

Barbara Ann Scherer, M.D., P.A.
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Please Print this Out

HMO, PPO & POS Patients

Please Read and Fill Out the Following Forms and Fax
or bring with you on Your Appointment

FAX: 954.771.9980

Patient Authorization and Assignment of Benefits Form

Commercial Insurance And Managed Care Members Lifetime Authorization

I authorize the release of any medical information necessary to process my insurance claim(s). I request that the payment authorized be made on my behalf, and I assign the benefits payable for physician services to Barbara Ann Scherer, MD, PA. I request that this authorization apply to all insurance claims, present and future. In consideration of the provision of medical services, I assume full responsibility for all physician charges for such medical services rendered to myself, derived from deductible and co-insurance amounts as well as any amounts not covered by my insurance carrier, from the actual physician charges. I have been advised that pursuant to 42 C.F.R., Section 405.420, the physician is authorized and obligated to undertake reasonable collection efforts, such as submitting follow-up letters, and engaging in personal and telephonic amounts due and owing pursuant to the rendering of medical services to myself. Further, I agree that, I will be responsible for all collection costs, attorney fees and court costs should this account be referred to an attorney or collection agency. In the event that I am unable to pay my bill, I will report in writing to the physician my inability to pay prior to services being rendered.

Initials: _____

HMO/PPO Acceptance: I certify that I am enrolled in _____ Health Maintenance Organization (HMO)/Preferred Provider Organization (PPO). I understand that if I change HMO/PPO enrollment I must notify Barbara Ann Scherer M.D., P.A. immediately. Subsequent rejection of a claim as a result of failure to notify us of this change will constitute responsibility for payment of claim on my part.

Initials: _____

HMO/PPO Disclaimer: I certify that I am not enrolled in any Health Maintenance Organization (HMO)/Preferred Provider Organization (PPO). Subsequent rejection of a claim due to current enrollment in a HMO will constitute responsibility for payment of claim on my part.

Initials: _____

Signature of Insured

Print Patient/Insured's Name

Today's Date

Barbara Scherer, M.D., P.A.
2001 East Commercial Boulevard
Fort Lauderdale, Florida 33308

REGISTRATION FORM
Please Print

Today's Date _____ Home Phone (____) _____

Name _____ Sex: Male Female
First Middle Last

Local Address _____

City _____ State _____ Zip Code _____

Work Phone (____) _____ Beeper/Cellular Number (____) _____

Social Security Number _____ - _____ - _____ Date Of Birth ____ / ____ / ____ Age ____
Month Day Year

Marital Status: Single Married (Spouse's Name _____) Widowed Divorced

Place of Employment _____ Occupation _____

Address _____
Street City Zip Code

Primary Language Spoken _____ Secondary Language _____

Person To Contact in Case Of Emergency: _____

Phone (____) _____ Relationship _____

How did you learn of our practice? _____

Primary Insurance Company _____

Please return this completed form (front and back), with your insurance card and your driver's license to the receptionist.

Thank You



Preventive Services Education Sheet

The promotion of healthy lifestyles and the early identification of potential health risks will benefit you and are important to us. In accordance with the current United States Preventative Services Task Force (USPSTF) guidelines, we have put together the following information for your guidance. Please read this preventative education sheet and feel free to discuss any of the topics with your physician, and/or Nurse Practitioner. Only **you** can take appropriate actions to maintain your health and well being.

1. Lifestyle changes:

• ***Diet and Exercise***

A healthy diet and regular exercise are the most effective ways to maintain good health, longevity and increase your quality of life. Choose a diet low in saturated fat, cholesterol, sugar and salt; eat plenty of vegetables, fruits, grains which provide vitamins, minerals and fiber, lean meats, pastas, etc. Twenty minutes of exercise, three times a week (i.e., walking, swimming, etc.) will keep your heart and bones healthy.

• ***Substance Abuse***

Use of tobacco is known to cause heart disease, strokes and lung cancer. Excessive alcohol intake is associated with many illnesses, including cancer, liver disease and impaired judgement (as in driving). Illicit drug use has many risks such as AIDS, hepatitis, heart problems, and mental and social disorders.

• ***Sexual Behavior***

Certain sexual practices (i.e., promiscuity, unprotected sex) can expose you to potentially fatal diseases such as AIDS, STDs (sexually transmitted diseases) and other common infections.

• ***Excessive Sun Exposure***

Causes skin cancer; always wear sunscreen when exposed to the sun. The higher the SPF (sun protection factor) you use, the higher the protection level against the ultraviolet rays.

• ***Injury Prevention***

Take advantage of the many safety products that are important in preventing serious injury. These include seat belts, bicycle helmets and other protective gear, safe work habits (lifting, bending, etc), smoke detectors, firearm safety, water safety practices for adults and children, CPR training for household members, etc., poison prevention.

• ***Dental Health***

Brush and floss regularly; see your dentist for routine visits every six months.

(Over)

2. Physical Examination – Preventive Measures

(may vary according to age and specific needs):

Birth – 6 years:

- Newborn: hemoglobin, PKU, thyroid screening
- Childhood immunizations: check with your pediatrician
- Well child checkup

6 years – 18 years:

- Immunizations (booster shots)
- Well child and adolescent checkups (safe sexual practices, injury prevention, i.e., seat belts, bicycle helmets, substance abuse, smoking, etc.)

19 years – 39 years:

- Routine physicals every five years to include pap smears, blood pressure, testicular exam, cholesterol screening (if appropriate)
- Adoption of healthy lifestyle practices (i.e., diet, exercise, smoking cessation, etc.)
- Immunization boosters, (tetanus, diphtheria every 10 years)

40 years - 64 years:

- Routine physicals every three years to include mammograms, sigmoidoscopy, blood pressure cholesterol screening, bone density test, estrogen replacement therapy for post menopausal women, prostate exams, testicular exams, stool tests for occult blood and self breast exam instructions.
- Adult immunizations (tetanus, diphtheria boosters every 10 years).

65+ years:

- Routine physicals every one-two years to include as above (40 years-64 years) as well as influenza vaccine every year, pneumovax once in a lifetime and tetanus diphtheria booster every 10 years.

3. Advance Directives:

A document called a Living Will advises your family and physicians of your desires should you become incapacitated and unable to make decisions regarding your healthcare.

Have you prepared a living will? Yes_____ No_____

The foregoing recommendations are for healthy individuals without symptoms of illness. Special conditions may change the frequency and type of tests you desire, and/or need.

Please sign below to acknowledge that you have read and understand this information.

Signature

Print Name

Date



Barbara Ann Scherer, M.D., P.A.

Diplomate, American Board of Internal Medicine

COMPREHENSIVE HISTORY QUESTIONNAIRE AND PHYSICAL EXAM

Name _____ Today's Date _____

CURRENT MEDICAL PROBLEMS

Please list the **current** medical problem(s) for which you came to see the doctor. About when did they begin?

Problems

Date Began

Doctor's notes on chief complaint and present illness:

D
O
C
T
O
R

U
S
E

O
N
L
Y

CURRENT MEDICATIONS

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as aspirin, cold tablets or vitamin supplements). List name, dosage, and times per day.

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

CURRENT ALLERGIES, SENSITIVITIES AND INTOLERANCES

List anything that you are allergic to such as certain foods, medications, dust, chemicals, soaps, household items, pollens, bee stings, etc. and indicate how each affect you.

RECENT TRAVEL AND IMMUNIZATIONS:

Write in the dates for the shots you had: Tetanus _____ Flu _____ Pneumococcal _____

Have you had a tuberculin (TB) skin test? _____ Date _____ Positive Negative Chest X-Ray Date _____

OTHER MEDICAL CARE:

If you are being treated for any other illness or medical problems by another physician or physical or mental health practitioner, please describe the problems and write the name of the physician, health practitioner or medical facility treating you. Use back page if more space is needed. Check if used

Illness or Medical Problem

Physician or Medical Facility

Address

PAST SURGERIES:

None

Blood Transfusions Yes

No

List here any past surgeries with approximate age: _____

SOCIAL:

Do you use drugs? _____ Which? _____

Hours of Sleep _____/day

Exercise Regularly? Yes No

Intake of Coffee/Tea _____ cups/day/ _____ years

Smoke Cigarettes _____ packs/day/ _____ years

Ex-Smoker _____ pack day _____ years

Alcohol (Occasional, Social, Rare) _____ drinks/day _____ years

PATIENT/PROVIDER CHECKLIST FOR MEDICAL HISTORY

PAST ILLNESSES:

List any serious illnesses, with approximate age.

List childhood diseases:

Sexually Transmitted Diseases: No Yes Which ones: _____

- No serious past illnesses Hypertension Heart Attack
 Diabetes Asthma
 High Cholesterol COPD
 Others _____

FAMILY HISTORY: If any of the following have run in your family, check appropriate box, and in whom:

- Cancer _____ Hypertension _____
 Heart Disease _____ Strokes _____
 Diabetes _____ Alcoholism _____
 Thyroid Disease _____ High Cholesterol _____
 Others _____

REVIEW OF CURRENT SYMPTOMS: Place a checkmark in the appropriate boxes in the following list of **current** symptoms.

MD/Provider Notes

1. HEAD AND NECK

- | | | | | | |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> |
| Vision glasses | <input type="checkbox"/> | <input type="checkbox"/> | Pain in ears | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye pain | <input type="checkbox"/> | <input type="checkbox"/> | Discharge from ear | <input type="checkbox"/> | <input type="checkbox"/> |
| Double Vision | <input type="checkbox"/> | <input type="checkbox"/> | Repeated nosebleeds | <input type="checkbox"/> | <input type="checkbox"/> |
| See "floating lights" | <input type="checkbox"/> | <input type="checkbox"/> | Teeth problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Severe hearing loss | <input type="checkbox"/> | <input type="checkbox"/> | Frequent colds | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Chronic nose obstruction | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Chronic sore tongue | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Persistent sore gums | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Prolonged hoarseness | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Persistent neck rigidity | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Swellings in neck | <input type="checkbox"/> | <input type="checkbox"/> |

2. HEART - CARDIOVASCULAR

- | | | | | | |
|----------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| Heart problems | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain on effort | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | Skipping/irregular heartbeats | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Ankles swell | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Difficult breathing | <input type="checkbox"/> | <input type="checkbox"/> |

3. PULMONARY - LUNGS

- | | | | | | |
|--------------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| Sit up to breathe easier | <input type="checkbox"/> | <input type="checkbox"/> | Spit up blood | <input type="checkbox"/> | <input type="checkbox"/> |
| Have chronic cough | <input type="checkbox"/> | <input type="checkbox"/> | Frequent chest colds | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Wheezing | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Have night sweats | <input type="checkbox"/> | <input type="checkbox"/> |

4. STOMACH AND INTESTINES

- | | | | | | |
|------------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| Chronic abdominal pain | <input type="checkbox"/> | <input type="checkbox"/> | Vomit blood | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent nausea | <input type="checkbox"/> | <input type="checkbox"/> | Skin turns yellow | <input type="checkbox"/> | <input type="checkbox"/> |
| Heartburn | <input type="checkbox"/> | <input type="checkbox"/> | Any chronic diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| Appetite loss | <input type="checkbox"/> | <input type="checkbox"/> | Any black tarry stools | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloating | <input type="checkbox"/> | <input type="checkbox"/> | Anal/Rectal itch | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any blood from rectum | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Clay covered stools | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Habitual constipation | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Have hemorrhoids | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Change in bowel habits | <input type="checkbox"/> | <input type="checkbox"/> |

5. URINARY TRACT - ETC.

- | | | | | | |
|----------------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| Frequent urination | <input type="checkbox"/> | <input type="checkbox"/> | Pain with urination | <input type="checkbox"/> | <input type="checkbox"/> |
| Hard to start urinary flow | <input type="checkbox"/> | <input type="checkbox"/> | Any leakage of urine | <input type="checkbox"/> | <input type="checkbox"/> |
| Scanty urination | <input type="checkbox"/> | <input type="checkbox"/> | Passed any stones | <input type="checkbox"/> | <input type="checkbox"/> |
| Any blood in urine | <input type="checkbox"/> | <input type="checkbox"/> | Any bedwetting | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent night urination | <input type="checkbox"/> | <input type="checkbox"/> | Any retention of urine | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Men - Prostate problem | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Painful menstruation | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Excess menstruation | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Bleed between periods | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any missed periods | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Last menstrual period _____ | | |
| | | | Number of pregnancies _____ | | |
| | | | Number of living children _____ | | |

6. MUSCLES - JOINTS

- | | | | | | |
|---------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| Phys. handicapped/limited | <input type="checkbox"/> | <input type="checkbox"/> | Any tingling sensations | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint or muscle problems | <input type="checkbox"/> | <input type="checkbox"/> | Any numbness | <input type="checkbox"/> | <input type="checkbox"/> |
| Shoulder pain | <input type="checkbox"/> | <input type="checkbox"/> | Disturbance in walking | <input type="checkbox"/> | <input type="checkbox"/> |
| Back pain | <input type="checkbox"/> | <input type="checkbox"/> | Any muscle jerking | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any paralysis | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any shaking | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any strokes | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any seizures | <input type="checkbox"/> | <input type="checkbox"/> |

7. NEUROPSYCHOLOGICAL

- | | | | | | |
|---------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis/weakness | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervous breakdown | <input type="checkbox"/> | <input type="checkbox"/> | Any memory loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Any mental problems | <input type="checkbox"/> | <input type="checkbox"/> | Personality changes | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizzy spells | <input type="checkbox"/> | <input type="checkbox"/> | Speech disturbances | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Psychotherapy/counseling | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any alcohol problem | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any drug problem | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Serious mental problem | <input type="checkbox"/> | <input type="checkbox"/> |

If there are any additional health factors in your history or if any of the above points need clarifying use this space for additional comments.



Barbara Ann Scherer, M.D., P.A.

Internal Medicine

MEDICAL RELEASE

1. I hereby authorize Barbara Ann Scherer, M. D., PA
- TO RELEASE copies of my medical records to:
 - TO RECEIVE copies of my medical records from:

2. I understand that my records may contain information pertaining to my diagnosis or treatment of my medical, psychiatric, AIDS/ARC/HIV testing, alcohol or drug abuse condition. I also understand that any topic discussed during my medical treatment was documented, and therefore, will be released.

Signature Date

3. Information to be released/requested: (Please Circle)

OFFICE NOTES	LAB	X-RAYS	EKG
D/C SUMMARY	DX	H&P	ALL

Date of Service(s) _____

4. I understand that this release can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. To revoke this consent, written notice must be given.
5. This consent expires in 90 days.
6. Barbara Ann Scherer, M. D. PA is released from any legal responsibility of liability; for the release of the above information to the extent indicated and authorized herein.

Signed _____ Date _____

Print Patient Name _____

Patient SS# _____ Date of Birth _____

Patient Address _____

Print name of person signing for the patient and their relationship to the patient: _____

Witness _____ Date _____