\_\_\_, am also giving Surgical Associates of Central Florida, PA permission to involve the below listed people in my complete medical care. I understand and give my permission to Surgical Associates of Central Florida, PA to discuss testing, treatment, and any results with the below people for the purpose of my medical care and wellbeing.

The Notice of Privacy Practices has been made available to me and I understand that I have the right to review it prior to signing this consent. Surgical Associates reserves the right to modify the Notice of Privacy Practices. Please refer to the Notice of Privacy Practices for additional information regarding your privacy rights.

I also give CONSENT FOR PELVIC EXAMINATION in the event one is needed. [Florida Senate Bill 698](#), defines a Pelvic Examination as an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis, abdominal, groin region. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation.

I understand that this permission will remain in place until I request a change.

**Name:** \_\_\_\_\_

Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

**Name:** \_\_\_\_\_

Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

# Surgical Associates of Central Florida, PA

1181 Orange Ave  
Winter Park, FL 32789  
Telephone 407-647-1331  
Fax 407-571-2757  
[www.saocf.org](http://www.saocf.org)

Roberto G. Posada, M.D.  
Timothy C. Childers, M.D.  
Thomas K. Mahan, M.D.  
Daniel G. Vanuno, M.D.

## PATIENT INFORMATION

(Please Print)

Today's Date \_\_\_\_\_  Male

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Female

Single  Married

Street \_\_\_\_\_ City & State \_\_\_\_\_ Zip \_\_\_\_\_  Divorced  Widow

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse or Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

## REASON FOR VISIT

What is your surgical problem? \_\_\_\_\_

What are your symptoms? \_\_\_\_\_ When did they start? \_\_\_\_\_

Primary Care Physician (Family Doctor) \_\_\_\_\_

Referring Physician \_\_\_\_\_ Other Physicians you are seeing \_\_\_\_\_

## MEDICAL HISTORY

List Operations (Include Date)  None

Medical Conditions  None

1) \_\_\_\_\_

1) \_\_\_\_\_

2) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

4) \_\_\_\_\_

Medications (State amount taken daily)  None

Allergies (Please list below)  None

1) Aspirin, Advil, Arthritis Medication  No  Yes

\_\_\_\_\_

2) \_\_\_\_\_

Smoke  No  Yes \_\_\_\_\_ Packs/Day

3) \_\_\_\_\_

Alcohol  No  Occasional  Moderate

4) \_\_\_\_\_

Drugs (recreational)  No  Occasional  Moderate

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**HEALTH HISTORY**

Reactions to Anesthesia	<input type="checkbox"/> No <input type="checkbox"/> Yes	AIDS	<input type="checkbox"/> No <input type="checkbox"/> Yes	Constipation	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes	HIV Positive	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hemorrhoids	<input type="checkbox"/> No <input type="checkbox"/> Yes
Lung Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis C	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sleep Apnea	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diarrhea	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	Short Breath	<input type="checkbox"/> No <input type="checkbox"/> Yes
Poor Vision	<input type="checkbox"/> No <input type="checkbox"/> Yes	Seizures/Convulsions	<input type="checkbox"/> No <input type="checkbox"/> Yes	Blood in Stools	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hearing Loss	<input type="checkbox"/> No <input type="checkbox"/> Yes	Alcoholism	<input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Frequent Urination	<input type="checkbox"/> No <input type="checkbox"/> Yes
Mental Illness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Burning on Urination	<input type="checkbox"/> No <input type="checkbox"/> Yes
Nosebleeds	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Number of times to Urinate during the night	_____
Sore Throat/Cough	<input type="checkbox"/> No <input type="checkbox"/> Yes	Gout	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rash	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hoarseness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Liver Trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	Varicose Veins	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	Thyroid Trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	Phlebitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chest Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stomach Ulcers	<input type="checkbox"/> No <input type="checkbox"/> Yes	Are you Pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Abnormal Heart Beat	<input type="checkbox"/> No <input type="checkbox"/> Yes	Poor Appetite	<input type="checkbox"/> No <input type="checkbox"/> Yes	Last Menstrual Period	_____
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Chills/Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other	_____
Bleeding Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	Nausea/Vomiting	<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you use a CPAP Machine?	_____
Anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stomach Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes		

Please Explain ALL "Yes" answers

\_\_\_\_\_

**FAMILY HISTORY**

	Living	Deceased	Age at Death	Stroke	High Blood Pressure	Diabetes	Cancer	Type
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Date of last Chest X-Ray \_\_\_\_\_ Where Done \_\_\_\_\_

Date of last Electrocardiogram (EKG) \_\_\_\_\_ Where Done \_\_\_\_\_

**ASSIGNMENT OF BENEFITS/MEDICAL NECESSITY**

I assign insurance or other medical coverage benefits directly to Surgical Associates of Central Florida, PA. I do understand that I am financially responsible for any services not covered by my plan or not deemed medically necessary. All balances are due and payable on demand. I authorize the release of my medical records as necessary to complete my care.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name



**Roberto G. Posada, M.D.**  
**Timothy C. Childers, M.D.**  
**Thomas K. Mahan, M.D.**  
**Daniel G. Vanuno, M.D.**

**Phone: 407-647-1331**  
**Fax: 407-647-2710**

[www.saocf.org](http://www.saocf.org)

## **AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS**

I \_\_\_\_\_ hereby authorize Surgical Associates of Central Florida,  
P.A. to :

obtain records on my behalf from:

\_\_\_\_\_

release medical records on my behalf to:

\_\_\_\_\_

Please release my complete medical records including medical, drug or alcohol abuse, mental health,  
and HIV testing.

Any portion of the medical record may be withheld according to additional instructions indicated on this  
release. This release is valid for one year and may be revoked at any time upon written notification from  
the patient.

Use or disclosure of Protected Health Information made according to this authorization may be subject  
to re-disclosure by the recipient and no longer protected by the Privacy Rule 45 CFR Part 164.

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Signature** of Patient or Personal Representative

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Social Security

\_\_\_\_\_  
Address