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 or providing treatment to me, 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.

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 _____, 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.

This permission also includes any and all financial issues involving my account and further care.

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

Name:_____
Relationship:_____
Phone:_____
Name:_____
Relationship:_____
Phone:_____
Name:_____
Relationship:_____
Phone:_____

Patient Signature:_____
Print Name:_____

Surgical Associates of Central Florida, PA

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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

1) _____

2) _____

3) _____

4)_____

Medical Conditions ☐ None

1) _____

2) _____

3) _____

4) _____

Medications (State amount taken daily) ☐ None

1) Aspirin, Advil, Arthritis Medication ☐ No ☐ Yes

2) _____

3) _____

4) _____

Allergies (Please list below) ☐ None

_____

Smoke ☐ No ☐ Yes _____Packs/Day

Alcohol ☐ No ☐ Occasional ☐ Moderate

Drugs (recreational) ☐ No ☐ Occasional ☐ Moderate

Patient Name_____ **Date of Birth**_____

HEALTH HISTORY

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

Please Explain ALL "Yes" answers

_____

FAMILY HISTORY

	Living	Deceased	Age at Death	Stroke	High Blood Pressure	Diabetes	Cancer	Type
Father	☐	☐	☐	☐	☐	☐	☐	_____
Mother	☐	☐	☐	☐	☐	☐	☐	_____
Brother/Sister	☐	☐	☐	☐	☐	☐	☐	_____
Brother/Sister	☐	☐	☐	☐	☐	☐	☐	_____
Brother/Sister	☐	☐	☐	☐	☐	☐	☐	_____
Brother/Sister	☐	☐	☐	☐	☐	☐	☐	_____
Other	☐	☐	☐	☐	☐	☐	☐	_____

Date of last Chest X-Ray _____Where Done _____

Date of last Electrocardiogram (EKG) _____ Where Done _____

ASSIGNMENT OF BENEFITS

I assign insurance or other medical coverage benefits directly to Surgical Associates of Central Florida, PA. I understand that I am financially responsible for any services not covered by my third party coverage. 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

SURGICAL ASSOCIATES of Central Florida, P.A.

Roberto G. Posada, M.D.
Timothy C. Childers, M.D.
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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