Carlos A. Labrador, M.D. **RoseAnna Javorsky, PA-C**
65 65TH STREET SOUTH ST. PETERSBURG, FL 33707
Phone: 727-381-8006 Fax: 727-381-9629
www.drlabrador.com

New Patient Information.
HUMANA GOLD AND WELLCARE ONLY

Today's Date: _____

Patient Name:_____DOB/Age:_____

Member effective date: _____

1. Do you have any current major medical problems or any current symptoms of concerns? No_____Yes_____

   if yes, explain_____

   _____

2. Have you been in the hospital or Emergency room anytime during the past 12 months? No_____ Yes_____ if yes, explain_____

   _____

3. Do you have any specialist appointments scheduled? No_____ Yes_____ if yes, explain_____

   _____

4. Who was you prior Primary Care Physician?_____
5. Medications:
   a. Are you on 5 or more prescription medications? Yes___ No____
   b. Do you need any refills within the next 10 days Yes___ No___
   c. Are you on any of the following medications
      i. Heart/Blood Pressure: Yes___No____
      ii. Blood Thinner: Yes___No____
      iii. Lung/breathing medications: Yes___No____
      iv. Diabetes medications: Yes___No____

Appointment Schedule Date: _____ Time_____

***Patient Name:**_____

Social Security #**_____Date of Birth:**_____**Sex: M F**

Single, Married, Widowed, Separated, Divorced

***Language:**_____ ***Race:** _____ ***Ethnicity:**_____

PRIMARY HOME

***Address:**_____
City: _____State:_____ Zip Code:_____Home Phone:_____
Work Phone: _____ **Cell Phone**:_____
Email:_____
Occupation:_____ Employer:_____

EMERGENCY CONTACT

Name:_____ Phone:_____ Relationship:_____
If you have a spouse:
Name:_____ Date of Birth:_____
Social Security #_____ Employer:_____
Work Phone:_____ Cell Phone: _____

INSURANCE INFORMATION

***Primary Insurance**:_____ **Effective Date**:_____
ID #_____Group #_____

****

STAFF ONLY: Demographics, Driver License or ID, Insurance Card.
_____ Initial
*Required
****

Answer all questions below.

Chief Complaint (affected body part)_____

History of Present Illness or Injury **(when and how did it happen):**

***Review of Systems/Past Medical History*:** (please circle all that apply)

High Blood Pressure High Cholesterol Diabetes Cancer Heart Attack Stroke COPD Asthma Renal Disease Liver Disease Bleeding Disorders Rheumatoid Arthritis Pacemaker HIV /AIDS Hepatitis A, B, or C GERD GI Disorders Neurological Disorders Osteoporosis .

Other: _____

Allergies (please circle): **None Penicillin Sulfa Codeine Aspirin Latex**

Other: _____ *Reaction*: _____

Current Medications (name, strength and dose):

1_____ 2 _____

3_____ 4_____

5 _____ 6 _____

7_____ 8_____

***Previous Surgeries & Year*:**

1_____ 2 _____

3_____ 4_____

5 _____ 6 _____

7_____ 8_____

_____

Social History (please circle): **Smoking** Qty_____ Non-Smoker / Quit (year)_____

Drinking Qty_____ **Drugs** Type/Qty_____

Family History

Mother Alive Deceased Unknown Age_____ Condition_____

Father Alive Deceased Unknown Age_____ Condition_____

Siblings Alive Deceased Unknown Age_____ Condition_____

Children Alive Deceased Unknown Age_____ Condition_____

Pharmacy _____

Telephone # _____

Authorization to view RX history from External Source

I authorize Carlos A. Labrador,M.D.,P.A. to view any and all available RX history from an external source. I am aware that Dr. Labrador and Staff uses a secure connection to SureScripts to send and receive most prescription in the office.

By initialing I have read and understand the above_____

I certify that the above information is correct to the best of my knowledge. I will not hold Carlos A. Labrador, M.D., RoseAnna Javorsky, PA-C or any staff members responsible for any errors or omissions that occur secondary to incorrect or incomplete data on this form.

*By initialing I have read and understand the above*_____

Form Fee Agreement

Please note: The completion of informational/insurance forms represents an administrative service to our patients above and beyond the provision of medical care.
Recent changes in health care have resulted in the tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs, especially when multiplied over the large number of patients our practice serves. The refusal of insurance companies and requesting agencies to cover the costs requires us to institute a policy of charges for the completion of the forms as follows:

$10.00:

- **Disabled Parking Applications (Forms are provided by DMV)**

$25.00/ per form:

- **Credit Card deferment forms**
- **Private Disability Insurance Form**
- **Educational, Disability or Limitation Forms**
- **If you are unable to make your scheduled appointment, please call the office within 24 hours prior to your appointment time.**

$35.00/per form

- **Family Medical Leave Act (FMLA) forms**

_____ _____

Patient Name (printed) Signature

Consent for the Release of Protected Health Information to Personal Representative.

I, _____ give my written consent for Carlos A. Labrador, M.D.,P.A. to share information regarding my protected health information and care to the following listed persons: I understand that these persons will be treated as personal representatives of myself.

Personal Representatives that Carlos A. Labrador, M.D., P.A. may share my Protected Health Information with:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I do not want my Protected Health Information shared with anyone other than myself at any time. (initial here) _____

Carlos A. Labrador, M.D.,P.A. staff may leave a message:

At Home _____ At Work _____ At Cell_____ On Answering machine _____

Please provide Insurance Card and Driver License to our Receptionist.

Patient Authorization Form

HIPPA Privacy Notice

I have received and read a copy of Carlos A. Labrador, M.D.,P.A. Notice of Privacy Practices

*By initialing I have read and understand the above*_____

Authorization to Release Information

I consent to the use or disclosure of my protected health information by Carlos A. Labrador, M.D.,P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills.

*By initialing I have read and understand the above*_____

Authorization for treatment

I hereby authorize the medical staff of Carlos A. Labrador, M.D.,P.A. to render medical services and treatments as deemed necessary.

*By initialing I have read and understand the above*_____

By signing, I have read, understand and agree to comply with Carlos A. Labrador, M.D.,P.A. policies so noted in the Notice of Privacy Practices.

Signature _____Date _____

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

The pain you are currently experiencing may be helped with the use of narcotic pain medications. A doctor may prescribe appropriate narcotic medications for your specific type of pain. Narcotic pain medications may:

a. Become ineffective with time.
b. Become habit forming or cause addiction.
c. Cause severe constipation that requires frequent use of laxative.
d. Interfere with your ability to operate complex machinery as power tools while taking narcotic medications.

I understand that I have a chronic problem that currently requires the prescription for narcotic pain medication for relief of pain and to improve my functional ability. The risks, benefits and alternatives of medication have been discussed with me by the physician in detail, including but not limited to, drug dependency, respiratory depression, cardiovascular depression, liver and/or kidney damage, etc.

I will have my prescription filled only by my Primary Care Physician at only one pharmacy. I will not request nor accept controlled substance medication from another physician or individual while I am receiving medication from Dr. Labrador. The only exception is if it is prescribed while I am admitted to the hospital. (NRS 453.391).

I waive my right to privacy regarding these medication(s). My physician may contact any health care provider, legal authority or pharmacy to obtain or provide information about the patient's care.

I will take the medication(s) only as prescribed and will notify my physician if I do not. If necessary, I agree to random urine and blood tests to asses my compliance.

I understand that the eventual goal is to taper off the narcotic medication(s). I agree to meet regularly with my physician to assets my progress.

Federal and State law regulates dispensing narcotic medications. Forging or altering a narcotic prescription is a crime. Mandatory compliance by both the patient and physician is required. Failure to comply with all the laws regarding narcotic medications may result in criminal action being taken against you. Refills will not be given early for any reason. PRESCRIPTIONS WILL ONLY BE GIVEN DURING REGULAR OFFICE HOURS AND WILL NOT BE GIVEN OR REFILLED BY THE PHYSICIAN DURING WEEKENDS. No narcotics can be given over the telephone. If the prescription or the medication(s) are lost or stolen, a police report will be required for replacement. NO AFTER HOURS CALLS WILL BE ACCEPTED FOR THESE MEDICATIONS.

An increase in your pain will NOT necessarily be a reason to increase you pain medication. Contact the doctor if you feel a change in your medication is needed.

Eliminating or rescuing the use of your narcotic medications may be a treatment goal, and this may require hospitalization.

A psychological evaluation regarding addiction and drug dependency may be necessary for continuation of narcotic more than 3(three) months.

Failure to follow these instructions may require the doctor to stop prescribing narcotic medications and recommend treatment in a psychiatric, substance abuse, or detoxification program. If this should occur, the doctor may still continue to manage your pain in other ways, such as with non-narcotic medications.

If I deviate from the above guidelines or if the medication losses its effectiveness in increasing my function ability, I understand that the narcotic may be tapered off by the physician. My signature at the bottom indicates my understating and agreement with the above guidelines. Failure to comply may result in requesting the dismissal from my practice.

Your signature below indicates that you have read and understand these instructions and that you agree to comply with the terms of this agreement.

PATIENT NAME (Print) _____

PATIENT SIGNATURE_____ DATE_____

Carlos A. Labrador, M.D.,P.A. 65 65TH ST S. ST. Petersburg FL 33707