

**Tamara R. Clancy, M.D.**  
*Board Certified Orthopaedic Surgery*  
*Subspecialty Certificate in Surgery of the Hand*

**Srikanth Eathiraju, M.D.**  
*Board Certified General Surgery*  
*Subspecialty Certificate in Surgery of the Hand*

**Sarah E. Henry, M.D.**  
*Board Certified Orthopaedic Surgery*  
*Fellowship Trained in Surgery of the Hand*

**Meaningful Use Patient Form**

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Email** \_\_\_\_\_

**Please circle one:**

**Ethnicity:**

Hispanic or Latino  
Not Hispanic or Latino  
Unknown

**Race:**

American Indian or Alaska Native  
Asian  
Black or African American  
Hawaiian Native or Pacific Islander  
Multiple  
Other  
Unknown  
White

**Smoking Status:**

Current every day Smoker  
Occasional smoker  
Former Smoker  
Never Smoker

**Preferred Language** \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_

**Referred by** \_\_\_\_\_

**VOLUSIA HAND SURGERY CLINIC, PA**

Tamara Ray Clancy, M.D.

Srikanth Eathiraju, M.D.

Sarah E. Henry, M.D.

Appointment Date: \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_ Place of Injury \_\_\_\_\_

Have you previously been treated by Dr. Clancy, Dr. Eathiraju or Dr. Henry? \_\_\_\_\_ No \_\_\_\_\_ Yes.

\_\_\_\_\_  
FIRST

\_\_\_\_\_  
MI

\_\_\_\_\_  
LAST

\_\_\_\_\_  
STREET (Please include apt. # if applicable)

\_\_\_\_\_  
CITY

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP CODE

\_\_\_\_\_  
Phone#

\_\_\_\_\_  
Age

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Work Phone#

\_\_\_\_\_  
Ext#

\_\_\_\_\_  
Social Security#

\_\_\_\_\_  
Spouse's Name/Parent's name: (If child is under 18 years of age)

\_\_\_\_\_  
Emergency Contact Name and Phone Number

\*\*\*\*\*PAYMENT IS EXPECTED AT TIME OF SERVICE\*\*\*\*\*

Insurance Company Name: \_\_\_\_\_

\_\_\_\_\_  
Policy Holder's NAME

\_\_\_\_\_  
INSURED ID# AND GROUP #

\_\_\_\_\_  
Policy Holder's DATE OF BIRTH

\_\_\_\_\_  
Policy Holder's S.S. #

\_\_\_\_\_  
Pharmacy Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
phone #

\_\_\_\_\_  
Fax #

\_\_\_\_\_  
REFERRED BY

\_\_\_\_\_  
PATIENT PRIMARY CARE PHYSICIAN

I hereby authorize the physician indicated above to furnish information to insurance carriers concerning this illness/accident and I hereby irrevocably assign to the doctor all payments for medical services rendered. I also request that authorized medical benefits be made on my behalf to the physician indicated above. I understand that I am financially responsible for all charges whether or not covered by insurance and for collection fees that may be incurred.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

## Chief Complaint

Why are you seeing the doctor today? \_\_\_\_\_

How are where did the injuries occur? \_\_\_\_\_

Current problem is the result of a (n): Check all that apply

- Car accident
- Work Accident
- Accident
- Other

Medications/Supplements/Over-the-counter	Dosage/Times per day	Reason for Medication

Last tetanus immunization \_\_\_\_\_  
 Are all immunizations up to date? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If no, which immunizations are due? \_\_\_\_\_

### Chronic Illnesses (Please Circle)

High blood pressure	Yes	No	Diabetes Type 1 or 2	Yes	No
Asthma	Yes	No	Hepatitis A, B or C	Yes	No
Tuberculosis	Yes	No	Phlebitis	Yes	No
Thyroid disease	Yes	No	Heart Attacks	Yes	No
Type _____			Arrhythmia	Yes	No
Anemia	Yes	No	Strokes	Yes	No
Bleeding disorder	Yes	No	Cancer	Yes	No
Type _____			Type _____		
Seizure disorders	Yes	No	Ulcers	Yes	No
Kidney disease	Yes	No	Birth defects	Yes	No
Arthritis	Yes	No	HIV/AIDS	Yes	No
Type _____					
High Cholesterol	Yes	No			

**ALLERGIES**

### Past Medical History

Surgeries/Hospitalizations	Year/Physician	Complications?

Last EKG \_\_\_\_\_ Cardiologist Name \_\_\_\_\_ Date of last labwork/Where \_\_\_\_\_

Have you ever had general anesthesia?      Yes \_\_\_ No \_\_\_

Have you ever had problems with anesthesia?    No \_\_\_ Yes \_\_\_ Explain \_\_\_\_\_

### Family History

Member	Alive	Deceased	Age	Health status/cause of death
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

**Vital signs:** HT \_\_\_\_\_ PN Level \_\_\_\_\_/10 W \_\_\_\_\_ BP \_\_\_\_\_/\_\_\_\_\_

T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_

## Social History

Smoker \_\_\_ No \_\_\_ Yes Former Smoker Yes \_\_\_ No \_\_\_ How much, what do you smoke? \_\_\_

Have you used drugs other than for medical reasons in the past 12 months, if so what? \_\_\_\_\_

Do you drink alcohol? \_\_\_ No \_\_\_ Yes, if yes \_\_\_ monthly or less \_\_\_ 2-4x month \_\_\_ 2-3x week \_\_\_ 4 or more x week How many drinks \_\_\_\_\_ ever 6 or more \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Partner \_\_\_ Divorced \_\_\_ Widowed \_\_\_\_\_

N0# of Adults \_\_\_ Children \_\_\_ in the home.

Level of Education \_\_\_\_\_ Employed \_\_\_\_\_ Yes \_\_\_ No

If yes, what is your occupation? \_\_\_\_\_

### Review of Systems (Please Circle)

Are you currently having or have you had problems with your:

Chills	No	Yes	Prolonged bleeding	No	Yes
Fatigue	No	Yes	Muscle aches	No	Yes
Fever	No	Yes	Painful joints	No	Yes
Weight gain	No	Yes	Swollen joints	No	Yes
Weight loss	No	Yes	Cold extremities	No	Yes
Diminished vision	No	Yes	Decreased sensation in extremities	No	Yes
Weakness	No	Yes	Keloid formation	No	Yes
Chest pain	No	Yes	Skin cancer	No	Yes
Sputum production	No	Yes	Skin lesions	No	Yes
Chest pain with exertion	No	Yes	Loss of strength	No	Yes
Dizziness	No	Yes	Memory loss	No	Yes
Fluid accumulation in the legs	No	Yes	Seizures	No	Yes
Irregular heartbeat	No	Yes	Tingling/Numbness	No	Yes
Shortness of breath	No	Yes	Tremor	No	Yes
Abdominal pain	No	Yes	Depressed mood	No	Yes
Diarrhea	No	Yes	Difficulty sleeping	No	Yes
Nausea	No	Yes	Mental or physical abuse	No	Yes
Vomiting	No	Yes	Substance abuse	No	Yes
Anemia	No	Yes			

Describe all YES responses: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ M.D.

Date: \_\_\_\_\_



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## **IMPORTANT INFORMATION REGARDING INSURANCE BILLING**

Our doctors are here to provide you with the best medical care. Their primary concern is your health and well-being, not your insurance company. Therefore, it is the patient's responsibility to be aware of what their policy covers.

It is very important for you to read your insurance policy very carefully. As we participate with numerous insurance companies and each company has many different plans, we cannot possibly be aware of each patient's particular coverage. You will receive a bill if the service is one that is not covered under your policy. It is important that you are familiar with the benefits and policies of your insurance.

I have read the above and understand that I am responsible for knowing the coverage and benefits of my insurance policy as well as choosing a lab that my insurance company participates with.

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Patient Signature

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Date

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3635 S. Clyde Morris Blvd, Ste 900  
Port Orange, FL 32129  
(386) 788-HAND (4263)

315 Palm Coast Parkway, NE, Ste 4  
Palm Coast, FL 32137  
(386) 246-3063

239 N. Ridgewood Ave, Ste 1  
Edgewater, FL 32132  
(386) 410-4972

211 South Volusia Ave  
Orange City, FL 32763  
(386) 218-4920

**FAX:(386)788-0679**

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### **Consent to Obtain Medication History**

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer and **E-FORCSE**, Electronic-Florida Online Reporting Of Controlled Substances Evaluation.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

The medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

**I give permission for Volusia Hand Surgery to obtain my medication history from my pharmacy, my health plans, E-FORCSE, and my other healthcare providers.**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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**Authorization for the Release and/or Discussion of Protected Health Information**

Patient Name: \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Authorization

1. I, \_\_\_\_\_, hereby authorize
2. Name of person or organization: \_\_\_\_\_

Street Address : \_\_\_\_\_

City, state, zip : \_\_\_\_\_ Telephone : ( ) \_\_\_\_\_

3. A. To release and/or discuss the following information

Complete Record	Outpatient Care	Inpatient Care
X-Ray Results	Laboratory Results	Treatment Plan Update

Other \_\_\_\_\_

If my record contains the following information, it is also released if *CIRCLED* below:

Substance Abuse	Mental Health Treatment	HIV Testing or Treatment
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4. To \_\_\_\_\_ of  
Volusia Hand Surgery Clinic, PA  
3635 South Clyde Morris Blvd Suite 900  
Port Orange, FL 32129

This information release is at my request for the purpose of legal assistance.

5. Signature :

I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

This authorization expires \_\_\_\_\_ 6 months \_\_\_\_\_ one year from today's date, or upon the following specific event: \_\_\_\_\_.

I authorize the use of a copy of this form for the disclosure of the information described above.

Signed \_\_\_\_\_ Relationship \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sent by initials \_\_\_\_\_