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**ADVANCED SURGICAL ASSOCIATES  
OF WEST FLORIDA**

DR. RICHARD S. GORDON

DR. JOHN-PAUL GONZALVO

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***PATIENT INFORMATION FORM***

*\*\* All information is kept confidential. Please answer honestly to assure the best possible treatment for you. Please complete all pages. \*\**

***(Please Print)***

Today's Date: \_\_\_\_\_

**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Street Address: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Sex:  Male  Female

Driver License Number: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**PRIMARY AND REFERRING PHYSICIAN INFORMATION:**

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**SPOUSE/GUARDIAN INFORMATION:**

Spouse's Name or Guardian's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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**Largo Location**

1258 West Bay Drive  
Largo, Florida 33770

Phone: (727) 586-3751

**Dunedin Location**

646 Virginia Ave. 5<sup>th</sup> Floor  
Dunedin, Florida 34698

Fax: (727) 584-3102

**Bardmore Location**

8787 Bryan Dairy Rd. Suite 280  
Largo, Florida 33775

[www.ASAWEST.com](http://www.ASAWEST.com)

# CLINICAL HISTORY FORM

PATIENT NAME: \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

## REASON FOR YOUR VISIT

What is the reason for this visit? \_\_\_\_\_

How long have you had the problem? \_\_\_\_\_

## CURRENT MEDICATIONS *(List all medications / herbal / dietary supplements / alternative medications and treatments you are currently taking):*

<i>Medication</i>	<i>Dosage</i>	<i># Per Day / Frequency</i>	<i>Reason for Taking</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\*\*\*\*\* Please list any other current medications on the other side of this sheet. \*\*\*\*\*

## MEDICATION ALLERGIES *(Are you allergic to any medications?)*

<i>Medication</i>	<i>Reaction</i>
_____	_____
_____	_____
_____	_____

Do you have any problems with anesthesia?  Yes  No

Have you had an allergic reaction to tape?  Yes  No

Do you have an allergy to latex products?  Yes  No

## PAST SURGICAL HISTORY

*Check all that apply and write in year if you remember:*

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Appendectomy _____                              | <input type="checkbox"/> Hernia, Inguinal _____ | <input type="checkbox"/> Hernia, Incisional/Ventral _____ |
| <input type="checkbox"/> Breast Biopsy _____                             | <input type="checkbox"/> Chest Surgery _____    | <input type="checkbox"/> Mastectomy _____                 |
| <input type="checkbox"/> Coronary Artery Bypass _____                    | <input type="checkbox"/> Prostate _____         | <input type="checkbox"/> Gallbladder _____                |
| <input type="checkbox"/> Tonsillectomy _____                             | <input type="checkbox"/> Hysterectomy _____     | <input type="checkbox"/> Tubal Ligation _____             |
| <input type="checkbox"/> Vascular Surgery _____ <i>(describe):</i> _____ | <input type="checkbox"/> Hip Replacement _____  | <input type="checkbox"/> Rotator Cuff Surgery _____       |
| <input type="checkbox"/> Knee Surgery _____                              |   |   |
| <input type="checkbox"/> Other _____                                     |   |   |
| <input type="checkbox"/> Other _____                                     |   |   |

Physician's Initials \_\_\_\_\_

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(Continued)

PATIENT NAME: \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

PAST MEDICAL HISTORY (Please check all medical problems that apply; Use lines below for any details you need to elaborate on):

- Stroke
- Diabetes (on insulin)
- Heart Attack(s); if yes, year(s): \_\_\_\_\_
- High cholesterol/lipids levels
- Low Thyroid
- Emphysema
- Large Prostate
- Diverticulosis
- Kidney Disease/Stones
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- TIA's
- Diabetes (on pills)
- Anemia
- High Thyroid
- Bronchitis
- Bleeding Disorder
- Arthritis
- Cancer (see below also)
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Hypertension
- Seizure disorder
- Angina/Chest Pains
- Glaucoma
- Gallstones
- Asthma
- Hepatitis
- Depression/Anxiety
- Migraines

Details:

\_\_\_\_\_  
\_\_\_\_\_

FAMILY HISTORY

Family Member:	Circle:	Age:	Health Problems (i.e. cancer, heart disease, etc):
Father	Alive/Deceased	_____	_____
Mother	Alive/Deceased	_____	_____
Brother / Sister	Alive/Deceased	_____	_____
Brother / Sister	Alive/Deceased	_____	_____
Brother / Sister	Alive/Deceased	_____	_____
Child	Alive/Deceased	_____	_____
Child	Alive/Deceased	_____	_____
Child	Alive/Deceased	_____	_____

SOCIAL HISTORY

Tobacco  None  Currently smoke \_\_\_ packs/day and have done so for \_\_\_\_ years.  
 Previously smoked \_\_\_\_\_ packs/day for \_\_\_\_\_ years. Stopped in \_\_\_\_\_.

Alcohol  None  Minimal  Moderate  Heavy  Previously Heavy  
Caffeine  None  1-3 Servings Daily  3-4 Servings Daily  More than 6 servings Daily  
Drug Use  \_\_\_\_\_  \_\_\_\_\_

PERSONAL HISTORY OF CANCER (if applicable):

Type of cancer(s) \_\_\_\_\_

When was/were your cancer(s) treated? \_\_\_\_\_

What type of cancer treatment did you receive?  Chemotherapy  Radiation Therapy  Surgery

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(Continued)

PATIENT NAME: \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

SYSTEMS REVIEW (Please place a check next to yes if the item applies to you)

	Yes		Yes		Yes
<b>GENERAL</b>		<b>CARDIO / HEART</b>		<b>SKIN</b>	
Weight Loss	<input type="checkbox"/>	Chest Pain or Angina	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	Heart Skips	<input type="checkbox"/>	Ulcerations	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	Rapid Heart Rate	<input type="checkbox"/>	Rash	<input type="checkbox"/>
Fever	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	Itching	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>
Chills	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Non Healing Lesions	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	History of Skin Cancer	<input type="checkbox"/>
<b>EYES</b>		Cardiac Testing within the last year (i.e. EKG)	<input type="checkbox"/>	<b>NEUROLOGICAL</b>	
Blurred Vision	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Loss of Consciousness	<input type="checkbox"/>
Episodic Blindness	<input type="checkbox"/>	<b>GI / DIGESTIVE</b>		Transient Loss of Function	<input type="checkbox"/>
Cataract (s)	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
<b>EARS</b>		Nausea	<input type="checkbox"/>	<b>EMOTIONAL</b>	
Earache	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Infection	<input type="checkbox"/>	Heartburn or GERD	<input type="checkbox"/>	Psychiatric Therapy	<input type="checkbox"/>
Drainage	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<b>ENDOCRINE</b>	
Pain	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>
Mild Hearing Loss	<input type="checkbox"/>	Blood in Stool	<input type="checkbox"/>	Masses	<input type="checkbox"/>
Hearing Impaired	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Heat or Cold Intolerance	<input type="checkbox"/>
<b>NOSE/THROAT</b>		Crohn's Disease	<input type="checkbox"/>	Diabetes Under Treatment	<input type="checkbox"/>
Frequent Nosebleeds	<input type="checkbox"/>	Irritable Bowel Disease	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	Ulcerative Colitis	<input type="checkbox"/>	Excessive Hunger	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	<b>HEMATOLOGIC</b>	
Difficulty Swallowing	<input type="checkbox"/>	<b>GENITO-URINARY</b>		Anemia	<input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>
Sores in Mouth of Lips	<input type="checkbox"/>	Difficulty Holding Urine	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>
Chronic Sinus Congestion	<input type="checkbox"/>	Frequent Urination at Night	<input type="checkbox"/>	Swollen Glands	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Lymphoma	<input type="checkbox"/>
<b>RESPIRATORY / LUNGS</b>		Herpes	<input type="checkbox"/>	Transfusions	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	Men: Prostate Cancer	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	Men: Discharge from Penis	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>
Emphysema or COPD	<input type="checkbox"/>	Women: Menopause	<input type="checkbox"/>	Deep Venous Thrombosis	<input type="checkbox"/>
Coughing up Blood	<input type="checkbox"/>	Women: Hysterectomy	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>
TB or positive skin test	<input type="checkbox"/>	<b>MUSCULOSKELETAL</b>		<b>BREAST</b>	
Sleep apnea	<input type="checkbox"/>	Pain in Joints	<input type="checkbox"/>	Lumps	<input type="checkbox"/>
Pulmonary Embolus	<input type="checkbox"/>	Pain in Muscles	<input type="checkbox"/>	Cysts	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
<b>INFECTIONS</b>		Chronic Back Problems	<input type="checkbox"/>	Breast Pain	<input type="checkbox"/>
HIV Positive	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	Family History	<input type="checkbox"/>
History of Hepatitis	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>		
Staph Infections	<input type="checkbox"/>				

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*(Continued)*

PATIENT NAME: \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

**OTHER INFORMATION** *(Please write below any other information not covered in this Clinical History Form that you feel the doctor or surgical staff should know about)*

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**PATIENT'S SIGNATURE**

I certify that, to the best of my knowledge, the above information is complete and accurate.

Patient's Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Thank you for choosing Advanced Surgical Associates of West Florida to provide your surgical care.**

*Dedicated To Delivering Quality Surgical Care*

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DR. RICHARD S. GORDON

DR. JOHN-PAUL GONZALVO

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## ***GENERAL PATIENT / PHYSICIAN AGREEMENT***

Please read the following paragraphs, initial below each paragraph that you have read, understand, and agree to the same.

### **CONFIDENTIALITY:**

In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method, and/or any physician that can assist with the care of the patient, as long as confidentiality is kept at the physician level. I have read, understand, and agree with the above.

Patient/Guardian Initials: \_\_\_\_\_ Date: \_\_\_\_\_

### **ARBITRATION:**

The patient understands that he or she is not required to use treating physician or any physician employed by or under the direction of this facility or practice for general healthcare and or surgery. The patient understands medicine is not an exact science and there is risk involved in any medical procedure. The patient understands he or she is being treated at their own risk. It is further understood that in the event of any controversy or dispute which might arise between the patient and the physician, regardless of whether the disputes concerns the medical care rendered by the treating physician, or any manner whatsoever, then the patient agrees that the controversy or dispute shall be resolved by arbitration as provided by the Florida Arbitration code, chapter 682 & 684, Florida Statutes. This arbitration shall be binding and shall be in lieu of the and instead of any trial by judge or jury. Each party shall choose one arbitrator and the two arbitrators should choose a third arbitrator. Each party shall be entitled to the discovery provided for under rules 1.280 – 1.390, Florida Rules of Civil Procedure. The panel or arbitrator shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction. I have read, understand, and agree with the above.

Patient/Guardian Initials: \_\_\_\_\_ Date: \_\_\_\_\_

### **FAILURE TO FOLLOW PHYSICIAN ORDERS:**

“Physician Orders” are meant to improve and/or resolve the patient’s medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility, thus releasing treating physician and/or facility from any injury or illness claim resulting from the patient’s failure to follow orders. Not following orders given can included but is not limited to missing, postponing or refusal of additional tests to rule out, confirm or discover illness. I have read, understand, and agree with the above.

Patient/Guardian Initials: \_\_\_\_\_ Date: \_\_\_\_\_

### **FORM COMPLETION POLICY**

The ever increasing time and cost burden required to complete the multitude of forms being requested by our patients requires **Advanced Surgical Associates of West Florida** to implement the following charge policy for all forms.

- **Completion of one (1) form page = \$25**
- **Completion of two (2) or more form pages = \$50 (maximum charge)**

Forms that will be accessed a form completion fee include FMLA (Family & Medical Leave Act) forms, Disability forms, Back-To-Work forms, and miscellaneous forms.

When your forms are completed, Advanced Surgical Associates of West Florida will contact you to let you know that your forms are complete. Prior to the completed forms being distributed to patients, Advanced Surgical Associates of West Florida will collect the related fee via cash, money order, personal check, credit card, or debit card.

Patient/Guardian Initials: \_\_\_\_\_ Date: \_\_\_\_\_

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***NOTICE OF PRIVACY PRACTICES***

\*\* This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. \*\*

At **Advanced Surgical Associates of West Florida**, we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Office Manager at 727-586-3751.

**Acknowledgement:** I have received a copy of **Advanced Surgical Associates of West Florida's** Notice of Privacy Practice.

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Patient / Guardian (Please Print Name)

Patient / Guardian (Signature)

Date

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***INSURANCE INFORMATION***

**PATIENT NAME:** \_\_\_\_\_ **SSN # :** \_\_\_\_\_ **TODAY'S DATE** \_\_\_\_\_

\*\*\* Even though we will copy your insurance cards, please complete all of the information requested below. \*\*\*

**PRIMARY INSURANCE:**           ☼ HMO   ☼ PPO

Primary Insurance Carrier: \_\_\_\_\_ Phone #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Subscriber's Social Security Number: \_\_\_\_\_ Subscriber's ID Number \_\_\_\_\_

Relationship to Subscriber: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**SECONDARY INSURANCE:**           ☼ HMO   ☼ PPO

Secondary Insurance Carrier: \_\_\_\_\_ Phone #: \_\_\_\_\_

PPO POS HMO Other \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Subscriber's Social Security Number: \_\_\_\_\_ Subscriber's ID Number \_\_\_\_\_

Relationship to Subscriber: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**WORKER'S COMPENSATION:**

Is this a work related injury?   ☼ Yes   ☼ No (If yes, please provide the following information)

Claim Adjuster's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Contact at Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

**FINANCIAL AGREEMENT:**

I authorize Surgical Associates of West Florida to bill my insurance company for services rendered. I realize that I will be responsible for co-payments and deductibles at the time of services. Any portion not covered by insurance will be billed to me. If I am uninsured, payment is expected at the time of service. If it becomes necessary to collect any balance due through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

I authorize Surgical Associates of West Florida to release medical information for insurance purposes. I authorize payment to be made directly to Surgical Associates of West Florida if an assignment is indicated by my insurance company. As a courtesy, Surgical Associates of West Florida will contact insurance companies for authorization for services required. Surgical Associates of West Florida is not responsible for lapses of insurance or for incorrect information.

I have read and understand the financial agreement above.

---

Patient / Guardian (Please Print Name)

Patient / Guardian (Signature)

Date

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***AUTHORIZATION FOR RELEASE OF  
MEDICAL INFORMATION***

*(Please Print)*

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- I hereby authorize **Advanced Surgical Associates of West Florida** to release any information in my chart to any medical practitioner, doctor, hospital, or medical institution / facility to whom I may be referred to assist with my care.
- Additionally, I authorize **Advanced Surgical Associates of West Florida** to obtain any medical information from any medical practitioner, doctor, hospital, or medical institution / facility to assist in my care.

\_\_\_\_\_  
Signature of Patient, Guardian, or Personal Representative

\_\_\_\_\_  
Date

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