PALM BEACH THORACIC SURGERY, P.A.
PATIENT INFORMATION SHEET

Please Print

PERSONAL INFORMATION: Date_____

Patient's Name_____ Date of Birth_____
First MI Last

Address_____
Street City State Zip

Marital Status: S M Sep W D SS#_____ Home Phone_____ Cell Phone_____

Email Address_____ Method of Preferred Communication; ❑ Home Phone ❑ Mobile Phone ❑ Email ❑ Text

Employer_____Occupation_____

Employer's Address_____Work Phone_____

Spouse's Name_____Work Phone_____

Emergency Contact_____ Relation to Patient_____ Phone_____

Referred by_____

INSURANCE INFORMATION:

Primary Insurance Co._____Effective Date_____

Subscriber's Name_____Policy #_____Group #_____

Subscriber Information: Relation to Patient_____ SS#_____ Sex: M F Date of Birth_____

Secondary Insurance Co._____ Effective Date_____

Subscriber's Name_____ Policy #_____Group #_____

Subscriber Information: Relation to Patient_____ SS#_____ Sex: M F Date of Birth_____

PERSON RESPONSIBLE FOR PAYMENT OR INSURANCE POLICYHOLDER (IF OTHER THAN PATIENT):

Legal Name_____Relation to Patient_____
First MI Last

Address_____Phone_____
Street City State Zip

Date of Birth_____SS#_____Sex: M F Marital Status: S M Sep W D

Employer's Name_____Occupation_____

Employer's Address_____Work Phone_____

PATIENT CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

I, the undersigned, consent to the use and disclosure of my protected health information for treatment, payment, operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. I accept that I am financially responsible for all services rendered on my behalf by PALM BEACH THORACIC SURGERY P.A., (PBTSPA). For those insurance plans for which PBTSPA participates with, I accept personal responsibility for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage. I authorize payment directly to Dr. Markwith for services for which the Practice accepts assignment. A copy of this agreement may be used in place of the original. This authorization is valid until such date that I rescind it in writing. I certify that the information stated on this form is correct.

_____ _____
Signature of Patient or Parent/Legal Guardian Date

PALM BEACH THORACIC SURGERY, P.A.
HEALTH QUESTIONNAIRE

PLEASE PRINT Today's Date_____

Patient Name_____SS#_____Sex: M F

Age_____Birthdate_____Height_____Weight_____Marital Status: M S Sep W D

Occupation_____

Reason for Visit Today (Please describe detail of your injury or problem):_____

_____

REVIEW OF HEALTH SYSTEMS: Please indicate any problems you have had in the **past six months.**

Weight gain-more than 10 lbs.	NO YES	**GASTROINTESTINAL SYSTEM:**	
Weight loss-more than 10 lbs.	NO YES	Persistent, recurring belly pain	NO YES
Appetite change	NO YES	Uncontrolled loss of stool	NO YES
Marked fatigue	NO YES	Heartburn/indigestion	NO YES
Unexplained night fever	NO YES	Pain with bowel movement	NO YES
Night sweats	NO YES	Diarrhea	NO YES
Difficulty sleeping	NO YES	Blood in stool	NO YES
Psychological difficulties	NO YES	Constipation	NO YES
SKIN/BREASTS:		Yellow jaundice	NO YES
Rash or itching	NO YES	**UROLOGICAL SYSTEM:**	
Pain	NO YES	Difficulty with urination	NO YES
Skin change	NO YES	Pain/burning on urination	NO YES
Breast lump	NO YES	Uncontrolled loss of urine	NO YES
Breast discharge	NO YES	Urinary tract infection	NO YES
RESPIRATORY SYSTEM:		**SKELETAL SYSTEM:**	
Chest pain	NO YES	Joint pain	NO YES
Recurring cough	NO YES	Joint stiffness	NO YES
Wheezing	NO YES	Joint redness	NO YES
Shortness of breath	NO YES	Joint swelling	NO YES
CARDIOVASCULAR SYSTEM:		**NERVOUS SYSTEM:**	
Chest pain/tightness/pressure	NO YES	Tremors	NO YES
Palpitations	NO YES	Headaches	NO YES
Lightheadedness/fainting	NO YES	Numbness	NO YES
EARS/NOSE/MOUTH/THROAT:		Dizziness/vertigo	NO YES
Chronic sinus problems	NO YES	Seizures	NO YES
Hearing loss	NO YES	**HEMATOLOGIC/LYMPHATIC:**	
Nose bleeds	NO YES	Anemia	NO YES
ENDOCRINE:		Sickle cell trait or disease	NO YES
Liver disease	NO YES	Enlarged glands	NO YES
Jaundice	NO YES	Mononucleosis	NO YES
High cholesterol	NO YES	Varicose veins, blood clots, phlebitis	NO YES
Hepatitis	NO YES	Bleeding disorder	NO YES
Diabetes	NO YES	Blood transfusion	NO YES
Thyroid problem	NO YES		

PERSONAL MEDICAL HISTORY

ALLERGIES:

Shellfish	NO YES	X-ray contrast/dye	NO YES
Latex	NO YES	Local Anesthetic	NO YES
Medications	NO YES If yes, list below		

Medication Allergies:_____

CURRENT MEDICATIONS	**Name**	**Dose**	**Frequency**	**Reason**

(Please turn page over)

Patient Name_____Date of Birth_____

PERSONAL MEDICAL HISTORY: Have you **ever** had any of the following conditions? Leave blank if uncertain.

Anemia	NO YES	Hemorrhoids	NO YES
Arthritis (other than back)	NO YES	Hepatitis	NO YES
Asthma/lung disease	NO YES	High blood pressure/hypertension	NO YES
Bleeding tendencies	NO YES	HIV/AIDS	NO YES
Blood clots	NO YES	Kidney stones	NO YES
Blood/plasma transfusion	NO YES	Kidney failure	NO YES
Cancer	NO YES	Liver disease	NO YES
Colitis	NO YES	Migraine headaches	NO YES
Depression	NO YES	Psoriasis	NO YES
Diabetes	NO YES	Rheumatic fever	NO YES
Exposure to hazardous chemicals	NO YES	Shingles	NO YES
Epilepsy	NO YES	Stomach ulcers	NO YES
Gall bladder disease	NO YES	Stroke	NO YES
Glaucoma	NO YES	Tuberculosis	NO YES
Gout	NO YES	Venereal disease	NO YES
Heart disease	NO YES	Other (please describe)	

HEALTH HABITS/DIETARY SUPPLEMENTS **Explain**

Vitamins NO YES
Calcium NO YES
Estrogen NO YES
Tobacco NO YES Type/amount/day_____
Have you ever used/smoked? NO YES If so, date you quit?_____
Alcohol NO YES
Drug Use NO YES Type/frequency_____
History of drug or alcohol abuse? NO YES (describe)_____
Caffeine NO YES Type/frequency_____
Exercise NO YES Type/frequency_____

HOSPITALIZATIONS/OPERATIONS **Reason** **Date**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

FAMILY HISTORY **List immediate family members with the following:**

Diabetes NO YES _____
Cancer NO YES _____
Gout NO YES _____
Heart Disease NO YES _____
Hypertension NO YES _____
Other NO YES Specify: _____

Any other information of which the doctor should be aware:

_____
_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctor's office of any changes in my medical status.

_____ _____
Signature of Patient, Parent or Guardian Date

PHYSICIAN USE ONLY: Reviewed by_____Date_____ (RS&F 3/18)

Palm Beach Thoracic Surgery

Jonathan Waxman MD

Patient Name: _____ DOB: _____

Please print the name of the most recent physicians that are providing care to you.

Cardiologist Name: _____ Phone: _____

Endocrinologist Name: _____ Phone: _____

Gastroenterologist Name: _____ Phone: _____

Infectious Disease Name: _____ Phone: _____

Internist Name: _____ Phone: _____

Medical Oncologist Name: _____ Phone: _____

Pulmonologist Name: _____ Phone: _____

Radiation Oncologist Name: _____ Phone: _____

Urologist Name: _____ Phone: _____

Patient Signature: _____

Palm Beach Thoracic Surgery PA

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