Bay Clinic
Pulmonary office of Dr. Jesus M. Ramirez
621 N Martin Luther King Jr. Blvd. Panama City, Fl 32401
Ph: 850.785.3212 Fax: 850.895.3085

Please give the receptionist your driver's license or other form of identification as well as your insurance cards so that we may make a copy to keep on file. Please hold any medications you brought with you to show to the nurse upon being called back into a room.

DEMOGRAPHICS

Patient Name: _____Sex: _____
Last First MI

Date of Birth: _____ Age: _____ SSN: _____

Address: _____
City State Zip

Marital Status: S☐ M☐ D☐ W☐ Email: _____

Phone Number: Home- _____ Cell- _____

Communication Preference: _____Pharmacy: _____

Ethnicity: _____ Race: _____ Language fluently spoken: _____

Employment Status: Employed☐ Unemployed☐ Retired☐ Disabled☐

Occupation: _____ Do you have insurance coverage? _____

Family Physician or Primary Care Physician: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Contact Number: 1) _____ 2)_____

Address: _____
City State Zip

Patient Signature: _____ Date: _____

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Patient Name: _____ DOB: _____

Health History

- My Main Complaint: _____
- Height: _____ Weight: _____

Please check all that apply and write any additional conditions not listed in the space below:

	COPD		Seizures		Heartburn
	Asthma		Impotence		Arthritis
	HX Bronchitis		Headaches		Gout
	HX Pneumonia		Fibromyalgia		Kidney Disease
	Cancer: _____		Vertigo/Dizziness		Hemophilia
	Emphysema		Syncope/Fainting		Meningitis
	Lung Mass/nodules		Heart Disease		Prostate Problems
	Pulm. Embolism		Hypertension		Dementia
	Bipolar		Depression		Anxiety
	PTSD		Back Pain		Low Blood Pressure
	Allergies		Muscle Disease		Heart Attack
	MS		ADHD		Renal Failure
	Restless Leg Syn.		Diabetes		Hypothyroidism
	Anemia		Head Injury		DVT
	High Cholesterol		Hyperlipidemia		Narcolepsy
	Sleep Apnea		Stroke/ TIA		CAD
	CHF		Cataracts		Chronic Congestion
	Neuropathy		Atrial Fibrillation		Herniated Disc
	IBS		Mitral Valve Disorder		Osteoporosis
	Visual Impairment		Alcoholism		Narcotic Use
	Insomnia		Migraines		Obesity

- Other:_____

_____

Smoker: ( ) No ( ) Yes, Packs per day: _____ Smoked For: _____yrs

Drink Alcohol: ( ) No ( ) Yes, How often: _____

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Patient Name: _____ DOB: _____

- Surgeries: _____

  _____

  _____

Family History: Please list any major medical problems

Father:	
Mother:	
Son/Daughter:	
Brother/Sister:	
Other:	

If you brought your medications with you or a detailed medication list, you can leave this portion blank and give the nurse your medications or list upon being called to the room and she will enter them into our system.

Medication Name	Dosage and Frequency	Prescribing Doctor

Allergies: _____

Thank you for choosing Bay Clinic for your pulmonary needs!!

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Release of Information

I hereby authorize Bay Clinic of Panama City, FL to release my information to any medical provider such as physicians, medical equipment companies, or hospitals as well as to any insurance company or responsible party. This information may include diagnosis, records of treatment, and any procedures or services rendered. In addition to the above release, I authorize Bay Clinic of Panama City, FL to release any information to the following persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Assignment of Benefits

I authorize and request payments of insurance benefits paid directly to Bay Clinic of Panama City, FL. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of information about me to be released to agents when information is needed to determine benefits. **I understand that I am fully responsible for all deductibles, coinsurances, and disallowed items at the time of service.** I also understand that if a particular item or service rendered if deemed "not reasonable and necessary" under Medicare standards and the claim is denied then I am fully responsible.

Consent to Treat

I authorize Bay Clinic of Panama City, FL and/or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize or order services on my behalf. I understand that in the even of a medical emergency, my physician will be contacted. If immediate medical care is required, 911 will be summoned and I will be transported to Bay Medical Sacred Heart. I understand that there have been no guarantees made to the results of the test(s)/ procedure(s).

Cancellation Policy

We ask that you call us **no later than 24 hours** in advance if you need to cancel or change your appointment. If you fail to comply you **will be charged a cancellation fee of $25.00**. If your insurance provider is Medicaid (or any of its affiliates such as Wellcare or Staywell), **you may be discharged**.

By signing this document I agree to and understand all of the information listed above.

_____ _____

Patient Signature Date Witness Signature Date

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Patient Name: _____ DOB: _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have been provided a copy of Bay Clinic of Panama City, FL's Notice of Privacy Practices.

_____ _____
Patient Signature Date Witness Signature Date

OR

_____
Personal Representative Date

_____
Personal Representative (print)

****For Office Use Only****

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ The patient refused to sign

_____ We were unable to communicate with the patient

_____An emergency situation prevented us from obtaining an acknowledgment

_____ Other: _____

_____ _____
Employee Signature Date