KAREN SINGER, M.D., P.A.

Patient Information and Consent (Page 1)

First Name	Last Name	Today's Date

Street Address

City	State	Zip

Phone	Email

Sex	Birth Date	Age	Marital Status
			☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Occupation	Referred by which of the below:
	☐ Groupon ☐Web Search ☐ Current Patient ☐ Email ☐ Brochure ☐Other

Pharmacy Name, Address and Phone

Emergency Contact Name	Emergency Contact Phone	Relationship to Patient

Emergency Contact Address

Agreements and Authorizations

I agree that medical photographs may be taken in the course of the treatment.

Patient Signature ____ Date ____________________________

I understand payment is due and payable to Karen Singer, M.D., P.A. Before any procedures/services are rendered.

Patient Signature ____ Date ____________________________

I understand that in accordance with Florida State law, any check returned to Karen Singer, M.D., P.A. As a NSF (non-sufficient funds) is subject to service fees as allowed by law.

Patient Signature ____ Date ____________________________

I authorize any holder of medical information about me to release full details of my medical history and treatment to Karen Singer, M.D., P.A. I also authorize Karen Singer M.D., P.A., to release information to any hospital or physician I may be referred to by this office.

Patient Signature ____ Date ____________________________

I have witnessed the above signatures.

Staff Member ____ Date ____________________________

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Patient Privacy Disclosure or Personal Information (Page 2)

Patient Name – Please enter name again on this page.

First Name	Last Name	Today's Date

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations) and allowed to pick up written prescriptions, samples, lab work results, etc., related to your care:

Name	Relationship	Phone Number

2. Please acknowledge that you received/read a copy from the office of Karen Singer M.D., P.A. HIPPA & Notice of Privacy Practices dated 2021

Signature____ Date ____________________

3. I am fully aware that a cell phone is not a secure and private line, and that email is not a secure and private form of correspondence. If I do not wish either to be used, I will notify Karen Singer, M.D., P.A. in writing.

Signature____ Date ____________________

4. By using a credit/debit card or a finance company for payment of services to Karen Singer, M.D., P.A., I am allowing Karen Singer, M.D., P.A. to discuss my medical case with the credit/debit/financing company, should any questions arise, and that Karen Singer, M.D., P.A. will not, therefore, be in violation of any HIPAA requirements.

Signature____ Date ____________________

KAREN SINGER, M.D., P.A.

Medical History (Page 1)

Patient Name – Please enter name again on this page.

First Name	Last Name	Today's Date

1. Main reason you have come to see Dr. Singer:

2. Have you consulted another doctor about this? ☐ Yes ☐ No If yes, whom?

3. Are you allergic to any medications? ☐ Yes ☐ No If yes, please specify.

4. Medications you are taking now, the dosage, and how often, including aspirin, birth control pills, eye drops, Retin-A, medicated creams, vitamins and herbal medications:

Medications/Vitamins/Herbal	Dosage	How often?	Doctor Notes

5. Do/did you Smoke? ☐ Yes ☐ No If yes, how much per day? ___________ If you stopped, when?

6. Do/did you drink alcohol? ☐ Yes ☐ No If yes, how much per day? __________ If you stopped, when?

7. List all surgical and non-surgical procedures and year, including cosmetic surgeries, wisdom teeth extractions, and non-surgical hospitalizations including child births:

Description	Year	Description	Year

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Medical History (Page 2)

Patient Name – Please enter name again on this page.		
First Name	Last Name	Today's Date

8. Previous major illness or injuries not listed above:

9. Dominant hand: ☐ Right ☐ Left

10. Your height: Your weight:

11. Do you have permanent makeup (e.g. facial tattoos)?	☐ Yes	☐ No
12. Have you ever had a bad reaction to a general anesthetic?	☐ Yes	☐ No
13. Have you ever had a bad reaction to a local anesthetic (novocaine. Etc.)?	☐ Yes	☐ No
14. Do you wear contact lenses or glasses?	☐ Yes	☐ No
15. Do you wear dentures?	☐ Yes	☐ No
16. Have you ever taken cortisone-type medication (prednisone) by mouth?	☐ Yes	☐ No
17. Have you ever had any significant emotional problems?	☐ Yes	☐ No
18. Have you ever seen a psychiatrist?	☐ Yes	☐ No
19. Do you form thick scars or keloids?	☐ Yes	☐ No
20. Are you overweight?	☐ Yes	☐ No
21. Women: Are you pregnant?	☐ Yes	☐ No
22. Do you have any prosthetic limbs, metal, screws, etc.?	☐ Yes	☐ No

23. Have you ever had: (check if yes and describe)	Yes	Description
Frequent Headaches		
Eye, ear, nose, or throat problems		
Sinus problems/Hay fever		
Bronchitis, asthma, or lung problems		
Shortness of breath while walking		
High cholesterol/High triglycerides		
Heart disease/Chest pain		
Heart murmur		
Scarlet fever/Rheumatic fever		
High blood pressure		
Circulation problems		
Stomach/Bowel/Gall bladder problems		
Hepatitis or liver problems		

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Medical History (Page 3)

Patient Name – Please enter name again on this page.		
First Name	Last Name	Today's Date

Cold sores		
Mononucleosis		
Kidney/Urine/Bladder/Prostate problems		
Breast disease/Gynecological problems		
Slow or poor healing/Frequent infections		
Diabetes		
Thyroid disease		
Anemia/Blood diseases/Easy bruising		
Arthritis/Joint pains/Fractures/Scoliosis		
Lupus/Scleroderma/Myasthenia/Fibromyalgia		
Stroke		
Seizures/Epilepsy		
Pinched nerves/Numbness		
Cancer (including skin cancer)		
Blood transfusions		
Skin diseases (boils, hives, eczema, rashes)		

If you answered yes to any of #23, please explain further:

24. Has anyone in your immediate family had: (list which side of family and who)

Condition	Side of Family/Who	Condition	Side of Family/Who
Cancer:		Stroke	
(what type?)		Heart Disease	
Diabetes:		Other family diseases:	
High Blood Pressure		(what type?)	