

VASCULAR, ENDOVASCULAR, & GENERAL SURGERY

H. CHARLES-HARRIS, MD & ASSOCIATES

PATIENT REGISTRATION

PLEASE MAKE ANY NECESSARY CORRECTIONS & FILL OUT FORM COMPLETELY.

PATIENT INFORMATION

LAST NAME: _____

FIRST NAME: _____ MIDDLE: _____

MARITAL STATUS: _____

DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____ APT# _____

EMAIL: _____

CITY: _____ ST: _____ ZIP: _____

SOCIAL SECURITY #: _____

HOME TELEPHONE: _____

CELL / ALTERNATIVE TEL: _____

EMPLOYER: _____

WORK TELEPHONE: _____

OCCUPATION: _____

EMPLOYER ADDRESS: _____

EMERGENCY CONTACT

NAME: _____

ADDRESS: _____

TELEPHONE: _____

CITY: _____ ST: _____ ZIP: _____

RELATIONSHIP: _____

SPOUSE / PARENT INFORMATION

NAME: _____

DATE OF BIRTH: _____ SSN # _____

EMPLOYER: _____

WORK TELEPHONE: _____

OCCUPATION: _____

RELATIONSHIP: _____

INSURANCE INFORMATION

PRIMARY: _____

ID#: _____

SECONDARY: _____

ID#: _____

GUARANTOR'S NAME: _____

MEDICAL INFORMATION

REFERRING DOCTOR: _____

TEL#: _____ FAX #: _____

PRIMARY CARE DR: _____

TEL#: _____ FAX #: _____

DIAGNOSIS: _____

DATE SYMPTOMS BEGAN: _____

MY SIGNATURE BELOW INDICATES THAT I AGREE ALL THE ABOVE INFORMATION IS TRUE AND CORRECT.

X _____
PATIENT'S / RESPONSIBLE PARTY'S SIGNATURE DATE

REVIEW OF SYSTEMS

| | YES | NO | | YES | NO |
|------------------------------|--------------------------|--------------------------|-----------------------------------------|----------------------------------------|--------------------------|
| 1. CONSTITUTIONAL | | | Prostate problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight Gain | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Fevers | <input type="checkbox"/> | <input type="checkbox"/> | 10. SKIN | | |
| Sweats | <input type="checkbox"/> | <input type="checkbox"/> | Cancers | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Rashes | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. EYES | | | 11. NEUROLOGIC | | |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Vision Surgery | <input type="checkbox"/> | <input type="checkbox"/> | Head injury | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. EARS, NOSE, THROAT | | | Nerve damage | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of hearing | <input type="checkbox"/> | <input type="checkbox"/> | 12. PSYCHIATRIC | | |
| Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| Nose bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| Gum bleeding | <input type="checkbox"/> | <input type="checkbox"/> | 13. MUSCULOSKELETAL | | |
| 4. RESPIRATORY | | | Osteoarthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic cough | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | 14. PERIPHERAL ARTERY DISEASE | | |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Pain that stops me from walking | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Cramping in buttock / calf / thigh | <input type="checkbox"/> | <input type="checkbox"/> |
| Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | Pain in the toes / foot | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. CARDIOVASCULAR | | | Dark discoloration toes / foot | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Gangrene of toes | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain/angina | <input type="checkbox"/> | <input type="checkbox"/> | Smoke: | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | Drink: | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Blood Thinner: | <input type="checkbox"/> | <input type="checkbox"/> |
| Transfusions | <input type="checkbox"/> | <input type="checkbox"/> | Allergies: _____ | | |
| Phlebitis or blood clots | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| 6. GASTROINTESTINAL | | | Medication: _____ | | |
| Reflux | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Blood in stools | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Diarrhea/constipation | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Hernia/repair | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Gall bladder disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| 7. ENDOCRINE SYSTEM | | | Family History of Cancer: | | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Breast Cancer <input type="checkbox"/> | Colon Cancer <input type="checkbox"/> | |
| Thyroid problem | <input type="checkbox"/> | <input type="checkbox"/> | Ovarian cancer <input type="checkbox"/> | Other: _____ | |
| Hormone treatment | <input type="checkbox"/> | <input type="checkbox"/> | Dialysis: | Mon Wed Fri <input type="checkbox"/> | |
| Anabolic steroids | <input type="checkbox"/> | <input type="checkbox"/> | | Tues Thur Sat <input type="checkbox"/> | |
| 8. BREAST/GENITAL | | | Previous Surgery: _____ | | |
| Menopause | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Masses | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Genital Infections | <input type="checkbox"/> | <input type="checkbox"/> | Patient's Name: _____ | | |
| 9. URINARY SYSTEM | | | Date of Birth: _____ | | |
| Bladder infections | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Kidney stones | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Incontinence | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Trouble urinating | <input type="checkbox"/> | <input type="checkbox"/> | | | |

VASCULAR, ENDOVASCULAR, & GENERAL SURGERY

H. Charles-Harris, MD & Associates

RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE STATEMENT,
AGREEMENT TO PAY FOR PROFESSIONAL SERVICES, AND SPECIFIC EXAM AGREEMENT

LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH: _____

I wish to be contacted in the following manner (check all that apply):

- | | | |
|-------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------|
| * Home Telephone | * Work Telephone | * Written Communication |
| <input type="checkbox"/> Leave detailed message | <input type="checkbox"/> Leave detailed message | <input type="checkbox"/> Mail to my home address |
| <input type="checkbox"/> Leave name & call-back number only | <input type="checkbox"/> Leave name & call-back number only | <input type="checkbox"/> Mail to my office address |

I authorize any discussion over the phone regarding my health care and treatment with the following individuals:

Name: _____ Relation: _____

Name: _____ Relation: _____

I acknowledge that I have been provided with the notice of privacy practices.

- I AUTHORIZE DR. HAKAN CHARLES-HARRIS TO RELEASE ANY INFORMATION REQUESTED BY ANOTHER PHYSICIAN/FACILITY ACTIVELY INVOLVED IN MY MEDICAL TREATMENT, IF MEDICALLY NECESSARY FOR THE PROMPT AND EFFECTIVE TREATMENT OF MY MEDICAL CONDITION(S).
- I AUTHORIZE DR. HAKAN CHARLES-HARRIS TO RELEASE ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM AND TO ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO PROCESS MY INSURANCE CLAIM(S).
- I AUTHORIZE AND DIRECT MY CARRIER(S) TO ISSUE PAYMENT CHECK(S) DIRECTLY TO DR. HAKAN CHARLES-HARRIS FOR ALL SERVICES RENDERED. REGARDLESS OF MY INSURANCE BENEFITS, IF ANY, I UNDERSTAND THAT I AM FULLY FINANCIALLY RESPONSIBLE FOR ANY AND ALL FEES INCURRED, AND I AGREE TO PAY SUCH FEES IN FULL. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COLLECTION COSTS AND INTEREST (1.5% OF UNPAID BALANCE PER MONTH) SHOULD I FAIL TO MAKE PAYMENT IN A TIMELY MANNER.
- THE INSURANCE INFORMATION FURNISHED HERE REPRESENTS A FULL DISCLOSURE OF THE INSURANCE BENEFITS TO WHICH I AM ENTITLED. I UNDERSTAND THAT FAILURE TO DISCLOSE PRE-CERTIFICATION/SECOND OPINION REQUIREMENTS FOR ANY AND ALL PLANS TO WHICH I SUBSCRIBE PUTS ON ME THE FULL LIABILITY FOR PROFESSIONAL CHARGES AS A RESULT OF NON-PAYMENT BY ANY CARRIER.
- I UNDERSTAND AND AGREE THAT DR. HAKAN CHARLES-HARRIS IS EXPECTED TO ONLY EXAMINE THE SPECIFIC AREA OF COMPLAINT ALONG WITH ANY RELEVANT AREAS IN RELATION TO THIS COMPLAINT. A COMPREHENSIVE PHYSICAL EXAM IS TO BE DONE/HAS BEEN DONE BY MY PRIMARY CARE PHYSICIAN.

 X

 PATIENT'S / RESPONSIBLE PARTY'S SIGNATURE DATE

| Office Use Only | Record of Disclosure of Protected Health Information | | |
|-----------------|------------------------------------------------------|------------------------------------------------------|-------------------|
| Date | Disclosed to Whom / Address or Fax Number | Description of Disclosure / Purpose of Disclosure | By Whom Disclosed |
| | | | |
| | | | |
| | | | |
| | | | |

VASCULAR, ENDOVASCULAR, & GENERAL SURGERY
H. Charles-Harris, MD & Associates

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

LAST NAME: _____ FIRST NAME: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

Office Use Only

DATE OF REQUEST: _____

AUTHORIZED: _____

TO RELEASE TO: H. Charles-Harris, MD & Associates
1190 NW 95 Street, Suite 101, Miami, FL 33150
Fax: 305-696-4435

INFORMATION TO BE RELEASED: _____

REASON FOR DISCLOSURE: _____

- I understand that I, or the person authorized to act on my behalf, am entitled to receive a copy of this authorization. The requester may be provided with a copy of this authorization.
- I am aware of the consequences that may occur as a result of my signing this authorization request or my denial to do so. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization.
- I am authorizing any physician, nurse, hospital, or other provider having treated or attended me to having possession of any records and/or information with respect thereto, to provide such records to the requesting party above.
- By signing below I am hereby authorizing Dr. H. Charles-Harris or his representative to request / release the requested information identified above.

X _____
PATIENT'S / RESPONSIBLE PARTY'S SIGNATURE DATE

H. Charles-Harris, M.D. & Associates
General, Vascular, & Endovascular Surgery

ACKNOWLEDGEMENT OF INSURANCE BENEFITS

LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH: _____

PRIMARY INSURANCE POLICY: _____ ID NUMBER: _____

GUARANTOR'S NAME: _____ RELATIONSHIP: _____

SECONDARY INSURANCE POLICY: _____ ID NUMBER: _____

GUARANTOR'S NAME: _____ RELATIONSHIP: _____

BY SIGNING BELOW I VERIFY THAT I HAVE NO OTHER MEDICAL INSURANCE OTHER THAN THE ONE/ONES LISTED ABOVE.

X _____
PATIENT'S/ RESPONSIBLE PARTY'S SIGNATURE DATE

1190 NW 95 Street, Suite 101, North Miami, FL 33150 • Tel: 305.691.2941 Fax: 305.696.4435

H. Charles-Harris, M.D. & Associates
General, Vascular, & Endovascular Surgery

MEDICAL MALPRACTICE ACKNOWLEDGMENT

“Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice up to the minimal amount pursuant to Florida Statue s.458.320. This notice is provided pursuant to Florida law.”

I have been informed that Dr. Håkan Charles-Harris does not carry medical malpractice insurance.

Signed:

Patient/Guarantor Signature

Patient's Name

Date of Birth

Chart copy

1190 NW 95 Street, Suite 101, North Miami, FL 33150 • Tel: 305.691.2941 Fax: 305.696.4435
