

VASCULAR, ENDOVASCULAR, & GENERAL SURGERY

H. Charles-Harris, MD & Associates

PATIENT INFORMATION

**If patient is a minor, please fill in parent/guardian's information in place of "spouse".*

LAST NAME: _____ FIRST NAME: _____

MARITAL STATUS: _____ DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____ APT. #: _____

CITY: _____ STATE: _____ ZIP: _____ HOME TELEPHONE: _____

CELLULAR PHONE: _____ SOCIAL SECURITY #: _____

EMPLOYER: _____ WORK TELEPHONE: _____

EMPLOYER ADDRESS: _____

OCCUPATION: _____ SPOUSE'S NAME: _____

SPOUSE'S DATE OF BIRTH: _____ SPOUSE'S SOCIAL SECURITY #: _____

SPOUSE'S EMPLOYER: _____ WORK TELEPHONE: _____

PRIMARY INSURANCE: _____ ID#: _____

SECONDARY INSURANCE: _____ ID#: _____

GUARENTOR NAME, IF DIFFERENT FROM PATIENT: _____

REFERRED BY DOCTOR: _____

EMERGENCY CONTACT: NAME: _____ RELATIONSHIP: _____

TELEPHONE: _____ ADDRESS: _____

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

- 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

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

REVIEW OF SYSTEMS

Patient's Name: _____ Date of Birth: _____

	YES	NO
1. CONSTITUTIONAL		
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
2. EYES		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Vision Surgery	<input type="checkbox"/>	<input type="checkbox"/>
3. EARS, NOSE, THROAT		
Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Gum bleeding	<input type="checkbox"/>	<input type="checkbox"/>
4. RESPIRATORY		
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
5. CARDIOVASCULAR		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain/angina	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis or blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
6. GASTROINTESTINAL		
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		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>
Hormone treatment	<input type="checkbox"/>	<input type="checkbox"/>
Anabolic steroids	<input type="checkbox"/>	<input type="checkbox"/>
8. BREAST/GENITAL		
Menopause	<input type="checkbox"/>	<input type="checkbox"/>
Masses	<input type="checkbox"/>	<input type="checkbox"/>
Genital Infections	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
9. URINARY SYSTEM		
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"/>
Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>
10. SKIN		
Cancers	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>
11. NEUROLOGIC		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>
Nerve damage	<input type="checkbox"/>	<input type="checkbox"/>
12. PSYCHIATRIC		
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
13. MUSCULOSKELETAL		
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
14. PERIPHERAL ARTERY DISEASE		
Pain that stops me from walking	<input type="checkbox"/>	<input type="checkbox"/>
Cramping in buttock / calf / thigh	<input type="checkbox"/>	<input type="checkbox"/>
Pain in the toes / foot	<input type="checkbox"/>	<input type="checkbox"/>
Dark discoloration toes / foot	<input type="checkbox"/>	<input type="checkbox"/>
Gangrene of toes	<input type="checkbox"/>	<input type="checkbox"/>
Smoke:	<input type="checkbox"/>	<input type="checkbox"/>
Drink:	<input type="checkbox"/>	<input type="checkbox"/>
Blood Thinner:	<input type="checkbox"/>	<input type="checkbox"/>
Allergies: _____		

Medication: _____		

Family History of Cancer:		
Breast Cancer <input type="checkbox"/>	Colon Cancer <input type="checkbox"/>	
Ovarian cancer <input type="checkbox"/>	Other: _____	
Dialysis:	Mon Wed Fri <input type="checkbox"/>	
	Tues Thur Sat <input type="checkbox"/>	
Previous Surgery: _____		

