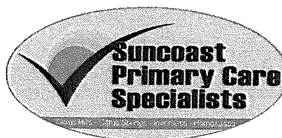

GENERAL INFORMATION:

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

(____)____ Home #

(____)____ Cell Phone #

Home Address ____ City ____ State ____ Zip ____

SS#: ____ - ____ - ____

Male Female (Please Circle)

Single Married Divorced Widowed (Please Circle One)

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 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 or not 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 Suncoast consent to perform medical treatment."

I received The Hippa Privacy Notice and Patient Self Determination Act.

Patient/Guardian Signature ____ Date ____

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Suncoast Primary Care Specialists

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

Preventative Service History

Preventive Services	Date Rec'd	Findings and Recommendations
Bone Mass Measurement (Density)		
Cardiovascular Disease Screening Cholesterol >>>>>>>>>>>>>>>>>>>>>>>>> LDL >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>> EKG >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>	 __________ __________ __________	Hypercholesterolemia ☐ Hyperlipidemia ☐ Other ☐ __________ EKG Results:
Colorectal Cancer Screening Flexible Sigmoidoscopy>>>>>>>>>>>>> Barium Enema >>>>>>>>>>>>>>>>>>>>>> Colonoscopy (not high risk)>>>>>>>>> Fecal Occult Blood Test>>>>>>>>>>>>>	 __________ __________ __________ __________	
Diabetes Screening Hg A1C >>>>>>>>>>>>>>>>>>>>>>>>> Foot Exam >>>>>>>>>>>>>>>>>>>>>>>>> Eye Exam >>>>>>>>>>>>>>>>>>>>>>>>>	 __________ __________ __________	 Cataracts ☐ Other __________
Glaucoma Screening		Glaucoma ☐
PAP and Pelvic Examination		
Prostate Cancer Screening Digital Rectal Exam (DRE) Prostate Specific Antigen Test (PSA)		
Mammogram Screening Breast Self Exam Mammogram		

Date reviewed ______________ Physician Signature ______________

***After review of the Health Risk Assessment please remember to code **99420**

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Patient Medical History

Patient Last Name: ____________ Patient First Name: ____________ D.O. B ____________
Date of last physical exam: ____________ Previous Physician Name: ____________
Physician Address: ____________

PAST HISTORY (Personal and Allergies): Have you had any of the following illnesses?

	Yes	No
Amputation	☐	☐
Anemia	☐	☐
Alcohol Overuse	☐	☐
Allergies (other than medications)	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Bleeding Disorder	☐	☐
Cancer location ____________	☐	☐
Cardiac Arrhythmias Pacemaker ____________	☐	☐
Chicken Pox	☐	☐
Colitis	☐	☐
Depression	☐	☐

	Yes	No
CVA/TIA	☐	☐
Diabetes	☐	☐
Emphysema/COPD	☐	☐
Falls	☐	☐
Gallbladder Disease	☐	☐
Gout	☐	☐
HIV / AIDS	☐	☐
Heart Attack / MI	☐	☐
Other Heart Disease (CHF / CAD)	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
Jaundice	☐	☐
Kidney Disease	☐	☐
Measles / Mumps	☐	☐

	Yes	No
Migraine Headache	☐	☐
Nervous Breakdown	☐	☐
Ostomies ____________	☐	☐
Paralysis	☐	☐
Rheumatic Fever	☐	☐
Seizures	☐	☐
Sexually Transmitted Diseases	☐	☐
Sickle Cell Anemia	☐	☐
Sleep Disorder	☐	☐
Stomach Ulcers	☐	☐
Thyroid Disease	☐	☐
Vascular Disease	☐	☐

PERSONAL HABITS:

1) Have you ever smoked? ☐Yes ☐No If yes, are you are 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, how often: ____________
3) Have you ever used any of the following: Marijuana☐ LSD☐ Heroin☐ Cocaine☐ Speed☐ Other☐

OPERATIONS: List and indicate approximate year.
____
____
____

SERIOUS INJURIES: List injuries & give approximate dates.
____
____
____

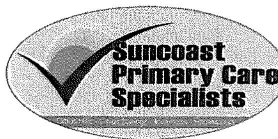
HOSPITALIZATIONS: (Other than operations)
List reasons and approximate dates
____
____
____

DIAGNOSTIC TESTS/EXAMS:

LAST TEST/EXAM	DATE	LOCATION/PROVIDER
EYE EXAM:		
FOOT EXAM:		

IMMUNIZATIONS: (Please give date) Hepatitis B ____________ Flu ____________ Polio ____________

Typhoid ____________ Smallpox ____________ Tetanus ________ Pneumococcal ____________ Chicken Pox ________



Patient Last Name: __________________ **Patient First Name:** ________________ **D.O. B** ______________

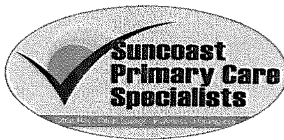
FAMILY HISTORY	Circle Sex	IF LIVING		IF DECEASED	
		AGE	HEALTH	AGE AT DEATH	CAUSE
Father					
Mother					
Brothers/Sisters	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughters	M F				
	M F				

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

	Yes	No	Relationship to you		Yes	No	Relationship to you
Arthritis	☐	☐	________	High Blood Pressure	☐	☐	________
Asthma	☐	☐	________	Intestinal Polyps	☐	☐	________
Bleeding Tendency	☐	☐	________	Kidney Disease	☐	☐	________
Cancer	☐	☐	________	Leukemia	☐	☐	________
Colitis	☐	☐	________	Migraine	☐	☐	________
Congenital Heart Disease	☐	☐	________	Nervous Breakdown	☐	☐	________
Diabetes	☐	☐	________	Rheumatic Fever	☐	☐	________
Emphysema	☐	☐	________	Sickle Cell Anemia	☐	☐	________
Epilepsy	☐	☐	________	Stomach Ulcers	☐	☐	________
Goiter	☐	☐	________	Stroke	☐	☐	________
Gout	☐	☐	________	Suicide	☐	☐	________
Hay Fever	☐	☐	________	Tuberculosis	☐	☐	________
Heart Attack	☐	☐	________	Other	☐	☐	________

MEDICATIONS:

- ☐ Asthma Wheezing Medicine
- ☐ Aspirin, Bufferin, Anacin, Tylenol or Similar Products
- ☐ Blood Pressure Pills
- ☐ Cortisone, Prednisone
- ☐ Cough Medicine
- ☐ Digitalis or Heart Medicine
- ☐ Hormones
- ☐ Insulin or Diabetic Pills
- ☐ Anemia Medications
- ☐ Laxatives
- ☐ Sleeping Pills/Tranquilizers
- ☐ Thyroid Medicine
- ☐ Stomach/Digestive Medicine
- ☐ Weight-Reducing Pills
- ☐ Blood Thinners or Coumadin
- ☐ Dilantin or Seizure Medications
- ☐ Water Pills or Diuretics
- ☐ Antibiotics
- ☐ Phenobarbital/Barbiturates
- ☐ Vitamins or Other Prescriptions or OTC



Patient Last Name: ____________________ **Patient First Name:**_________________ **D.O. B**______________

List each medication; its dosage and how often you take it, including vitamins and herbal supplements.

Medication	Dosage	How Often?	When Started?

Are you allergic to any medications: Yes ☐ o ☐ yes, please list medications and the reactions.

Medication	Reaction

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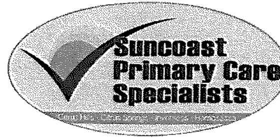


Patient Last Name: ____________ **Patient First Name:** ____________ **D.O. B** ____________

Social / Lifestyle History:		Primary Language ____________
Is there someone that lives in your residence?	YES NO	If yes, please list name and relationship:
Type of Residence		Apartment Mobile Home House One Story Two Story Assisted Living Facility Facility Name ____________ Other ____________
Durable Medical Equipment	YES NO	Wheelchair ________ Oxygen ________ Walker ________ Nebulizer ________ Cane ________ CPAP/BIPAP ________ Other ________
Can you afford medicines?	YES NO	Potential Referral to Patient Assistance Program
Transportation provided by?		
Nutritional History:		
Current Weight ____ **Lbs**	Current Height ____ Ft ____ In	Weight Changes in the past 6 months? **Yes / No**
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: ____________

Additional Comments and Notes:

____

____

Patient Name: ______________________________ **DOB:** ______________

ADVANCED DIRECTIVES

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

Have you executed an advanced 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 directives please ask the nurse or receptionist.

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

____

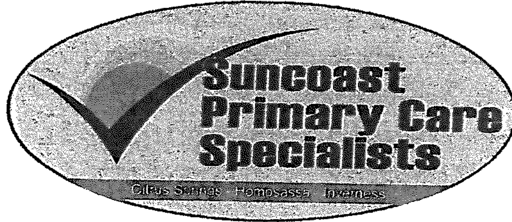
Signature of patient or representative Date

Please provide us with the following information:

Race	Ethnicity	Language
____ White	____ Non-Hispanic	____ English
____ African American	____Hispanic	____ Spanish
____ Asian	____ UNKNOWN	____ Indian (Hindi, Gujarathi etc)
____ Native American/ESKIMO		____ Other
____ Pacific Islander/Native Hawaii		
____ Other	____ Permission to review prior prescription history	
____ UNKNOWN		

____

Signature of patient or representative Date



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Alberto P. Lorenzo, Jr. M.D.
Maria N. Villacastin, A.R.N.P.
Sheila M. Villacastin, A.R.N.P.
Alexander T. Villacastin, A.R.N.P.
Lawrence J. Stawkowski, P.A.

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' WAS ALSO CREATED TO PROVIDE A STANDARD FOR CERTAIN HEALTH CARE PROVIDERS TO OBTAIN THEIR PATIENT'S 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 WE 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 WITH OUR 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 HOW TO ACCESS THE PORTAL.

EMAIL ADDRESS____

10489 N. Florida Ave.
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Fax (352) 489-5786

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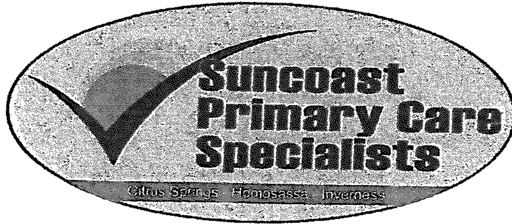

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CONTROLLED SUBSTANCE CONTRACT

Patient Name________________________________ DOB ____________

By signing this contract you agree to the following:

1. You MUST have scheduled office visit 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 prescriptions 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

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SUNCOAST PRIMARY CARE SPECIALISTS

Alex T. Villacastin, M.D.
Marion M. Capahi, M.D.
Alistair Co, M.D.
Alberto P. Lorenzo, M.D.

Request for Release of Medical Records

Date: ______________________

To: ______________________________________
____
____

I Hereby Request That My Medical Records Be Released To:

Suncoast Primary Care Specialists
7991 S. Suncoast Blvd.,
Homosassa, Fl. 34446
Phone: 352-382-8282 Fax: 352-382-2289

Patient Name: ______________________________________

Date of Birth: ______________________________________

Address: ______________________________________
____

Signature: ______________________________________

10489 N. FLORIDA AVE.
CITRUS SPRINGS, FL. 34434
PH: 352-489-2486
FX: 352-489-5786

3733. E. GULF TO LAKE HWY.
INVERNESS, FL 34453
PH: 352-341-5520
FX: 352-341-5523

7991 S. SUNCOST BLVD.
HOMOSASSA, FL. 34446
PH: 352-382-8282
FAX: 352-2289

2623 N. FOREST RIDGE BLVD
HERNANDO, FL, 34442
PH: 352-513-5906
FAX: 352-513-4872

Patient Name: ______________________________ **DOB:** ______________

ADVANCED DIRECTIVES

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

Have you executed an advanced directive? YES ______ NO ______

If YES, is this directive in the form of:

____ A Living Will or DNR (Do not resuscitate) Please provide Copy

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____ 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 directives please ask the nurse or receptionist.

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Please provide us with the following information:

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____ Native American/ESKIMO		____ Other
____ Pacific Islander/Native Hawaii		
____ Other	____ Permission to review prior prescription history	
____ UNKNOWN		

____

Signature of patient or representative   Date