NEW PATIENT PAPERWORK

PALM SPRINGS INTERNAL MEDICINE INC.
MANUEL BORNIA M.D.
180 JFK Drive, Suite 260, Atlantis, Fl 33462

DEAR FUTURE PATIENT, PLEASE READ:

-FILL OUT FORM COMPLETELY AND DON'T FORGET TO ATTACH ID AND INSURANCE CARD.

-DUE TO COVID19, WE ARE REQUESTING YOU TO ALSO ATTACH A PROVE OF VACINATION.

-ADD PHARMACY NAME AND NUMBER AND ALL MEDICATION TAKEN AS WELL (WITH THE STRENGTH).

-WHEN YOU SEND IT WAIT FOR OUR EMAIL RECEIPT OR PHONE CALL. IF YOU DON'T GET IT, PLEASE CALL THE OFFICE.

THANK YOU.

THE MANAGEMENT

DEMOGRAPHIC - PALM SPRINGS INTERNAL MEDICINE - MANUEL BORNIA M.D.
180 JFK Drive, Suite 260, Atlantis, Fl 33462 P: 561 439 4480 F: 561 641 6626

PATIENT INFO

LAST NAME _____ FIRST NAME _____

D.O.B: _____ SEX: ____ LAST 4 SSN: _____ PRIMARY LANGUAGE _____

RACE: _____ MARITAL STATUS: ____ SPOUSE NAME: _____

ADDRESS: _____

CITY_____ STATE__ ZIP CODE _____

CELLPHONE: _____ HOME PHONE: _____

EMAIL ADDRESS: _____ OR DON'T HAVE.

EMERGENCY CONTACT

NAME: _____ PHONE: _____ RELATION_____

INSURANCE INFO

PRIMARY INSURANCE: _____POLICY#_____GROUP#_____

SECONDARY (IF ANY): _____POLICY#_____GROUP#_____

EMPLOYER NAME AND NUMBER _____

PHARMACY INFO

NAME: _____ NUMBER: _____

I acknowledge full responsibility for the payment of services rendered and agree to pay them in full if my insurance failed to do so. A photocopy of this signature is valid as the original. I also authorize the physician to release any information required in processing my insurance. I policy acknowledge by my signature, that I understand Palm Springs Internal Medicine, Inc. Manuel Bornia M.D. DOES ACCEPT MEDICARE ASSIGMENT and they will submit my Medicare Assignment for me. I recognize receiving a copy of the Notice of Privacy Practices from PSIM Inc.

SIGNATURE: _____ DATE: _____

HEALTH HISTORY CONFIDENTIAL - PALM SPRINGS INTERNAL MEDICINE - MANUEL BORNIA M.D.
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PATIENT: _____ **D.O.B:** _____ **DATE:** _____

REASON OF VISIT: _____

PHARMACY NAME AND NUMBER: _____

ALLERGIES TO MEDICATIONS OR SUBSTANCES: _____

_____.

CURRENT MEDICATION LIST WITH STRENGTH: _____

_____

_____

_____

☐ **NOT KNOW ALLERGIES** ☐ **NO MEDICATIONS**

SYMPTOMS (Check symptoms you currently have or have had in the past year)

GENERAL
☐ Chills
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fever
☐ Forgetfulness
☐ Headaches
☐ Loss of sleep
☐ Loss of weight
☐ Nervousness
☐ Numbness
☐ Sweats

MUSCLE/JOINT/BONE
☐ Arms
☐ Back
☐ Feet
☐ Hands
☐ Hips
☐ Legs
☐ Neck
☐ Shoulders

GENITOURINARY
☐ Blood in urine
☐ Frequent urination
☐ Lack of bladder control
☐ Painful urination

GASTROINTESTINAL
☐ Poor appetite
☐ Bloating
☐ Bowel changes
☐ Constipation
☐ Diarrhea
☐ Excessive hunger
☐ Excessive thirst
☐ Gas
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal bleeding
☐ Stomach pain
☐ Vomiting
☐ Vomiting blood

CARDIOVASCULAR
☐ Chest pain
☐ High blood pressure
☐ Irregular heartbeat
☐ Low blood pressure
☐ Poor circulation
☐ Rapid heartbeat
☐ Swelling of ankles
☐ Varicose veins

EYE, EAR, NOSE, THROAT
☐ Bleeding gums
☐ Blurred vision
☐ Crossed eyes
☐ Difficulty swallowing
☐ Double vision
☐ Earache
☐ Ear discharge
☐ Hay fever
☐ Hoarseness
☐ Loss of hearing
☐ Nosebleeds
☐ Para latent cough
☐ Ringing in ears
☐ Sinus problems
☐ Vision - Plastics
☐ Vision - Halos

SKIN
☐ Bruise easily
☐ Hives
☐ Itching
☐ Change in moles
☐ Rash
☐ Scars
☐ Sore that won't heal

MEN only
☐ Breast bump
☐ Erection difficulties
☐ Lump in testicles
☐ Penis discharge
☐ Sore on penis
☐ Other

WOMEN only
☐ Abnormal pap smear
☐ Bleeding between periods
☐ Breast lump
☐ Extreme menstrual pain
☐ Hot flashes
☐ Nipple discharge
☐ Painful intercourse
☐ Vaginal discharge
☐ Other

Date of last menstrual period_____

Date of last pap smear_____

Date of last mammogram _____

Pregnant? ☐Yes ☐No

Number of children ___

CONDITIONS (Check conditions you have or have had in the past)

☐ AIDS
☐ Alcoholism
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding disorders
☐ Breast lump
☐ Bronchitis
☐ Bulimia
☐ Cancer _____
☐ Cataracts
☐ Chemical dependency
☐ Chicken pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heart disease _____
☐ Hepatitis
☐ Hernia
☐ Herpes
☐ High cholesterol
☐ HIV positive
☐ Kidney disease
☐ Liver disease
☐ Measles
☐ Migraine headaches
☐ Miscarriage
☐ Mononucleosis
☐ Multiple sclerosis
☐ Mumps
☐ Pacemaker
☐ Pneumonia
☐ Polio
☐ Prostate problem
☐ Psychiatric care
☐ Rheumatic fever
☐ Scarlet fever
☐ Stroke
☐ Suicide attempt
☐ Thyroid problems
☐ Tonsillitis
☐ Tuberculosis
☐ Thyroid fever
☐ Ulcers
☐ Vaginal infections
☐ Venereal disease

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FAMILY HISTORY																
	Father Age__	Mother Age__	Brothers Age__	Age__	Age__	Sisters Age__	Age__	Age__	Maternal Grandparents Age__	Age___	Paternal Grandparents Age__	Age__	Children Age__	Age__	Age__
Name															
State of health															
*Age of death															
*Cause of death															
Check if blood relatives had any of the following:															
Arthritis															
Asthma															
Gout															
Hay fever															
Cancer ___															
Chemical Dependency															
Diabetes															
Heart disease															
Strokes															
High blood pressure															
Kidney disease															
Tuberculosis															
Other															

*If family member died.

☐ Patient is adopted

HOSPITALIZATIONS		
Year	Hospital	Reason of hospitalization

SERIOUS ILLNESS / INJURIES		
Condition	Date	Outcome

- **Have you ever had a blood transfusion?** ☐ Yes ☐ No
  If yes please give approximate dates_____
- **Do you smoke? (e-cigarettes included)** ☐ Yes ☐ No
  If yes please tell us how often _____
- **Do you drink coffee?** ☐ Yes ☐ No
  If yes tell us how often _____
- **Do you take drugs? (Marijuana, cocaine, etc.)** ☐ Yes ☐ No
  If yes tell us how often_____

OCCUPATIONAL CONCERNS	ONLY WOMEN: PREGNANCY HISTORY		
	YEAR	SEX	Complication if any
☐ Stress ☐ Hazardous Substances ☐ Heavy lifting ☐ Other _____			
YOUR OCCUPATION: ----------			

Any other comments:

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient name: _____ Patient Signature: _____ Date: _____

OFFICE RULES AND OTHER-PALM SPRINGS INTERNAL MEDICINE. MANUEL BORNIA M.D.
180 JFK Drive, Suite 260, Atlantis, Fl 33462 P: 561 439 4480 F: 561 641 6626

OFFICE RULES

1. Patient is responsible to know their insurance copayment and to pay before services are rendered, not after. Patients can pay cash or card. Checks are not accepted.
2. Patient is responsible to let the doctor's office know when they change health insurance before the services are rendered. If patient doesn't do so they are responsible for all the expenses.
3. Patient is responsible to keep their appointments. Patients who fail to show up for an appointment or fail to cancel 24 hours prior to the appointment will be charged a fee of $50.
4. Patient is responsible to call one week before they are out of their prescription. Patient most call the pharmacy to get refills on medications. Please do not call the office unless completely necessary.
5. Patient is responsible to request referrals one week before the appointment. Referrals will not be done same day unless is and emergency.
6. Medical results are not given over the phone, patient needs to make an appointment. The office will contact the patient if results are abnormal. If not, patient can come to the regular appointment to speak with the doctor about the results.

REGULAR OFFICE SCHEDULE (SUBJECT TO CHANGE) :

MON-TUES-THURS	WED	FRI	SAT-SUN
8:30am to 5:00pm Lunch 12:00pm to 1:30pm.	8:30am to 5:00pm Lunch 12:00pm to 1:30pm Office is open but no for patient appointments (only emergencies).	8:30am to 2:00pm	CLOSED

OFFICE NUMBERS

Phone: 561 439 4480 FAX: 561 641 6626 After hours: 561 358 9792

ATTENTION! FOR EMERGENCIES CALL 911. THE AFTER HOURS NUMBER IS ONLY TO ASSIST URGENT MATTERS, DON'T CALL FOR REFILLS OR APPOINTMENTS TO THIS NUMBER. THE MANAGER WILL BE ANSWERING TO TRIAGE THE CALL.

By signing below, I acknowledge that I received, understand, and agree with all the policies mentioned above.

Patient name: _____ Patient Signature: _____ Date: _____

ER (EMERGENCY ROOM) VISITS

Dear patient I'm asking for your help to be able to adapt with the new regulations from insurances companies regarding visits to the ER.

Simply, if you think you are having any life-threatening medical conditions you must call 911.

Otherwise, if you think that is not life-threatening condition, but need to be seen as soon as possible, and is occurring during business hours; please call or show up at the office first.

PLEASE DO NOT GO TO ANY ER DURING REGULAR OFFICE HOURS WITHOUT CALLING FIRST UNLESS YOU ARE HAVING A LIFE THREATING EMERGENCY.

Together we can prevent unnecessary visits or even admissions to the hospital, remember I'm your doctor, and I know your health problems better than any other one.

Let me decide if you really need to be treated at the hospital, or if I can treat you symptoms at the office right away without further delays.

If you insist on going to the ER during office hours without calling the office first, you will have to change Doctor.

Sincerely,

Manuel Bornia M.D.

Patient name: _____ Patient Signature: _____ Date: _____

PREVENTIVE SERVICES EDUCATION - PALM SPRINGS INTERNAL MEDICINE. MANUEL BORNIA M.D.
180 JFK Drive, Suite 260, Atlantis, Fl 33462 P: 561 439 4480 F: 561 641 6626

PREVENTIVE SERVICES EDUCATION SHEET

The promotion of healthy lifestyles and the early identification of potential health risks will benefit you and are important to us. Please read this preventive education sheet and feel free to discuss any of the topics with your physician. Only you can take appropriate actions to maintain your health and well-being.

1. Life-style Changes:

Diet and Exercise.
A healthy diet and regular exercise are the most effective ways to maintain good health, longevity and increase your quality of life. Choose a diet low in saturated fat, cholesterol, sugar, and salt, eat plenty of vegetables, fruits, grains which provide vitamins, minerals and fibers, lean meats, pastas, etc. Twenty minutes of exercise three times a week (i.e., walking, swimming, etc.) will keep your heart and bones healthy.

Substance Abuse.
Use of tobacco is known to cause heart disease, strokes and lung cancer. Excessive alcohol intake is associated with many illnesses, including cancer, liver disease and impaired judgement (as in driving): Illicit drug use has many risks such as AIDS, hepatitis, heart problems, and mental and social disorders:

Sexual Behavior.
Certain sexual practices (i.e., promiscuity, unprotected sex) can expose you to potentially fatal diseases such as AIDS, STDs (sexually transmitted diseases) and other common infections.

Excessive Sun Exposure.
Causes skin cancer; always wear sunscreen when exposed to the sun. The higher the SPF (sun protection factor) you use; the higher the protection level against the ultraviolet rays.

Injury Prevention.
Take advantage of the many safety products that are important in preventing serious injury. These include seat belts, bicycle helmets and other protective gear, safe work habits (lifting, bending, etc.), smoke detectors, firearms safety practices for adults and children, CPR training for household members, etc. poison prevention.

Dental Health.
Brush and floss regularly; see your dentist for routine visits every six months.

2. Advance Directives:

A document called a **Living Will** advises your family and physicians of your desires should you become incapacitated and unable to make decisions regarding your healthcare.

Have you prepared a living will? ☐ **Yes** ☐ **No**

Please sign below to acknowledge that you have read and understand this information.

Patient name: _____ Patient Signature: _____ Date: _____

Suggested form of a Living Will, Florida Statutes Section 765.303

LIVING WILL

Declaration made this _____ day of _____2_____, I _____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and

_____ (initial) I have a terminal condition.
or _____ (initial) I have an end stage condition.
or _____ (initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct, that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

If I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name _____
Address _____
City_____ State ___ Zip_____
Phone _____

Y understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):_____

Signature: _____

Witness: _____
Street Address: _____
City, State& Zip : _____
Phone: _____

Witness: _____
Street Address: _____
City, State& Zip : _____
Phone: _____

The principal's failure to designate a surrogate shall not invalidate the living will.
This form offered as a courtesy of The Florida Bar and the Florida Medical Association

HIPAA CONTACT INFO - PALM SPRINGS INTERNAL MEDICINE - MANUEL BORNIA M.D.
180 JFK Drive, Suite 260, Atlantis, Fl 33462 P: 561 439 4480 F: 561 641 6626

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT: _____ D.O.B: _____LAST 4 SOCIAL: _____

Initials:

_____ Palm Springs Internal Medicine is permitted to share all medical information with the individuals listed below, including test results, sensitive information as stipulated by the State of Florida, and information disclosed during office visits.

_____ Palm Springs Internal Medicine is permitted to share any medical information with the individuals listed below, including test results, sensitive information as stipulated by the State of Florida, and information disclosed during office visits except: _____.

Persons authorized to receive any medical information (full name, relationship, and phone number):

NAME RELATIONSHIP PHONE NUMBER

_____

_____

_____

_____

_____

_____

☐ Check here if you don't want any information to be disclosure to anybody. Also, nobody can go with you inside the room with the doctor.

This authorization is not valid for the request of copies of your medical records. You or your personal legal representative must sign a Health Information Release Form to obtain copies of your medical records.

I understand this authorization will remain in effect until it is revoked by me in writing.

Patient name: _____ Patient Signature: _____ Date: _____

PREVIOUS DOCTORS FORM - PALM SPRINGS INTERNAL MEDICINE - MANUEL BORNIA M.D.
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NO MEDICAL RECORDS = NO APPOINTMENT

ATTENTION!

PATIENTS WILL NOT BE ABLE TO GET AN APPOINTMENT UNTIL WE GET THE RECORDS.

PLEASE FILL THE LIST WITH THE LATEST DOCTORS, HOSPITALS OR URGENT CARE YOU HAVE BEEN.

THE NEXT PAGE IS FOR MEDICAL RECORDS RELEASE YOU JUST HAVE TO SIGN IT AND WE GET THE RECORDS.

PLEASE MAKE SURE THE INFORMATION IS CORRECT. WRONG INFORMATION WILL DELAY THE PROCESS.

LIST OF DOCTORS:

	DOCTOR	**PHONE#**	**FAX#**
PREVIOUS PRIMARY CARE			
GYNECOLOGY (FEMALES ONLY)			
GASTROENTEROLOGY IF COLONOSCOPY			
EYE DOCTOR			
OTHERS			

RECORDS REQUEST - PALM SPRINGS INTERNAL MEDICINE - MANUEL BORNIA M.D.
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☐ URGENT REQUEST!

MEDICAL RECORDS REQUEST AND CONSENT OF TREATMENT

PATIENT:		
DOB:	LAST 4 SSN:	PHONE:

By signing this form, I authorize the release of all my PHI (i.e., medical records) to Palm Springs Internal Medicine and Manuel Bornia M.D. for continuation of care. Unless otherwise revoked, this authorization has no expiration. Please release information as follows:

Date range: _____.

__ Entire Medical records
__ H&P/Problem List
__ Medication List
__ Clinic/Office Notes
__ Lab/Pathology Report
__ Radiology Reports
__ Mammogram Reports
__ Pap Smear Results
__ Colonoscopy Report
__ Eye Check Visit
__ Discharge Summary
__ Operative Report
__ Behavioral Health
__ Substance Use Disorder
__ STD/HIV/AIDS
__ Genetic Testing
__Other:_____
_____
_____

Records to be released from: _____

PH: _____ FAX: _____

I acknowledge that I have read and fully understand the above information.

Patient's Signature: _____ Date: _____

ALLERGY QUESTIONARY - PALM SPRINGS INTERNAL MEDICINE - MANUEL BORNIA M.D.
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ALLERGY QUESTIONNAIRE

Name: _____ DOB: _____ Ph: _____ Date: _____

1. Do you sneeze repeatedly throughout the day? O Occasional O Often

2. Do you wake up in the morning with your nose congested? O Occasional O Often

3. Do you feel the need to clear your throat frequently? O Yes O No

4. Do you get sinus headaches? O Yes O No

5. Do your eyes turn red, itch or tear? O Yes O No

6. Does your chest ever feel tight or wheeze? O Yes O No

7. What are your symptoms? (Please check all that applies)

O Stuffy Nose O Runny Nose O Headaches O Itchy / watery eyes

O Postnasal drip O Wheezing O Sneezing O Hives

8. Are the symptoms worse in the:

O Morning O Afternoon O Night-time

----------PHYSICIAN USE ONLY----------

Patient has tried and/or is taking OTC allergy medications: O Yes O No

Patient has tried and/or is taking RX allergy meds: O Yes O No

What RX Meds: _____

Results of Allergy Medications: O Poor O Fair O Good

Do Antihistamine Medications cause significant side effects? O Yes O No

Ear Exam: _____

Nasal Exam: _____

Throat Exam: _____

Physician Recommendations: _____

Circle Diagnosis: Allergic Rhinitis 477.0 Allergic Conjunctivitis 372.1 Asthma 493.82

_____
Physician Signature