**N. B. Edgerton, Jr. M.D.**
**2706 W. Dr. Martin Luther King Jr. Blvd**
**Tampa, FL 33607**
**813-875-8650**

Date_____

Patient Name: _____
(last) (first) (middle init.)

Address: _____ City_____

State: _____ Zip: _____ **Best** Phone Number: (  )_____

**Alternate** Phone Number:(  )_____ **Alternate** Phone Number:(  )_____

Sex: M or F Date of Birth: _____Age: _____ SS#_____

Email address: _____

Employer: _____ Occupation: _____

Primary Dr. Name: _____ Primary Dr. Phone Number: _____
(**please** provide ph. number)

Emergency Contact Name/Relation: _____ Ph:_____

Primary Health Insurance:_____
Subscriber's Name and Date of Birth: _____

Secondary Health Insurance:_____
Subscriber's Name and Date of Birth:_____

****Please DO NOT make your own copies of your insurance card(s). Please let us make our own copies****

**Assignment and Release**

I request that payment of authorized benefits be made payable to Dr. Edgerton for any services furnished to me. I further authorize Dr. Edgerton to release my medical information to my insurance company(ies) in order to determine these benefits or the benefits payable for related services.

I agree to comply with the terms of my insurance, including payment of my co-payment at the time of the office visit. I understand that co-insurance and deductible amounts are payable in full upon receipt of the bill, unless other arrangements have been made with the office.

Finally, I understand that the filing of secondary insurances is a courtesy, and will be done if the amounts due are over $50 for any one date of service. (These amounts are non-cumulative).

Signature_____Date_____

# Patient Medical History Form

N.B. EDGERTON, Jr., M.D.
Gastroenterology

Patient Name : _____

Date of Birth: _____ Age: _____ Sex: _____

Have you ever had: (check all that apply)

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Cataracts | | Heart Attack/Angina | | Pleurisy | | Kidney Stone | | German Measles | |
| Glaucoma | | Heart Disease | | Jaundice/ Liver Disease | | Diabetes | | Rheumatic Fever | |
| Asthma | | Heart Murmur | | Ulcers | | Thyroid Disease | | Chicken Pox | |
| Allergies | | High Blood Pressure | | Digestive Disorder | | Anemia | | Syphilis | |
| Stroke | | Pneumonia | | Hemorrhoids | | Bleeding Disorder | | Depression | |
| Seizures/ Epilepsy | | TB / Lung Disease | | Kidney Disease | | Bone/Joint Disease | | Recurrent Infections | |
| Cancer (type) | | | | | | | | | |
| List any other chronic illnesses that you have had: | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

| **Operations: ( please list any surgery and approximate year )** | |
|---|---|
| Year | Surgery |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| **Hospitalizations: ( other than operations )** | | |
|---|---|---|
| Date | Reasons | Hosp |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Medications** (incl. over the counter items such as, Vitamins, Supplements and Herbals) | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Name _____ Page 1 Date _____

Reviewed by _____
(Physician signature)

| List all medication allergies | Immunizations | Yes | Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Social History

| | | |
|---|---|---|
| Marital status: (circle) S M D W | Occupation: (if retired, prev. occupation) | |
| Birthplace: | Hobbies: | |
| Routine exercise: (circle) no yes | What/How often: | |
| Are you under a lot of pressure at work or home? (circle) no yes | | |
| Have you ever smoked? (circle) no yes Cigar Pipe Cigarettes | If yes: # year's | # cigarettes/day |
| Are you a regular smoker now? (circle) no yes If no, when did you quit? | | |
| Caffeine: Do you drink (circle) coffee, caffeinated teas or sodas regularly? No yes #/day | | |
| Do you drink alcohol (circle) no yes If yes, check the following: | | |
| ☐ Hard Liquor, 1-3 oz. /day | ☐ Hard Liquor, over 3 oz. /day | |
| ☐ Beer, 12 oz. /day | ☐ Beer, 2 bot. /day | ☐ Beer, 3 bot. or more/day |
| ☐ Wine, 1 glass/day | ☐ Wine, 2 glasses/day | ☐ Wine, 3 or more glasses/day |
| ☐ Hard Liquor, Beer, Wine - occasional use | | |
| Have you ever used any of the following? No yes (circle) Marijuana LSD Cocaine Speed Other | | |
| Transfusions: have you ever had a blood or plasma transfusion (circle) no yes | | |
| Females only: are you pregnant, planning a pregnancy or nursing a child? (circle) no yes | | |

## Family Medical History

| Family member: | Age | Health | Age at death | If deceased, cause | Has any blood relative ever had | Yes | Relationship |
|---|---|---|---|---|---|---|---|
| Father | | | | | Alzheimer's | | |
| Mother | | | | | Tuberculosis | | |
| Brothers or sisters | | | | | Diabetes | | |
| Spouse | | | | | Heart disease | | |
| Children | | | | | Bleeding disease | | |
| | | | | | Stroke | | |
| | | | | | Seizures | | |
| | | | | | Depression | | |
| | | | | | Suicide | | |
| | | | | | Mental disorder | | |
| | | | | | Allergies | | |
| | | | | | Asthma | | |
| | | | | | Cancer (type) | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |



Reviewed by _____

(Physician signature)

# Review of Systems

Please indicate those problems that have been a recurrent problem or a recent significant change to you.
Explain "yes" answers.

| Yes | No | General Constitutional Symptoms | Explanation |
|---|---|---|---|
| | | Good general health lately | |
| | | Recent significant weight change | |
| | | Unusual fatigue or weakness | |
| | | Fevers | |
| | | Frequent headaches | |
| | | **Eyes** | |
| | | Change in vision | |
| | | Double vision | |
| | | Glaucoma | |
| | | Eye disease or injury | |
| | | **Ears/Nose/Mouth/Throat** | |
| | | Do you wear hearing aids? | |
| | | Recent change in hearing | |
| | | Earaches or drainage | |
| | | Ringing in ears | |
| | | Chronic sinus problems or runny nose | |
| | | Nose bleeds | |
| | | Bleeding gums | |
| | | Bad breath or bad taste in mouth | |
| | | Sore throat/hoarseness or voice change | |
| | | Swollen glands | |
| | | Difficulty swallowing | |
| | | **Neck** | |
| | | Enlarged thyroid | |
| | | Lump or swelling | |
| | | Pain or stiffness | |
| | | **Cardiovascular** | |
| | | Heart trouble | |
| | | Chest pain or angina | |
| | | Palpitations | |
| | | Shortness of breath when walking | |
| | | or lying flat | |
| | | Swelling of feet or ankles | |
| | | **Respiratory** | |
| | | Chronic or frequent cough | |
| | | Coughing up blood | |
| | | Shortness of breath | |
| | | Asthma or wheezing | |
| | | **Gastrointestinal** | |
| | | Loss of appetite | |
| | | Change in bowel movements | |
| | | Nausea or vomiting | |
| | | Frequent diarrhea | |
| | | Painful bowel movement or | |
| | | constipation | |
| | | Rectal bleeding or blood in stool | |
| | | Stomach pains or heartburn | |
| | | Black tarry stools | |
| | | **Genitourinary** | |
| | | Frequent urination | |
| | | Burning or pain when urinating | |

## Review of Systems (continued)

Please indicate those problems that have been a recurrent problem or a recent significant change to you.

| Yes | No | Genitourinary (continued) | Explanation |
|---|---|---|---|
| | | Blood in urine | |
| | | Change in force or strain when urinating | |
| | | Incontinence or dribbling of urine | |
| | | Sexual difficulties | |
| | | In men - testicular pain | |
| | | In women | |
| | | - irregular or painful periods | |
| | | - date of last menstrual period | |
| | | - if applicable, method of birth control | |
| | | - if menopausal, since when | |
| | | - # pregnancies # deliveries # miscarriages | |
| | | - date of last Pap smear | |
| | | **Musculoskeletal** | |
| | | Joint pain | |
| | | joint stiffness/swelling or warmth | |
| | | Weakness of muscles or joints | |
| | | Muscle pain or recurrent cramps | |
| | | Back pain | |
| | | Cold hands? or feet | |
| | | Difficulty in walking | |
| | | **Skin/Breast** | |
| | | Rashes or itching | |
| | | Changes in skin color or moles | |
| | | Change in hair or nails | |
| | | Varicose veins | |
| | | Breast pain | |
| | | Breast lump | |
| | | Breast discharge or rash | |
| | | **Neurological** | |
| | | Increasing or frequent headaches | |
| | | Recurrent light-headedness or dizziness | |
| | | Spasms or convulsions | |
| | | Numbness or tingling sensations | |
| | | Tremors | |
| | | Paralysis | |
| | | Stroke | |
| | | Head injury | |
| | | **Psychiatric** | |
| | | Memory loss or confusion | |
| | | Nervousness | |
| | | Depression | |
| | | Insomnia | |
| | | **Endocrine** | |
| | | Glandular or hormone problem | |
| | | Cold or heat intolerance | |
| | | Excessive thirst or urination | |
| | | Excessive skin dryness | |
| | | Change in hat or glove size | |
| | | **Hematologic/lymphatic** | |
| | | Slow to heal after cuts | |
| | | Bleeding or bruising tendency | |
| | | Recurrent anemia | |
| | | Swelling or tenderness/warmth of veins | |

# NOTICE OF PRIVACY PRACTICES
## N. B. Edgerton, Jr., M.D.

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on 4/14/03 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Barbara Edgerton. Information on contacting us can be found at the end of this Notice.

### TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security: The** health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

## YOUR PRIVACY RIGHTS AS OUR PATIENT

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ 1.00 for each page and the staff time charged will be $ *25.00* per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

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## QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Please request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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## HOW TO CONTACT US

Practice Name: N. B. Edgerton, Jr., M.D.

Privacy Officer: Barbara Edgerton

Telephone: 813-875-8650 Fax:

E-Mail:

Address: 2706 W. MLK Blvd. Tampa, FL 33607

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
## N.B Edgerton, Jr., M.D.

**Notice to patient:**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

---

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

***Please print your name here***

_____

***Signature***

_____

***Date***

**You may disclose my protected health information (medical records) to:**
Family Member(s) (enter relationship):

_____
_____
_____

**FOR OFFICE USE ONLY:**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

__The patient refused to sign
__Due to an emergency situation it was not possible to obtain an acknowledgment
__We weren't able to communicate with the patient
__Other (Please provide specific details):

_____
_____
_____

_____ _____

*Employee signature* *Date*

**HIPAA Acknowledgment of Receipt of the Notice of Privacy Practices**
This form does not constitute legal advice and covers only federal, not state, law.