James J. Macool, MD
765 Douglas Ave.
Altamonte Springs, FL 32714-2919
(407)774-7781
(407) 774-7743 – fax

Please complete all sections and sign the yellow highlighted area. Please give me your Insurance card and Driver's License so I can obtain a copy.

Patient Registration

Parent/Guardian Name: _____ Date: __ /___/_____

Name: _____ Date of Birth: __ /___/_____ Sex: _____

Address: _____ Age: _____

_____, _____, _____ Cell Phone: (___) ___-_____

Marital Status: ☐Married ☐Divorced ☐Widow ☐Single ☐Domestic Partner ☐Other

Home Phone: (___) ___-_____ Work Phone: (___) ___-_____ **Email**: _____

Name of Primary Insured/Policy Holder: _____ **Date of Birth:** ___/___/_____

Primary Insurance: **Secondary Insurance**

Ins. Company: _____ Ins. Company: _____

Insurance Policy # _____ Insurance Policy # _____

GOVERNMENT MANDATED QUESTIONS

Ethnicity (circle 1): Hispanic / Non-Hispanic / Decline Preferred Language: _____

Race (circle 1): American Indian /Alaska Native Asian Black/African-America Unknown

Native Hawaiian/Other Pacific Islander White/Caucasian Other Decline

Guarantor Name: _____ Guarantor Name: _____

Pharmacy name, telephone & address: _____, (___) ___-_____, _____

Allergies to Medications, Dyes, or Other Substances: ☐No ☐Yes (if Yes, please list names and type of reaction):

_____

Emergency Contact: _____ Phone #: (___) ___-_____ Relationship: _____

What is your preferred method of contact for appointment reminders (circle one): Home Cell Work Leave Message? YES NO

What is your preferred method of contact for medical information (circle one): Home Cell Work Leave Message? YES NO

Smoking Status

☐ Unknown if ever smoked ☐Never Smoked ☐Former Smoker ☐Current Some Day Smoker

☐Current Every Day Smoker ☐Smoker, Current Status Unknown

Alcohol Use

☐Denies Alcohol Use ☐Past Alcohol Use ☐Recovering Alcoholic ☐Rare Alcohol Use

☐Social Alcohol Use ☐Daily Alcohol Use

Drug Use

☐ Yes ☐No Additional Information: _____

ALL PROFESSIONAL SERVICES RENDERED ARE THE RESPONSIBILITY OF THE PATIENT. THE PATIENT IS RESPONSIBLE FOR THE FEES, REGARDLESS OF INSURANCE COVERAGE. ALL DEDUCTIBLES, CO-PAYS, ETC. ARE TO BE PAID AT THE TIME OF SERVICE.

I HEREBY AUTHORIZE JAMES J. MACOOL, M.D. TO RELEASE INFORMATION TO ANOTHER DOCTOR/PROVIDER/INSURANCE COMPANY AND HEREBY AUTHORIZE ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO BE PAID DIRECTLY TO JAMES J. MACOOL, M.D.

Responsible Party Signature/*Firma* Signature of Patient/Guardian: _____Date/*Fecha*: __ /___/_____

I ACKNOWLEDGE RECEIVING A COPY OF JAMES J. MACOOL, M.D. PRIVACY ACT.

James J. Macool, MD
765 Douglas Ave.
Altamonte Springs, FL 32714-2919
(407)774-7781
(407) 774-7743 – fax

MEDICATION RECORD

Name: _____ DOB: _____ Page # _____

Drug Allergies: _____

Date	Notes	Rx/Dosage	Refills	Stop/Change

Help avoid medication problems by using this chart to keep an updated list of your medications. Remember to take your list to your doctor, pharmacist or hospital visit and keep an updated record of all prescriptions, vitamins, herbals, dietary supplements and over-the-counter medications that you are taking.

EXAMPLE:

Medication interactions can cause serious health problems. You can avoid medications issues by being a partner with your health care team. Your health care team includes:

- Doctors, physician assistants, nurse practitioners or other medical professionals who prescribe your medicine for you or are in charge of your care
- Nurses who help with your care at home, a doctor's office or a hospital
- Pharmacists who fill your prescription and are available to answer questions about your medicines

It is helpful to your healthcare team if you keep a record of all the medicines, vitamins, herbals and dietary supplements you are taking including:

- Prescription medicines
- Over-the-counter medicines that you can buy without a prescription (aspirin, antacids, laxatives, cough medicine)
- Vitamins and dietary supplements including herbal products.

After you create your medication record, be sure it is always correct. Update the form when new medications are started, a dosage is changed or a medicine is stopped. Once you stop taking a medication, keep it on your record for one year after the stop date. Keep your list in a convenient place and take it with you to every healthcare provider visit. Give a copy of your medication list to a friend or loved one so they can be informed if an emergency situation should arise. Also be sure to tell your healthcare provider:

- If you have medicine allergies or if you have had problems when taking a medicine before.
- If other doctors or health care professionals have prescribed medicine for you or suggested you take a vitamin or herbal supplement
- If you are pregnant, may get pregnant or are nursing a baby
- If you have any other illness or medical condition, like diabetes or high blood pressure

Be an active part of your healthcare team by keeping an accurate list of your medications and sharing it with your healthcare provider. This Personal Medication Record (PMR), while intended to serve as a communication aid between patient (or other use) and healthcare provider, is not a substitute for obtaining professional healthcare advice or treatment. Under no circumstances should medication be changed or stopped without consulting a doctor

James J. Macool, MD, PA
FAMILY PRACTICE

HISTORY & PHYSICAL

Name: _____ **SS#:** _____-_____-_____ **Date:** _____/_____/_____
Address: _____ **Occupation:** _____
City, State, ZIP: _____ **Date of Birth:** _____/_____/_____ **Age:** _____
Phone (Home): (_____) _____-_____ **Phone (Work):** (_____) _____-_____
Chief Complaint: _____

DRUG ALLERGIES

_____
_____
_____
_____
_____

CURRENT MEDS

_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

HOSPITALIZATION OR SURGERY

REASON	Date	REASON	Date
_____	___/___/____	_____	___/___/____
_____	___/___/____	_____	___/___/____

WOMEN ONLY: Pregnant? [ ] Yes [ ] No Planning pregnancy? [ ] Yes [ ] No

MEDICAL HISTORY

☐ Headache _____
☐ Shortness of breath _____
☐ Heart palpitations _____
☐ Heart murmur _____
☐ Chest pain _____
☐ Dizziness/Fainting _____
☐ Peripheral Vascular Disease _____
☐ Allergies/Hay fever _____
☐ Asthma _____
☐ Bronchitis _____
☐ Pheumonia _____
☐ Ulcer _____
☐ G.I. Disorder _____

☐ Lactose intolerance _____
☐ Gallbladder Disease _____
☐ Prostate Disease _____
☐ Bowel Irregularity _____
☐ Incontinence _____
☐ Sexual/Menstrual Dysfunction _____
☐ Venereal Disease _____
☐ Frequent Infections _____
☐ Hepatitis _____
☐ Anemia _____
☐ Arthritis _____
☐ Osteoporosis _____
☐ Nervousness _____

☐ Depression _____
☐ Gout _____
☐ Scarlet fever _____
☐ Chronic rashes _____
☐ Rheumatic fever _____
☐ Mumps _____
☐ Measles _____
☐ Rubella _____
☐ Polio _____
☐ Diphtheria _____
☐ Tetanus _____
☐ Other _____
☐ Other _____

HABITS

☐ Smoke: Packs daily _____
How long? _____
Interested in stopping? _____
☐ Exercise routine: _____
_____
_____

☐ Coffee: Cups daily _____
Other caffeine _____
☐ Alcohol: Type _____
Amount _____
☐ Diet: Salt intake _____
Fat intake _____

[ ] Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring _____
Early morning awakening ____
Daytime drowsiness _____
Other _____

Hepatitis C Risk Factor

☐ Blood transfusion prior to 1992
☐ IV drug use (1+ times)
☐ Contact with blood/bodily fluid
☐ Tattoos
☐ Shared razor/toothbrush
☐ Body piercing

ADULT PHYSICAL

ALLERGIES:

Name: _____ **DOB:** ___/___/____ **Age:** _____ **Date:** _____/_____/_____

PATIENT COMPLAINTS:

HT. _____ **WT.** ____ **T** _____ **P** _____ **R** _____ **B/P** _____

_____

Signature

INTERVAL HISTORY:

Current Medications:

_____

_____

Illness/Accidents:

ER Visits/Hospitalizations/Surgeries:

Transfusions:

Changes in Family Hx:

Tobacco, Drugs, Alcohol Use:

Diet/Exercise:

	Date	Result
LAST PAP		
Last Mammogram		
Last Breast Exam		
Last Prostate Exam		
Last EKG		
Last Colon Cancer Screening		
Last Cholesterol IBS (labs)		

PHYSICAL EXAMINATION	NORMAL	ABNORMAL	OBJECTIVE FINDINGS:
GENERAL APPEARANCE			
SKIN			
EYES/EARS			
VISION			(R) (L) Referred:
HEARING			(OS) (OD) Referred:
NOSE/THROAT/THYROID			
TEETH/GUMS/DENTAL			
CHEST/LUNGS			
CARDIOVASCULAR			
ABDOMEN			
BREASTS			
GENITAL/URINARY			
PELVIC			
RECTAL			
PROSTATE			
EXTREMITIES			
HIP / SPINE / ORTHOPEDIC			
NEUROLOGICAL			
LYMPHATIC			

IMMUNIZATIONS: **Hep B: series complete** _____ **TD** _____

Flu _____ **Pheumovax** _____ **MMR** _____ **Polio** _____

Last M.P.: _____

HEALTH EDUCATION

Nutrition/diet/exercise

Diabetes

Cardiovascular

Substance Abuse

Smoke Cessation

Medications

Injury Prevention Safety

Family Planning

HIV/STD

Family/Domestic Violence

Breast/Testicular Self-Exam

Osteoporosis _____

Next Physical: _____ **RTC:** _____

ASSESSMENT:

Serum cholesterol indicated: YES ___ NO ___

STD screen indicated: YES _____ NO _____

TB testing indicated: YES _____ NO _____

Impression:

Plans:

Signature: _____

James J. Macool, MD
765 Douglas Ave.
Altamonte Springs, FL 32714-2919
(407)774-7781
(407) 774-7743 – fax

ADVANCED DIRECTIVES

(For compliance with the patient self-determination act)

Have you executed an advanced directive? (Have you decided upon the degree of care you want in the event of a catastrophic medical event?)

YES ☐ NO ☒

If **YES**, is this directive in the form of:

☐ A LIVING WILL

☐ A DURABLE POWER OF ATTORNEY

☑ A HEALTH CARE SURROGATE

If you have executed an advanced directive in any of the above formats, have you provided this office with a copy for your medical records?

☐ YES ☑ NO

PATIENT NAME: _____
(Signature of Patient or Representative)

DATE: _____

If you would like more information regarding advanced directives, please ask the receptionist or nurse.

James J. Macool, MD
765 Douglas Ave.
Altamonte Springs, FL 32714-2919
(407)774-7781
(407) 774-7743 – fax

Living Will

Declaration made this _____ day of _____, 20___, I, _____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated (and I have initialed one or more of the following 3 conditions):

_____ (initial) I have a terminal condition,

_____ Or (initial) I have an end-stage condition,

_____ Or (initial) I and in a persistent vegetative state,

And if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care, or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: _____

Address: _____

_____

Phone: (_____) _____ - _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____

_____

Signed: _____ Date: _____ / _____ / _____

Witness signature, address, and phone number:

1. _____
   _____
   _____
2. _____
   _____
   _____

James J. Macool, MD
765 Douglas Ave.
Altamonte Springs, FL 32714-2919
(407)774-7781
(407) 774-7743 – fax

Designation of Health Care Surrogate

Name (Last): _____ (First): _____ (Middle Initial): _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogates for health care decisions:

Name: _____
Address: _____
Phone: (_____) _____ - _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: _____
Address: _____
Phone: (_____) _____ - _____

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law, and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of healthcare; and to authorize my admission to or transfer from a health care facility.

Additional instructions (optional) _____
_____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify send a copy of this document to the following persons other than my surrogate, so they may know my surrogate is.

Name: _____
Name: _____
Name: _____

Signed: _____ Date: _____ / _____ / _____

Witness #1: _____ Witness # 2: _____

Rev. 5-23-15

James J Macool, M.D., PA
Notice of Health Information Practices

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

Introduction

At James J Macool, M.D., PA, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information.

Understanding Your Health Records/Information

- Each time you visit James J Macool, M.D., PA, a record of your visit is made. Typically, this record contains your demographic information, medical history, procedure notes, test results, diagnosis, prescription copies, discharge instructions & signed consents. This information, often referred to as your health or medical record, serves as:
- Basis for planning your care and treatment.
- Means for nursing to contact you for follow-up.
- Legal documents describing the care you received, and consents you have given.
- Means by which a 3rd party payer (Insurance Company) can verify who you are, and that services billed were actually provided.
- A source of information for public health officials charged with improving the health of the state and the nation (such as AHCA & FDA).
- Means by which a pathology lab can process & bill for biopsy samples.
- A tool with which we can assess and continually work to improve the care we render at our facility, and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of James J Macool, M.D., PA, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record as provided for in 45 CFR 164.528.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 46 CFR 164.522.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

James J Macool, M.D., PA is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Give Notice to you if we are unable to agree to a requested restriction.
- Accommodate reasonable request you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail or revise notice to the address you supplied us.
We will not use or disclosure health information without your authorization, except as described in this notice. We will also discontinue to use or disclosure health information after we have received a written revocation of the authorization according to the procedures included in this authorization.

For More Information or to Report a Problem:

If you have questions or would like additional information, you may contact the Administrator or Medical Director at 407-774-7781.

If you believe your privacy rights have been violated, you can file a complaint as above with the Office for Civil Rights, US Department of Health and Human Services. The address for the OCR is listed below:

Office for Civil Rights
US Department of Health and Human Services
200 Independence Ave., SW
Room 509F, HHH Building,
Washington, DC 20201

PATIENTS SIGNATURE: _____ DATE: _____