Matthew D. Imfeld, M.D., LLC

Central Florida Physiatrists, P.A.

Board Certified: Physical Medicine and Rehabilitation
Electrodiagnostic Medicine
Diplomat American Academy of Pain Management

Patient Name: _____ **Date:** _____

Address: _____ **zip:** _____

Cell phone: _____ **email:** _____

Date of Birth: _____ **Age:** _____ **last four digits of SS#:** _____

Employer Name: _____ **Occupation:** _____

Sex: M_____ F_____ **Marital Status:** _____

Emergency Contact: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

IF Workers' Compensation or Auto Accident:

Date of Accident: _____ **Place of Accident:** _____

How did Accident Happen: _____

Adjuster or NCM: _____ **Phone/Fax:** _____

Private Insurance

Insurance Name: _____ **Phone:** _____

Policy or Claim Number: _____ **Group #** _____

Secondary Insurance: _____

Responsible Party: _____ **D.O.B.:** _____

I agree to be financially responsible for all services not covered by my insurance unless it is Workers' Compensation.

I authorize the release of all medical information necessary to process this claim and is pertinent to my medical care.

Patient Signature: _____ **Date:** _____

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Orlando, Florida 32801
2020 Oakley Seaver Drive, Clermont Fl. 34711
Phone (407) 352-6121 Fax (407) 370-7100 email: imfeld@imfeldmd.com

Matthew D. Imfeld M.D., LLC
MEDICAL HISTORY

Name: _____ **Date of Birth:** _____ **Gender:** _____ **Today's date:** _____

Primary Language: _____ **Ethnicity:** ___Hispanic/Latino ___Not Hispanic/Latino

Race: ___American Indian/Alaskan Native ___Asian ___Black/African American
___Native Hawaiian/Other Pacific Islander ___White/Caucasian ___Other ___Unknown

Health History:
___Diabetes
___Cancer
___ High Blood Pressure
___Heart Trouble
___Alcoholism
___Stomach Ulcer
___Liver Trouble
___ Thyroid Trouble
___ Bleeding Disorder
___ Lung Disease
___ Kidney Trouble or Stones
___Seizures
___Mental Illness
___Arthritis
___Stroke
___ Drug Addiction
___Anemia
___Other Illnesses

Family History:
___Diabetes
___Cancer
___ High Blood Pressure
___Heart Trouble
___Alcoholism
___Stroke
___Rheumatoid Arthritis
___ Bleeding Disorder
___ Kidney Trouble or Stones
___ Drug Addiction

Social History:
Occupation: _____
Work Restrictions:
_____

Marital Status: _____

Number of Children Living: __

Review of Systems:
___ Change of Vision
___ Difficulty Swallowing
___Shortness of Breath
___Chills or Fever
___Heart or Chest Pain
___ Badly Swollen Ankles
___ Calf Cramps with Walking
___Nausea or Vomiting
___Stomach Pain
___Ulcers
___Frequent Loose Bowel Movement
___Blood in Bowel Movement
___Frequent Constipation
___Frequent Urination (pass water)
___Frequent Headaches
___Blackouts
___Seizures
___ Recent Weight Change
___Insomnia

Reason for visit: _____
_____
_____
_____

Surgeries/Dates: _____
_____

Current Medications/Dosages: _____
_____
_____

Allergies/Reactions: _____

Smoking: Years Smoked: _____ ___ packs per day / week / month. ___ Never Smoked ___Former Smoker
Alcohol: Never ___ Occasional ___ Moderate ___ Heavy ___ Recovering ___
Drug Use: Never ___ Occasional ___ Moderate ___ Heavy ___ Recovering ___

Height: _____ **Weight:** _____ **B/P:** _____ **Pulse:** _____

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HIPAA ACKNOWLEDGMENT

With my consent, Matthew D. Imfeld M.D., LLC, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Matthew D. Imfeld M.D., LLC Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Matthew D. Imfeld M.D., LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Matthew D. Imfeld M.D., LLC c/o Privacy Officer at 214 E. Lucerne Circle, Suite B. Orlando, FL 32801.

With my consent, Matthew D. Imfeld M.D., LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Matthew D. Imfeld M.D., LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements and laboratory results as long as they are marked Personal and Confidential.
I have the right to request that Matthew D. Imfeld M.D., LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Matthew D. Imfeld M.D., LLC the use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already used or disclosed PHI to carry out TPO.

If I do not sign this consent, Matthew D. Imfeld M.D., LLC may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Patient Name

_____ _____

Print Name of Legal Guardian (if applicable) Date

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