Dennis L. Fernandez, M.D., F.A.C.S.

Patient Information

Patient's Name_____
Last Name First Name Middle Name

Address_____ City_____

State_____ Zip_____ Home Phone (_____)_____ Cell Phone (_____)_____

Sex_____ Date of Birth _____ SSN_____
MM/DD/YY

Patient's Employer_____ Occupation_____ Work Phone (_____)_____

Emergency Contact

Contact's Name_____ Relationship_____ Phone (_____)_____

Primary Care Physician

Name _____ Phone number _____

Address _____

Insurance Information

Insurance #1_____

Group #_____ Contract #_____ Co-Pay_____

Name of Insured_____ Relationship to Patient_____

Sex___ Birth Date_____ SSN_____ Address_____

City, State, Zip_____

Insurance #2_____

Group #_____ Contract #_____ Co-Pay_____

Name of Insured_____ Relationship to Patient_____

Sex___ Birth Date_____ SSN_____ Address_____

City, State, Zip _____

Insurance #3:

If you have a third health insurance policy, please include the details of it on the back of this form.

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Patient's Signature_____ Date_____

If not signed by patient, name and relationship to patient _____

I hereby authorize Dennis L. Fernandez, M.D., P.C. to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request the payment from my insurance company be made directly to Dennis L. Fernandez, M.D., P.C. or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

Patient's Signature_____ Date_____

If not signed by patient, name and relationship to patient _____

I will be responsible for payment of any and all services rendered to the patient listed above by Dennis L. Fernandez, M.D., P.C. and the costs of collection, including a reasonable attorney's fee, and authorize Dennis L. Fernandez, M.D., P.C. to release information to a collection agency or attorney, file insurance and receive payment.

Patient's Signature_____ Date_____

If not signed by patient, name and relationship to patient _____

Dennis L. Fernandez, M.D., F.A.C.S.

Patient Information

Patient's Name_____
Last Name First Name Middle Name

Date of Birth _____

As a result of the healthcare bill that was passed into law by Congress in 2010 (Patient Protection and Affordable Care Act), we are *legally required* to ask *all patients* the following questions. However, *you are not required* to give the requested information. If you choose not to provide the information, please check the "decline to answer" box.

What is your preferred language?
☐ English
☐ French
☐ Greek
☐ Italian
☐ Japanese
☐ Portuguese
☐ Russian
☐ Spanish
☐ Decline to answer

Which one best describes your Ethnicity?
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown
☐ Decline to answer

What is your Race?
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Unknown
☐ Decline to answer

Patient Signature: _____ **Date:**_____

Dennis L. Fernandez, M.D., F.A.C.S.

Patient Name_____ **Date of Birth** _____

Drug Allergies	Reaction Experienced

List any additional allergies on the back of this page

Are you allergic to: **Latex?** Yes No **Penicillin?** Yes No **The antibiotic Keflex?** Yes No

Medications/Supplements and Dosages:

Circle any you are taking: *Blood thinners* *Aspirin* *Fish Oil* *Krill Oil* *Vitamin E*
Diuretic (fluid pill) *Garlic (in pill form)* *Over the counter herbs or vitamins*

☐ I am not taking any of the above mentioned items.

List all medications and supplements you are taking

Medication/Supplement Name	Dosage	Frequency
List additional medications, dosages, and frequencies on the back of this page.		

Family Health History: (please circle health problems of family) ☐**Check box if no known family health history**

Father: High Blood Pressure Heart Disease Diabetes Stroke Cancer (Type_____) Other_____

Mother: High Blood Pressure Heart Disease Diabetes Stroke Cancer (Type_____) Other_____

Brother(s): High Blood Pressure Heart Disease Diabetes Stroke Cancer (Type_____) Other_____

Sister(s): High Blood Pressure Heart Disease Diabetes Stroke Cancer (Type_____) Other _____

Grandparents_____

Social History: (please circle your responses)

Do you smoke? Never smoked No longer a smoker Current smoker _____ packs per day Current E-cigarette user

Occupation: Employed Retired Unemployed Disabled

Marital Status: Married Divorced Separated Single Widowed Widower

Do you drink alcohol? YES NO If yes, how much? ____ Seldom OR ____ drinks per week

Patient's Signature_____ Date_____

Dennis L. Fernandez, M.D., F.A.C.S.

Patient Name_____ **Date of Birth** _____

Past Medical History: (circle all that you are currently treated for) ☐**Check box if past medical history is unremarkable**

High Blood Pressure	High Cholesterol	Stroke	Diabetes Type 1
Heart Disease	Anemia (what kind?)	Emphysema/COPD	Diabetes Type 2
Heart attack	_____	Asthma	GERD
Irregular heartbeat	Osteoporosis	Stomach Ulcers	Enlarged Prostate
Pacemaker (date inserted)	Glaucoma	Menopause	Seizures
_____	Migraines	Rheumatoid Arthritis	Hepatitis A
Varicose veins	Leg pain, itching, swelling	Osteoarthritis	Hepatitis B
AIDS	HIV	Dementia	Hepatitis C
			Alzheimer's disease

Have you been diagnosed with cancer? Yes No

Type cancer _____ Date diagnosed _____

Type cancer _____ Date diagnosed _____

Type cancer _____ Date diagnosed _____

Any other diagnoses or chronic diseases: _____

_____

Do you use a CPAP machine? Yes No (Cirlce one.) Do you use a BIPAP machine? Yes No (Circle one.)

For female patients, are you pregnant? Yes No (Circle one.) If yes, number of weeks gestation _____

Have you had a colonoscopy? Yes No If yes, date of your last colonoscopy _____

Are you a patient of a chronic pain management facility? Yes No

If yes, what is the name of the pain management facility? _____

What is the nature of your pain? _____

Past Surgeries	**Date**
List additional surgeries and associated dates on the back of this page.	

Patient's Signature_____ Date_____

DENNIS L. FERNANDEZ, M.D., P.C.
Dennis L. Fernandez, M.D., F.A.C.S.
General Surgery
4025 Pepperwood Circle SW, Suite C
Huntsville, AL 35801
Office: (256) 882-1908 • Fax: (256) 882-1907

Due to Federal Privacy Laws relating to the new HIPAA regulations we are unable to provide information to *anyone except you*, the patient regarding medical conditions, prescriptions, appointment times or any other information held by the practice *without your specific permission*.

If you desire your spouse, friends, parent, sister or brother or any other designated person to pick up prescriptions, make or check appointments, receive laboratory results or discuss your private medical information, please list that person's name below and sign and date this authorization.

I, _____ Date of Birth_____

hereby authorize Dennis L. Fernandez, M.D., P.C. to release information from my medical records to include, but not limited to my complete medical record, prescription information, appointment or visit information, x-ray results, tests and test results, and laboratory results to the person/persons noted below.

I understand that this consent may be revoked at any time to the extent that disclosure made in good faith has already occurred in release of information on this consent.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

FOR TRANSFER OF MEDICAL RECORDS

I authorize Dennis L. Fernandez, M.D., P.C. and associated personnel to release my medical information to the following:

Name of Physician_____

Name of Physician_____

Name of Physician_____

Patient Signature_____ Date_____

Dennis L. Fernandez, M.D., P.C. employees and officers, and attending physicians are released from legal responsibility or liability for release of the above noted information to the extent authorized herein.

Patient's Signature_____ Date_____

If not signed by patient, relationship to patient _____

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PRESCRIPTION REFILL POLICY

Please read the following prescription refill policy carefully and sign below.

1. I agree to allow 48 hours for prescription refills.
2. I understand that prescription refills requested after 3:00 p.m. will not be received until the next day.
3. I understand that a follow up visit may be required from my physician in order to obtain a refill.
4. I agree to take all medication exactly as instructed. I may not change the dosage or alter the time to take the medication without first speaking to my physician.
5. I must keep all appointments as recommended, so that prescription medications can be monitored.
6. I will not give, trade, or sell medication.
7. I will not alter or forge a prescription. This is a felony and will be reported.
8. I will not combine any narcotic medications with the consumption of alcohol.

I have read, understand and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe pain medications to me.

Patient's Name_____

Date _____

Signature_____

My pharmacy's information is:

Name_____

Location _____

Phone ( ) _____

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I have received the "Notice of Privacy Practices" and give my permission to Dennis L. Fernandez, M.D., P.C. to use and disclose my health information in accordance with the notice provided.

Patient's Name_____

Signature_____

Date _____

If not signed by patient, name and relationship to patient: _____