Dr. George Elias, DO & Dr. Theresa Oakley, DO

63 East Third Street Apopka, FL 32703

www.apopkafamilydoctors.com

ADULT PATIENT INFORMATION: Please write clearly

Last Name: ______________________ First Name: ______________________ MI:______

Mailing Address: ______________________ City: ______________________

State______________ Zip______________ Sex: M or F Date of Birth: ______________ Age:________

Home Phone #:______________ Cell #:______________ Work/other # ______________

Marital Status : __________ Occupation: ______________ Employer:______________

Home Address (if different from mailing address) ______________________ City: ______________

State ____________ Zip ____________ Spouse Name: ______________________

EMAIL ADDRESS:____

Please check the appropriate box:

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ decline to answer

Ethnicity: ☐Hispanic or Latin ☐ Not Hispanic or Latin ☐decline to answer

Primary Language: ☐ English ☐ Spanish ☐ Other:____________________

Please provide insurance card and drivers license to receptionist. Please notify us of any changes in your insurance information. COPAY AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.

Policy Holder's Name :______________________ Date of Birth:______________ Relationship to Patient__________________

Please provide contact information for nearest living relative, not in your household, that we may contact in case of emergency.

Name: ______________________________ Relationship:______________________ ______________________

Phone: ______________________ Alternate Phone Number:______________________________

At times, we may need to view your previous prescriptions so that we may care for you to the best of our abilities. By signing this, you grant Drs. Elias & Oakley, permission to view prescription history from external sources.

SIGNATURE: ______________________________________ **DATE:**____________________

I understand that I am responsible for payment of deductibles, copays and any other charges not paid by my insurance company. **Payments and deductibles are due at time of your office visit**. There is a $30.00 return check fee. If your account becomes delinquent, you are responsible for your bill plus all collection costs. **You are responsible for notifying us of any changes in your insurance information, billing address, email address, and phone numbers.**

You may request a copy of our Notice of Privacy Practices in accordance with HIPAA law.

You are consenting to Drs. Elias & Oakley, PA use of Artificial Intelligence Software for the recording and processing of our medical conversations to help create precise medical documentation and record keeping.

To the best of my knowledge the above information is correct. I understand and agree to comply with Drs. Elias & Oakley, PA financial policies.

SIGNATURE: ______________________________________ **DATE**: ____________________

PRINT NAME: ____

Drs. Elias & Oakley, PA

NAME: ________________________________ **DATE OF BIRTH**: ________________ **AGE**:____________

MEDICAL HISTORY: Please indicate if you have ***now (or have had)*** any of the following:

Seizures ____ Stroke____ HIV/AIDS____ Melanoma____ Thyroid Disease____
Migraines____ Angina____ Bowel Trouble____ Gout____ Blood Clots____
Anemia____ Arthritis____ Liver Disease____ Drug/Alcohol abuse____ Bleeding Disorders____
Allergies____ Heart Trouble____ Stomach Ulcers____ Prostate Trouble____ Emphysema/COPD____
Eye Disease____ Heart Murmur____ Kidney Infections____ Cancer ______________ Asthma____
Sleep Apnea____ Palpitations____ Kidney Stones____ Depression____ Osteoporosis____
High Cholesterol____ Pacemaker____ Kidney Disease____ Suicide Attempt____
High Blood Pressure___ Diabetes ____ Other________________________________

REVIEW OF SYSTEMS: Please indicate if you are ***currently*** having any of the following symptoms:

Weight loss/gain____ Swallowing Difficulties____ Chest Pain____ Excessive Urination____
Ear Pain____ Abdominal Pain____ Painful Urination____ Anxiety/Depression____
Bleeding____ Allergies____ Nausea/Vomiting____ Blood in Urine____
Fever____ Joint Pain____ Sleeping Problems____ Dizziness____
Cough____ Diarrhea/Constipation____ Neck/Back Pain____ Heartburn____
Shortness of Breath____ Memory loss____ Headaches____ Rashes____
Wheezing____ Rectal Bleeding____ Leg Swelling____ Palpitations____
Other:________________________________

SOCIAL HISTORY: ☐ Nonsmoker ☐ Vaping ☐ Current Smoker-for how many years?____________________
☐ Former Smoker—When did you quit?__________________How long did you smoke?____________________
Did you have alcohol in the past year? ☐ No ☐ Yes—how often? ______________________________
How many drinks on a typical day?____________ How often do you consume more than 5 in a single day_______________
Any street drugs?________________________________

LIST PREVIOUS SURGERIES: ________________________________

____

____

List of Specialists:________________________________

Family History:

Relation:	Age	Health Problems	Cause of Death
Father			
Mother			
Siblings			

Date of last wellness exam/physical:__________________
Date of last colonoscopy:____________________________
Pneumonia Vaccine:________________________________

ALLERGIES: Do you have any medication allergies?
____
____

FEMALES ONLY: Could you be pregnant now?__________ Birth Control Method ______________________

How many times have you been pregnant?____________ How many children do you have? ____________________

Date of last pap smear ______________ last mammogram ____________________ last bone density ____________

Please indicate if you have ***now (or have had in the past)*** any of the following:

Breast Surgery____ Sexually Transmitted Disease____ Menstrual Difficulties____ Abnormal pap smear____
D&C____ Hysterectomy____ Ovarian Cysts____ Tubal Ligation____

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MEDICATION LIST

Med Name	Strength	Directions
Example :Abcillin	*500mg*	*1 pill in the AM and 2 in the PM*

Pharmacy Name/Number/Address:____

Patient Allergies:____

Patient Name:____

Name: Date:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Interpretation of Total Score for Depression Severity l 1-4 Minimal depression, 5-9 Mild depression, 10-14 Moderate depression l 15-19 Moderately severe depression 20-27 Severe depression	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
Little interest or pleasure in doing things?				
Feeling down, depressed or hopeless				
Depression is causing sleeping issues				
Depression is causing you to be tired or have little energy				
Depression is affecting eating either too much or too little				
Feeling bad about yourself or that you are a failure, or have let yourself or your family down				
Trouble concentrating on things like reading or watching TV				
Moving or speaking so slowly that other people could notice: or the opposite, being fidgety or restless				
Thoughts that you would be better off dead or hurting your-self in some way				

WellRX/SDOH	**NO**	**YES**
In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?		
Are you homeless or worried that you might be in the future?		
Do you have trouble paying for your utilities (gas, elec-tricity, phone)?		
Do you have trouble finding or paying for a ride?		
Do you need daycare, or better daycare, for your kids?		
Are you unemployed or without regular income?		
Do you need help finding a better job?		
Do you need help getting more education?		
Are you concerned about someone in your home using drugs or alcohol?		
Do you feel unsafe in your daily life?		
Is anyone in your home threatening or abusing you?		

	NO	**YES**
Do you exercise regularly?		
Have you had any falls in the past year?		
Is urinary incontinence a problem for you?		
Do you have difficulty paying for your medication?		
Are you aware of Advanced Directives/Living Will?		
Have you completed Advanced Directives?		

Drs. Elias & Oakley, PA

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care of treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you.

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEATLHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV/AIDS, drug/alcohol use, and mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with other healthcare professionals, laboratories, hospitals, etc) or to others as may be required by law or court order concerning your treatment, payment or healthcare.
- To request from other healthcare entities or providers (doctors, dentists, hospitals, labs, imaging centers, etc) specific healthcare information we may need for planning you care and treatment.
- To submit the necessary information for coverage verification, as well as submit the diagnosis and treatment information to your insurance company, other agencies or individuals for payment of our services and treatment provided to you.
- To leave appointment reminders or other minimum necessary information related to your healthcare or payments on your answering machine, mobile voice mail, text, email, regular mail or with a family member.

If you choose, please list by name and relationship the persons with whom we may discuss any and all your protected health care information including medical, psychiatric, drug or alcohol abuse, HIV testing/AIDs information and/or payment information (example spouse, children, close friend):

Name:____ Relationship:_________________________________

Name:____ Relationship:_________________________________

Name:____ Relationship:_________________________________

- You may request a copy of our "Notice of Patient Privacy Practices" prior to signing this authorization. You have the right to revoke your consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

____ ____________________________

Signature of Patient or Legal Guardian Date

____

Print Patient Name and/or Legal Guardian

Drs. Elias & Oakley, PA

www.ApopkaFamilyDoctors.com

Thank you for choosing us as your board certified Family Medicine Physicians. We are committed to providing you with quality care and creating a long-lasting relationship. Every physician office that you go to may operate differently; therefore we have created this information sheet so that you may be aware of our office policies. Please read it, ask us any questions you may have, and sign in the space provided.

1. **Prescription Refills**: **Please bring all medications to each office visits**. We will review current medications at every office visit. Please keep us updated on changes. Antibiotics, pain medications, or controlled drugs will not be refilled without the patient being seen. Prescription refills are not given over the phone after hours. Refill requests may be made through the patient portal.
2. Physicals/Wellness Visits: Physicals are intended to address wellness and preventive care. In most cases, because of your insurer's payment policy, we may have to complete your wellness care and health concerns on two separate visits.
3. After Hours: We are available after hours by phone for emergency advice only. The after- hours doctor will not call in medications over the phone, this includes pain medications and antibiotics. We take pride in being available for same day appointments and can usually provide care by evaluating a non-emergent problem in person the next business day. Same day appointments do fill up quickly; please call early to be worked in. For Non-Urgent matters, kindly send us a message through your patient portal.
4. No Shows/Cancellation: We request that you notify us 24 hours in advance of an appointment cancellation. Please note that we expect you to reschedule all missed/cancelled appointments so that continuity of care and follow-up of previous problems or test results are not missed.
5. Test Results: Test results automatically upload on the patient portal once available. We will review test results in detail at your follow up office visit. If you do not see your results on the portal within 10 days, please send us a message on the patient portal and we will be happy to assist you. If your test results are abnormal, our office will contact you to provide further instructions. If you have not been contacted please reach out to us. Do not assume that unreported results are normal.
6. Labs/Referrals: All patients are required to know which laboratory, medical provider, or facilities their insurance company is contracted with. We will not be responsible for any expenses incurred by a patient if they utilize any non-covered facility/provider/lab.
7. **Patient Portal:** We ask all patients to use the patient portal for non-emergent office communication. This can include requesting refills, test results, looking up referral information, and asking general questions to the doctor and staff.
8. **Artificial Intelligence:** We may use HIPAA Compliant AI Technology to assist with charting and documentation.

Payment Policy:

1. Insurance. Knowing your insurance benefits is your responsibility: Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service.
3. Proof of insurance: All patients must complete our patient information form yearly, sooner if there is a change in address, phone number, or insurance. We must obtain a copy of your State or Federal Government Issued Identification; and current valid insurance card.
4. Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
5. Nonpayment: If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. In addition to the amount owed, you also will be responsible for the fees charged by the collection agency for costs of collections, attorney fees and court costs.
We understand that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us for assistance in the management of your account. We accept cash, check, debit and credit cards. There is a 3% fee for credit cards. There is a $30.00 return check fee.

Thank you for understanding our office policies. Please let us know if you have questions or concerns.

Our practice is committed to providing the best treatment to our patients.

I have read and understand these policies and agree to abide by their guidelines:

____ ____________________

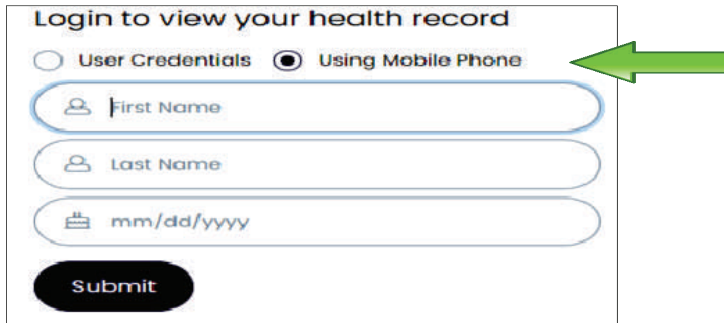
Print Patient Name **Date**

____

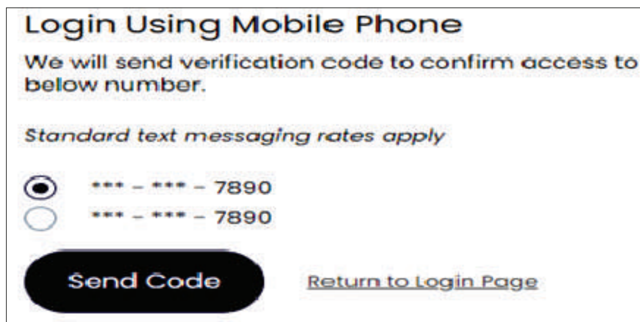
Signature of Responsible Party/Person

Patient Portal Instructions for Drs. Elias & Oakley

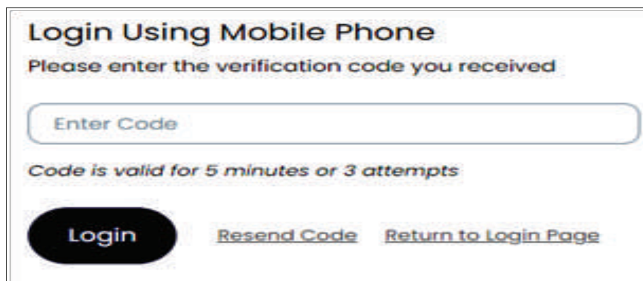
1) Go to our webpage: www.apopkafamilydoctors.com
2) Click on "Patient Portal" in the header.
3) Log in to view your health record "Using Mobile Phone"



4) Input first name, last name and date of birth as noted in our medical records.
5) Using your cell phone number that is displayed, press the "send code" button to receive a verification code to your cell number. (We must have your cell phone number on file).



6) When you receive your portal verification code on your cell phone input code as directed and "Login".



We ask all patients to use the patient portal to **request medication refills, check on test results,** and **send all NONURGENT messages** directly to your physician or office staff.
Patients can also see referral information, appointments, and update pharmacy and contact information.

You can log in using your user name and password that were given to you upon portal activation however, we find it easier to login using your mobile phone number as instructed above.

Lastly, you can download the HEALOW app on your cell phone. Our practice code is **AJCFBA.**