General Information:

_____ _____ _____/____/_____
Patient Last Name First Name MI DOB

(____)_____ (____)_____
Home # Cell Phone #

_____
Home Address City State Zip

SS#: _____-_____-_____ Male__Female Single__Married__Divorced__Widowed
(Please Circle) (Please Circle one)

_____ Pharmacy: _____
Employer

_____ _____
Primary Insurance Carrier Policy ID
___HMO___PPO___POS___Other__ (___)_____
(Type of Plan) Insurance Carrier Phone #

_____ _____
Second Insurance Carrier Policy ID
___HMO___PPO___POS___Other__ _____
(Type of plan) Insurance Carrier Phone #

IMPORTANT: In case of an emergency, who would we contact and who can we speak to about your conditions

_____ _____
Name Relationship Phone

_____ _____
Name Relationship Phone

_____ _____
Name Relationship Phone

I understand that I am financially responsible for all charges, whether paid by said insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give the medical center (JSA Medical Group) consent to perform medical treatment.

_____ _____
Patient/Guardian Signature Date

Advanced Directives

(For compliance with the Patient Self-Determination Act of Florida Statutes Chapter 765)

Have you Executed an Advance Directive? YES_____ NO _____

If YES, is this directive in the form of:

____ A living will or DNR (Do not Resuscitate) Please provide copy

____ A Durable Power of Attorney

____ A Health Care Surrogate

Have you provided this office with a copy of Advanced Directive: YES ____ NO ____
If you would like more information regarding advanced directive, please ask the nurse or receptionist

I have been provided with information regarding the "PATIENT SELF-DETERMINATION ACT"

_____

Signature of patient or Representative Date

Please provide us with the following information:

Race	**Ethnicity**	**Language**
____White	____ Non-Hispanic	____ English
____ African American	____ Hispanic	____ Spanish
____ Asian	____Unknown	____ Indian
____ Native American		____ Other
____ Pacific Islander		
____ Other	____ Permission to review prior prescription history	
____ Unknown		

_____

Signature of patient or representative Date

Suncoast Primary Care Specialists

Patient Medical History

Patient last name:_____ Patient first name:_____DOB:_____
Date of last physical Exam:_____ Previous physician name:_____
Physician Address:_____

Past history (Personal and Allergies): Have you ever had any of the following illnesses?

	Yes	No		Yes	No		Yes	No
Amputation	☐	☐	CVA/TIA	☐	☐	Migraine Headache	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Nervous Breakdown	☐	☐
Alcohol Ov	☐	☐	Emphysema/COPD	☐	☐	Ostomies_____	☐	☐
Allergies	☐	☐	Falls	☐	☐	Paralysis	☐	☐
Arthritis	☐	☐	Gallbladder Disease	☐	☐	Rheumatic Fever	☐	☐
Asthma	☐	☐	Gout	☐	☐	Seizures	☐	☐
Bleeding dis	☐	☐	HIV/AIDS	☐	☐	STD's	☐	☐
Cancer	☐	☐	Heart Attack/MI	☐	☐	Sickle Cell Anemia	☐	☐
Location:_____			Heart Disease	☐	☐	Alzheimer's	☐	☐
Cardiac	☐	☐	Hepatitis	☐	☐	Sleep Disorder	☐	☐
Pacemaker_____			High Blood Pressure	☐	☐	Stomach Ulcers	☐	☐
Chicken Pox	☐	☐	Jaundice	☐	☐	Thyroid Disease	☐	☐
Colitis	☐	☐	Kidney Disease	☐	☐	Vascular Disease	☐	☐
Depression	☐	☐	Covid 19	☐	☐	Dementia	☐	☐

Personal Habits:

1)Have you ever smoked? ☐ Yes ☐ No If yes, are you a regular smoker now? ☐ Yes ☐ No
Have you used chewing tobacco? ☐ Yes ☐ No If yes, number of yrs___ If no, when did you quit?_____
2) Do you regularly drink alcohol ☐ Yes ☐ No If yes, number of yrs___ If no, when did you quit?_____
3) Have you ever used any of the following: Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Speed ☐

Operations: List and indicate year.

_____
_____

Serious Injuries: List injuries & give approximate dates.

_____
_____

Hospitalizations: Other than operations.

_____
_____

Diagnostic Tests/Exams:

Last test/Exam Date Location/Provider
Eye Exam: _____
Foot Exam:_____

Immunizations: Hepatitis B_____ Flu_____ Polio _____ Typhoid _____ Small Pox_____
Tetanus _____ Pneumococcal _____ Chicken Pox _____ Covid 19 _____ Zostavax_____

Suncoast Primary Care Specialists

Patient last Name: _____ **Patient First Name:** _____ **D.O.B:** _____

Family History	**Circle Sex**	**If Living**		**If Deceased**	
		Age	Health	Age at Death	Cause
Father					
Mother					
Brother/Sister	M F				
Husband/Wife					
Son/Daughter	M F				
	M F				

Check if any blood relative has or had any of the following and enter their relationship:

	Yes	No	Relationship to you
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Bleeding	☐	☐	_____
Tendency	☐	☐	_____
Cancer	☐	☐	_____
Colitis	☐	☐	_____
Heart Disease	☐	☐	_____
Diabetes	☐	☐	_____
Emphysema	☐	☐	_____
Epilepsy	☐	☐	_____
Goiter	☐	☐	_____
Gout	☐	☐	_____
Hay Fever	☐	☐	_____
Heart attack	☐	☐	_____

	Yes	No	Relationship to you
High Blood BP	☐	☐	_____
Thyroid Disorder	☐	☐	_____
Intestinal Polyp	☐	☐	_____
Kidney Disease	☐	☐	_____
Leukemia	☐	☐	_____
Migraine	☐	☐	_____
Nervous Break	☐	☐	_____
Rheumatic fever	☐	☐	_____
Sickle Cell	☐	☐	_____
Stomach Ulcers	☐	☐	_____
Stroke	☐	☐	_____
Suicide	☐	☐	_____
Tuberculosis	☐	☐	_____
Other			_____
			_____

Medications:

- Asthma Wheezing Medicine
- Aspirin, bufferin, Anacin, Tylenol, or similar
- Blood Pressure medication
- Cortisone, Prednisone
- Cough Medicine
- Laxatives
- Hormone Medication
- Insulin/Diabetic Medication
- Anemia Medication
- Heart Medication
- Sleeping Medicine
- Thyroid medicine
- Weight reducing medicine
- Blood Thinners
- Seizure Medication
- Antibiotics
- Vitamins, or other OTC medication
- Phenobarbital/Barbiturates
- Digestive medication
- Water pills/Diuretics

Patient Last Name: _____ Patient First Name: _____DOB:_____

List each medication; Its dosage and how often you take it, **including** vitamins and herbal medications

Medication	Dosage	How often?	When Started?

Are you Allergic to any medications: ☐ Yes, please list medications and reactions ☐ No

Medication	Reaction

Patient Last Name: _____ Patient First Name: _____ D.O.B _____

Social / Lifestyle History: _____ Primary Language _____

Is there someone that lives in your Residence?	Yes No	If yes, please list name & relationship
Type of residence		Apartment Mobile Home House One Story Two Story Living Facility Facility Name Other
Durable Medical Equipment	Yes No	Wheelchair_____ Oxygen _____ Walker _____ Nebulizer_____ Cane _____ CPAP/BIPAP _____ Other _____
Can you afford medicine?	Yes No	
Transportation Provided by?		
Nutrition History:		
Current Weight? _____LBS		Current Height Weight changes in the past 6 months? **Yes/No** Ft_____ IN_____
Current Diet Plan		
Exercise / Activity:		
Current Activity		How often
Physical Limitations:		
Activities of daily living:		
Do you require assistance to bathe or groom?	Yes No	If yes Explain _____ _____ _____
Do you require assistance for your toilet needs?	Yes No	If yes, Explain _____ _____ _____
Do you require assistance to eat?	Yes No	If yes, Explain _____ _____ _____
Do you have Hearing loss?	Yes No	Do you wear hearing aids? Yes No Last hearing exam date: _____

Patient Consent Form

The department of health and human services has established a “privacy rule” to help ensure that personal health care information is protected for privacy. The ‘privacy rule’ also created their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. We want you to know as our patient, that we respect the privacy of your personal medical records and will do all we can to protect the privacy. When it is appropriate and necessary, we will provide the minimum amount of information to only those who deem necessary or to those you have given permission to speak to as we always strive to take reasonable precautions to protect your privacy. Suncoast Primary Care Specialists supports your full access to your personal medical records. We may have indirect treatment relationships with others, such as laboratories, and may have to disclose PHI for the purpose of treatment, payment, or healthcare operation. Such entities are often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your PHI, but this must be done in writing, under this law, we have the right to refuse to treat you should you refuse to disclose PHI. If you choose to give consent, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already taken place which relied on this or a previously signed consent. If you have any objections to this statement, you may speak without the HIPPA compliance office. Also, you have the right to review our privacy notice, to request restrictions, and to revoke consent in writing after you have reviewed the privacy notice.

Patient Name _____

Signature _____ **Date** _____

By providing us with your email, you will be given access to your protected health information. You will receive an email confirming your request and giving you instructions on how to access the portal.

Email Address_____

Alex T. Villacastin, M.D.
Alistair Cyril W. Co, M.D.
Lydia Wallace D.O.
Beena Stanley M.D.
Sheila M. Villacastin, A.P.R.N.
Alexander T. Villacastin, A.P.R.N.
Frances Villacastin, A.P.R.N.
Jennifer Conran, A.P.R.N.
Catherine T. Joyo, A.P.R,N
Erica Clark, A.P.R.N.
Sara Bland A.P.R.N
Jennifer M. Casola, A.P.R.N.
Erica A. Kardenas, A.P.R.N.
Alec Breckenridge PA-C

Authorization To Release Health Information

Patient name:_____DOB:_____

I authorize the use or release of above names individual's health information as described below:
The following individual or organization is authorized to release information:
Name: **Suncoast Primary Care Specialists**
Address: **2671 W Norvell Bryant Hwy. Lecanto ,FL 34461**
Phone: **352-513-5906** Fax: **352-513-4872**

The Type and amount of information to be used or released is as follows:
Emergency Dept: _____ Radiology: _____ Consultation: _____
Pathology: _____ Entire Record: _____ Other: _____
I understand this information may include records relating to sexually transmitted disease, AIDS/HIV, behavioral or mental health services, or treatment for alcohol or drug abuse.

This information may be released to and used by the following individual(s) or Organization:

Name: _____ Name: _____ Name:_____
Relationship: _____ Relationship: _____ Relationship: _____
Phone: _____ Phone: _____ Phone: _____

By Signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have the right to revoke this authorization at any time and that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, _____.

Signature of patient or legal representative: _____

If signed by legal representative, Relationship to patient: _____

Date: _____/_____/_____ Signature of witness: _____

Controlled Substance Contract

Patient Name _____ DOB _____

By signing this contract, you agree to the following:

1. You MUST have scheduled office visits with the physician who orders the controlled substance at least every month to refill the Prescription. No walk-in visits.
2. Your use of the medications will be re-evaluated at least every three months.
3. NO refill orders will be given evenings or weekends.
4. Any dosage changes must be requested in person during your office visit and will NOT be changed over the phone. If symptoms are worse, you must be seen in the office or proceed to the nearest emergency room.
5. You agree to fill any controlled substances at only one pharmacy of your choosing. Your selected pharmacy is _____.
6. You agree to safeguard all medications/written prescriptions from loss or theft as police reports are no longer accepted. A lost or stolen medicine/written prescription will NOT be replaced under any circumstances. No other types of opiates will be given in its place.
7. If you are referred to pain management, we will no longer prescribe pain medication. You understand the following:
   A. Patients who take opiates or other controlled substances can possibly develop psychological and/or physical dependence and tolerance.
   B. Opiates and other controlled substances may harm your mental and physical ability required to do tasks that can be unsafe such as driving or operating machinery.
   C. You should not take opiates or other controlled substances with alcohol.
   D. Tablet must be taken whole. Do not break, crush, chew or inject any controlled drugs.
   E. You allow the doctor to work with any city/state/federal law enforcement agency such as the DEA and FLA board of pharmacies to check your possible misuse or sale of the product. You also allow your doctor to share a copy of this agreement with the pharmacy. You agree to give up the right to privacy or confidentiality with respect to these organizations.
   F. If you do not follow this protocol, the doctor may stop the medicine or stop your care.
   G. Unethical behavior such as taking controlled substances or taking controlled substances for reasons other than prescribed will result in discharge from the practice.
   H. You agree to RANDOM DRUG SCREENS to monitor your adherence.

_____ _____

Patient Signature Date

****Request for Release of Medical Records****

Date: _____

To: _____
_____
_____

I hereby request that my Medical records be released to:
Suncoast Primary care Specialists
2671 W Norvell Bryant Hwy,Lecanto FL 34461
Phone: 352-513-5906
Fax: 352-513-4872

This Authorization is for release of patient information which includes diagnosis, treatment, and/or examination related to mental health, substance and alcohol abuse, HIV/AIDS, and STD's. By signing this authorization, you give permission for the uses and disclosures of the information described above. I understand that this authorization will remain for a period of (1) year or until I revoke it by submitting a written statement expressing such wishes to Suncoast Primary Care Specialists. I understand that I may be charged a fee of up to $1.00 per page to cover copy fees. This fee is waived for copies provided to healthcare providers and continuing treatment. I also understand that this fee is within the allowable limits as per Florida Statute 395.3025. The information contained herein may be legally privileged and confidential intent only for the use of the individual or entity names above. If the reader of this message is not the intended recipient, you are hereby notified that any use, discrimination, and distribution or copying of this information is strictly prohibited and may result in violations of federal or state law.

Patient Name: _____
Date of Birth: _____
Address: _____
Signature of patient: _____