BAY CLINIC

Jesus M Ramirez. MD
Pulmonary Critical Care and Sleep Medicine
621 N Martin Luther King Jr. Bvld
Panama City, FL 32401
Phone: 850-7853212 Fax: 850-7853218

DEMOGRAPHICS

Patient Name: _____Sex: _____
Last First MI

Date of Birth: _____ Age: _____ SSN: _____

Address: _____
City State Zip

Marital Status: S [☐] M [☐] D [☐] W [☐] Email: _____

Phone Number: Home- _____ Cell- _____

Communication Preference: _____Pharmacy: _____

Ethnicity: Hispanic/Latino Yes ☐ No ☐ Language fluently spoken: _____

Sexual Orientation: _____or Decline [☐] Race: _____

Gender Identification: _____or Decline [☐]

Employment Status: Employed [☐] Unemployed [☐] Retired [☐] Disabled [☐]

Occupation: _____ Do you have insurance coverage? _____

Family Physician or Primary Care Physician: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Contact Number: 1) _____ 2)_____

Address: _____
City State Zip

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Health History

- My Main Complaint: _____
- Height: _____ Weight: _____

Please check all that apply and write any additional conditions not listed in the space below:

☐	COPD	☐	Seizures	☐	Heartburn
☐	Asthma	☐	Impotence	☐	Arthritis
☐	HX Bronchitis	☐	Headaches	☐	Gout
☐	HX Pneumonia	☐	Fibromyalgia	☐	Kidney Disease
☐	Cancer: _____	☐	Vertigo/Dizziness	☐	Hemophilia
☐	Emphysema	☐	Syncope/Fainting	☐	Meningitis
☐	Lung Mass/nodules	☐	Heart Disease	☐	Prostate Problems
☐	Pulm. Embolism	☐	Hypertension	☐	Dementia
☐	Bipolar	☐	Depression	☐	Anxiety
☐	PTSD	☐	Back Pain	☐	Low Blood Pressure
☐	Allergies	☐	Muscle Disease	☐	Heart Attack
☐	MS	☐	ADHD	☐	Renal Failure
☐	Restless Leg Syn.	☐	Diabetes	☐	Hypothyroidism
☐	Anemia	☐	Head Injury	☐	DVT
☐	High Cholesterol	☐	Hyperlipidemia	☐	Narcolepsy
☐	Sleep Apnea	☐	Stroke/ TIA	☐	Coronary Art disease
☐	CHF	☐	Cataracts	☐	Chronic Congestion
☐	Neuropathy	☐	Atrial Fibrillation	☐	Herniated Disc
☐	IBS	☐	Mitral Valve Disorder	☐	Osteoporosis
☐	Visual Impairment	☐	Alcoholism	☐	Narcotic Use
☐	Insomnia	☐	Migraines	☐	Obesity

Other:_____

Surgeries: _____

Current Smoker: (☐) No (☐) Yes, Packs per day: _____Smoked For: _____yrs

Former: (☐) No (☐) Yes, Packs per day: ____Smoked For: ____yrs, quit on_____

Drink Alcohol: (☐) No (☐) Yes, How often: _____

Patient Name: _____ DOB: _____

Family History: Please list any major medical problems

Father:	
Mother:	
Son/Daughter:	
Brother/Sister:	
Other:	

If you brought your medications with you or a detailed medication list, you can leave this portion blank and give the nurse your medications or list upon being called to the room and she will enter them into our system.

Medication Name	Dosage and Frequency	Prescribing Doctor

Allergies: _____

Thank you for choosing Bay Clinic for your pulmonary needs!!

Patient Name: _____ DOB: _____

Release of Information

I hereby authorize Bay Clinic of Panama City, FL to release my information to any medical provider such as physicians, medical equipment companies, or hospitals as well as to any insurance company or responsible party. This information may include diagnosis, records of treatment, and any procedures or services rendered. In addition to the above release, I authorize Bay Clinic of Panama City, FL to release any information to the following persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Assignment of Benefits

I authorize and request payments of insurance benefits paid directly to Bay Clinic of Panama City, FL. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of information about me to be released to agents when information is needed to determine benefits. **I understand that I am fully responsible for all deductibles, coinsurances, and disallowed items at the time of service.** I also understand that if a particular item or service rendered if deemed "not reasonable and necessary" under Medicare standards and the claim is denied then I am fully responsible.

Consent to Treat

I authorize Bay Clinic of Panama City, FL and/or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize or order services on my behalf. I understand that in the event of a medical emergency, my physician will be contacted. If immediate medical care is required, 911 will be summoned and I will be transported to Bay Medical Sacred Heart. I understand that there have been no guarantees made to the results of the test(s)/ procedure(s).

Cancellation Policy

We ask that you call us **no later than 24 hours** in advance if you need to cancel or change your appointment. If you fail to comply you **will be charged a cancellation fee of $25.00**. If your insurance provider is Medicaid (or any of its affiliates such as Wellcare or Staywell), **you may be discharged**.

By signing this document I agree to and understand all of the information listed above.

_____ _____

Patient Signature Date Witness Signature Date

Patient Name: _____ DOB: _____

Acknowledgement of Receipt
of Notice of Privacy Practices

By signing below, I acknowledge that I have been provided a copy of Bay Clinic of Panama City, FL's Notice of Privacy Practices.

_____ _____
Patient Signature Date Witness Signature Date

OR

_____
Personal Representative Date

_____
Personal Representative (print)

****For Office Use Only****

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ The patient refused to sign

_____ We were unable to communicate with the patient

_____An emergency situation prevented us from obtaining an acknowledgment

_____ Other: _____

_____ _____
Employee Signature Date