

# CONFIDENTIAL PATIENT INFORMATION

## PERSONAL INFORMATION

NAME: \_\_\_\_\_  
LAST FIRST MIDDLE

HOME ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP CODE

HOME PHONE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

CELL#: \_\_\_\_\_ SSN: \_\_\_\_\_ SEX: MALE / FEMALE

EMERGENCY CONTACT AND PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

## INSURANCE INFORMATION:

AUTO OR HEALTH INSURANCE (CIRCLE ONE)

PRIMARY INSURED PARTY: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ INSURANCE PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

POLICY #: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

SECONDARY INSURED PARTY: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ INSURANCE PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

POLICY #: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

## MEDICAL INFORMATION:

REASON FOR TODAY'S VISIT? \_\_\_\_\_

WHAT ARE YOUR SYMPTOMS? \_\_\_\_\_

WAS THIS ACCIDENT: ( ) AUTOMOBILE ( ) JOB INJURY ( ) OTHER

DATE OF ACCIDENT OR INJURY: \_\_\_\_\_

# CONFIDENTIAL PATIENT INFORMATION

**PAST MEDICAL HISTORY:** HAVE YOU EVER BEEN TREATED FOR:

	NO	YES		NO	YES
ANEMIA	_____	_____	HIGH BLOOD PRESSURE	_____	_____
ULCER	_____	_____	CANCER	_____	_____
ASTHMA	_____	_____	EPILEPSY	_____	_____
STROKE	_____	_____	DIABETES	_____	_____
BLEEDING DISORDER	_____	_____	HEART ATTACK	_____	_____
HIV/AIDS	_____	_____	EMPHYSEMA	_____	_____
LIVER PROBLEMS	_____	_____	KIDNEY PROBLEMS	_____	_____
HEART DISEASE / ANGINA	_____	_____	ALCOHOL OR DRUG ABUSE	_____	_____

ARE YOU CLAUSTROPHOBIC?       YES       NO

DO YOU SMOKE?       YES       NO      IF YES HOW MANY PACKS PER DAY? \_\_\_\_\_

**CURRENT MEDICATIONS:**

<u>NAME OF MEDICATION(S)</u>	<u>TAKEN FOR</u>
_____	_____
_____	_____
_____	_____

**ALLERGIES:**

\_\_\_\_\_

\_\_\_\_\_

**SURGERIES:**

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY:** PLEASE LIST ANY SERIOUS ILLNESS THAT HAVE OCCURRED IN YOUR FAMILY:

CANCER	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	LOCATION OF CANCER: _____	RELATION: _____
HEART DISEASE	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	RELATION: _____	_____
HIGH BLOOD PRESSURE	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	RELATION: _____	_____
STROKE	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	RELATION: _____	_____
DIABETES	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	RELATION: _____	_____
INTERCRANIAL ANEURYSM	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	RELATION: _____	_____
BRAIN TUMOR	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	RELATION: _____	_____
OTHER SERIOUS ILLNESSES	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	RELATION: _____	_____

PLEASE SPECIFY : \_\_\_\_\_

# CONFIDENTIAL PATIENT INFORMATION

**REVIEW OF SYSTEMS:** DO YOU CURRENTLY, OR HAVE YOU HAD PROBLEMS WITH:

GLAUCOMA	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
WEARING HEARING AIDS	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
HEARING LOSS	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
RINGING IN THE EARS	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
BALANCE DISTURBANCE (e.g. VERTIGO, SPINNING)	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
CHEST PAIN OR ANGINA	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
HIGH BLOOD PRESSURE	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
HEART MURMUR	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
HIGH CHOLESTEROL	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
ASTHMA	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
BRONCHITIS	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
EMPHYSEMA	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
NAUSEA	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
LIVER DISEASE	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
ABDOMINAL PAIN	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
BROKEN BONES	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
BACK PAIN	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
JOINT PAIN OR SWELLING	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
ARM OR LEG PAIN / WEAKNESS	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
ARTHRITIS	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
SKIN DISEASE	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
DOUBLE OR BLURRED VISION	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
SEIZURES	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
FAINTING SPELLS OR "BLACKING OUT"	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
ANXIETY	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
DEPRESSION	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
DIABETES	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
ANEMIA	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
BRUSING EASILY	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
T.B.	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

DATE OF LAST EXAM: \_\_\_\_\_

LEFT     RIGHT     BOTH

LIST: \_\_\_\_\_

WHERE: \_\_\_\_\_

WHERE: \_\_\_\_\_

**CANCER INFORMATION**

LUNG CANCER	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
COLON CANCER	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
PROSTATE CANCER (MALES)	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
ENDOMETRIOSIS (FEMALES)	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
UTERINE OR CERVICAL CANCER (FEMALES)	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
BREAST CANCER	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
SKIN CANCER	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

DATE OF LAST CHEST X-RAY: \_\_\_\_\_

ANY OTHER ACTIVE (MILIGNANT) CANCER \_\_\_\_\_

**CONFIDENTIAL PATIENT INFORMATION**

**ATTORNEY INFORMATION:**

ATTORNEY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_

I UNDERSTAND THAT THIS OFFICE WILL PREPARE MY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I PERMIT DR. CRIS E. LANGHEIER TO ENDORSE MY NAME TO ANY CHECK WRITTEN IN BOTH OUR NAMES, WHERE AS SUCH A CHECK IS PAYMENT FOR SERVICES REGARDING MY INJURY. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

OR  
GUARDIAN'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

## APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

DATE	OUR POLICY HOLDER	DATE OF ACCIDENT	FILE NUMBER
------	-------------------	------------------	-------------

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY. Thank You.

TO: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE."

YOUR NAME	PHONE NO. (Include Area Code)	HOME	BUSINESS
-----------	----------------------------------	------	----------

YOUR ADDRESS (No, Street, City or Town, State & Zip Code) Permanent Address if Different	How Long Have You Lived In Florida?	Date of Birth	Social Security #
---	-------------------------------------	---------------	-------------------

Date and Time of Accident A.M. _____ P.M. _____	Place of Accident (Street, City or Town & State)
---	--

Brief Description of Accident and Vehicles Involved: (If Additional Space is Needed, Use Reverse Side)

Describe Motor Vehicle You Own:

Describe Motor Vehicle Owned By Any Member of Your Family:

As a Result of This Accident Were You Injured? YES  NO  If Your Answer is Yes, Complete The Rest of This Form  
If No, Sign Here and Return This Form To Us.

Signature \_\_\_\_\_ DATE \_\_\_\_\_

Describe Your Injury: (If Additional Space is Needed, Use Reverse Side)

Were You Treated By A Doctor YES <input type="checkbox"/> NO <input type="checkbox"/>	Doctor's Name and Address
--	---------------------------

If You Were Treated In A Hospital Were You AN IN-PATIENT? _____ OUT-PATIENT? _____	Hospital's Name and Address
---	-----------------------------

Amount of Medical Bills To Date \$	Will You Have More Medical Expense? YES <input type="checkbox"/> NO <input type="checkbox"/>	At The Time of Your Accident Were You In The Course of Your Employment? YES <input type="checkbox"/> NO <input type="checkbox"/>
---------------------------------------	---	---

Did You Lose Wages or Salary As A Result Of Your Injury? YES <input type="checkbox"/> NO <input type="checkbox"/>	If YES, Amount Lost To Date \$	What Is Your Average Weekly Wage or Salary? \$
--	-----------------------------------	---

If You Lost Wages:	Date Disability From Work Began: / /	Date You Returned To Work: / /
--------------------	---	-----------------------------------

Have you received or are you eligible for payments under any Workmen's Compensation or unemployment law? YES <input type="checkbox"/> NO <input type="checkbox"/>	If YES, Amount	\$ Per Week Per Month
--	-------------------	--------------------------

List Names and Addresses of Your Present Employer(s) and Give Your Occupation and Dates of Employment for Each.

<i>Employer and Address</i>	<i>Your Occupation</i>	<i>From</i>	<i>To</i>
<i>Employer and Address</i>	<i>Your Occupation</i>	<i>From</i>	<i>To</i>

As A Result of Your Injury, Have You Had Any Other Expenses YES  NO  If "YES", Explain On Reverse Side

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

- IMPORTANT:
1. To Be Eligible For Benefits, Complete and Sign This Application
  2. Sign Attached Authorization(s)
  3. Return Promptly With Any Medical Bills You Have Received To Date

**Langheier Healthcare**  
P.O. Box 1287  
Tarpon Springs, Fl. 34688  
**Authorization for Release of Protected Health Information**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Information Requested From: \_\_\_\_\_

Recipient of Information: \_\_\_\_\_ Self \_\_\_\_\_ Other \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax#: \_\_\_\_\_

Information To Be Disclosed:

- All Patient intake data/patient history.
- All Doctor's and Nurse's notes, memos, phone messages, or other such documents.
- Office notes and records of office visits.
- All reports containing opinions, diagnosis, recommendations, or evaluations of the patient's medical condition, prognosis, disabilities, future medical needs, limitations, or ability to work.
- Records from other Health Care Providers.
- Diagnostic and lab test results, as well as, reports interpreting such tests or data.
- All Correspondance
- X-ray, CT Scan, Myelogram, bone scan, and/ or MRI reports or results.
- Any psychological testing reports and results.
- Information related to HIV tests and results.
- Financial Statement

Purpose of Disclosure

- Continuing care with another physician or hospital
- Personal Copy
- Other: \_\_\_\_\_

Authorization

I Understand that:

1. This authorization will remain in effect for 1 year.
2. I may revoke this authorization at any time in writing, but if I do , it will not affect any actions taken prior to receiving the revocation.
3. I may refuse to sign this authorization and that is strictly voluntary.
4. My treatment, payment, enrollment, or eligibility for benefits may not be conditiones on signing thisk authorization.
5. If the requestor or receiver is not a health plan or health care provider, the release of information may no longer be protected by federal privacy regulations and may be redisclosed.
6. I understand that I may see and obtain a copy of the information described on this form, for any reasonable copy fee, If I ask for it.
7. I will receive a copy of this form.I acknowledge, and hereby consent to such, that the protected health information released may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. I also acknowledge I have reas the above and authorize the disclosure of the protected health information as stated.

Patient/ Guardian  
Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient/ Guardian  
Printed Name \_\_\_\_\_

Relationship to Patient  
\_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_

**NOTICE: PATIENT PRIVACY**  
**October 15, 2002**

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

**HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.**

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact Tiffany Cole, Administrator of Langheier Healthcare at 727 943-7354.

I have received a copy of this notice for my personal file:

---

Patient signature

---

Date



5 Locations Serving Pasco ● Pinellas ● Hernando ● Hillsborough

Orthopedic & NeuroSurgical Evaluations ● Medical ● Chiropractic ● Massage & Physical Therapy ● Diagnostic Evaluations

**AUTHORIZATION  
INSURANCE BENEFITS AND ATTORNEY**

**RE:**

To Whom It May Concern:

I hereby authorize and DIRECT you, my attorney, to PAY DIRECTLY TO **DR. CRIS E. LANGHEIER, P.O. Box 1287 Tarpon Springs, FL. 34688** such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due to this office, and to withhold such sums from any disability, medical payments benefits, no-fault benefits, health and accident benefits, workers compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said office.

I, the undersigned, hereby agree that in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay any additional charges equal to the cost of collection, including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

I understand that I remain personally responsible for the total amounts due this office for their services. I further understand and agree that this Authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering service at their option.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Authorization.

I agree that the above-mentioned office be given Power of Attorney to endorse/sign my name on any and all checks/forms for payment of my doctor's bill.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

THE UNDERSIGNED, BEING ATTORNEY OF RECORD FOR THE ABOVE PATIENT DOES HEREBY ACKNOWLEDGE RECEIPT OF THE ABOVE AUTHORIZATION, AND DOES AGREE TO HONOR THE SAME TO PROTECT ADEQUATELY SAID PROVIDER NAMED ABOVE.

**Attorney's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

ATTORNEY: PLEASE DATE, SIGN AND RETURN ONE COPY TO PROVIDERS OFFICE.

P.O. Box 1287 • Tarpon Springs, FL • 34688

Phone (727) 942-4140 • Fax (727) 938-7807 • 24Hr. Phone • Toll Free (800) 465-TEST (8378)

www.langheier.com



## CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize Langheier Healthcare to use and disclose my health and medical information for the purposes of Treatment, Payment and Health Care Operations.\*

**\*Treatment** (includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

**\*Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

**\*Health Care Operations** (includes the necessary administrative and business functions of our office).

You may review Langheier Healthcare "Notice Of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. Please verify that you have received a copy of our Notice by placing your initials here: \_\_\_\_\_.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

***I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Langheier Healthcare has already used or disclosed the information in reliance on this Consent.***

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Person Authorized by Law

\_\_\_\_\_  
Date