Benjamin J. Cousins, M.D.

Medical Information

Please answer the following questions to the best of your ability. Your answers are for our records only and will be considered confidential.

Name: _____ Age: _____ Sex: M F Height: _____ Weight: _____
BMI: _____

Medical Problems: _____

_____

Prior Operations: Date: / /

_____

Date: / /

_____

Name of Physician: Phone#: ( ) -

_____

Address of physician: _____

1- Are you in good health?..... Yes or No

2-Any changes in your health in the past year?..... Yes or No

3-Have you had rheumatic heart disease?..... Yes or No

4-Damaged heart valves, artificial valve, heart murmur?..... Yes or No

5-Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis? Yes or No

6-Chest pain or shortness of breath with mild exertion?..... Yes or No

7-Diabetes?..... Yes or No

8-Lung disease, asthma, bronchitis, emphysema?.....Yes or No

9-Tuberculosis?..... Yes or No

10-Fainting's or seizures?..... Yes or No

11-Liver disease, hepatitis, jaundice?..... Yes or No

12-Thyroid problems?..... Yes or No

13-stomach ulcer or hyperacidity?..... Yes or No

14-Kidney problems, stones, urinary tract infection?..... Yes or No

15-HIV/AIDS, blood disorders, anemia, abnormal bleeding, blood transfusions?..... Yes or No

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16-Persistent swollen neck glands?..... Yes or No

17-Have you ever been treated for a growth of tumor?……Yes or No

18-Any history of cancer?.....Yes or No

19-Do you drink alcohol on a regular basis?.....Yes or No

20-Do you smoke? .....? Yes or No If yes, how many years? _____

Allergies and Current Medications

1-Do you have any allergies?.....Yes or No

If you are allergic, please list medications that you are allergic to:

Medication	Type of Reaction

2-Have you ever taken weight reduction (diet) pills?.....Yes or No

3-Do you take medication for osteoporosis (bisphosphonates) such as Fosamax?.....Yes or No…….If so which ones?

_____

Please list any medications that you currently take including vitamins and over the counter medications:

Medication	Dose	Frequency

4-Are there any other medical issues not covered by this form?.....Yes or No

5-Do you wish to speak to the doctor privately about anything?.....Yes or No

Women:

1-How many pregnancies:_____ Births:_____ C-Sections:_____ Miscarriages:_____
2-Are you pregnant or trying to become pregnant?.....Yes or No
3-Do you have problems associated with your menstrual period?.....Yes or No
4-Are you smoking?.....Yes or No
5-Are you taking birth control pills?.....Yes or N

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I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor or any staff responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature: _____ **Date:** ___/___/_____

For completion of the Doctor

Comments on medical history**:** _____
_____
_____
_____

Physician's Signature: _____ **Date:** ___/___/____

Notice to Patients of Dr. Benjamin J. Cousins, M.D.

Under Florida law Statues (458.320 F.S.), 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 NO TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law (459.320 F.S.).

_____ _____
Patient Signature (or Personal Representative) Date:

_____
Printed Name

_____
Personal Representative's Authority (if applicable)

PATIENT INFORMATION FOR PHOTOGRAPHIC CONSENT

Dear Sir or Madam,

For all patients and surgeries, as a benefit for patient education, medical student/resident/fellow and academic teaching and/or learning, I wish to obtain consent/release and permission for the use of photographs, medical records, illustrations and/or other imaging records/documents which may be needed and/or useful. I pledge and promise to maintain patient confidentially and to follow HIPAA requirements and state laws appropriate. I hereby grant permission for the use of any of my medical records, illustrations, photographs, or other imaging records created in my case for use in presentations, teaching credentialing/re-credentialing or certifying purposes.

Patient Signature _____ **Date:** ___/ _____/ _____

Witness Signature _____ **Date:** ___/ _____/ _____

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Receipt of Notice of Privacy Practices Written Acknowledgement Form

I,_____ have reviewed/received a copy of Notice of Privacy Practices.

Signature of Patient/Guardian _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on

This Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ **Initials:** _____ **Reason:** _____

H I P A A

PATIENT CONSENT & FINANCIAL AGREEMENT FORM

In connection with the medical services that I am receiving, I hereby authorize the release of my information and medical records, including copies of applicable hospital and medical records to:

A. Any third party payer covering the medical services of the patient.

B. Other health care professional and institutions involved in the delivery of health care to the patient

C. The proponent of any legally sufficient subpoena, or in response to a court order

D .Employees and agents of the degree necessary to facilitate the provision of healthcare services and payment for such services

E. Pharmacies

F. As otherwise required by law

I further consent that photographs may be taken of me or part of my body, under the following conditions:

A. The photograph may be taken only with consent of my physician and under such conditions and at such time as approved by him/her.

B. The photographs shall be taken by my physician or by a designated person approved by any physician

C. The photographs be used for medical records and if in the opinion of my physician, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other in the interest of medical education, knowledge, or research; provided, however that it is specifically understood that in any such publications or use I shall not be identified by name and reasonable steps are taken to preserve my identity.

D. The aforementioned photographs may be modified or retouched in any way that my physician, in his or her direction may consider desirable.

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Regarding Financial Arrangements:

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must however realize that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contact.

2. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filling of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for the assistance in the management of your account.

All Patients Must Sign Below:

_____

Patient's/ guardian's signature:

_____

Print name of patient or guardian

_____

Witness/Translator:

_____

Date: