# Daniel W. McGrane, MD PA

Diplomat American Board of Internal Medicine

**PATIENT AUTHORIZATIONS** **Today's Date:** ____________

**Patient Name** ______________________________ **Birth Date** ____________________

**Local Address:** ____________________________________________________________

**Other Address:** ____________________________________________________________

**Do you live in Florida year round? YES NO**

**Local Phone number #** ______________________ **Cell #** ____________________________

**SS#** ________________________________ **Email Address:** ____________________________

**Are you employed? Yes No** **If no are you RETIRED? Yes No**
**If you are EMPLOYED list EMPLOYERS NAME:** ____________________________________

**Gender: Male Female** **Race:** ____________________________________________

**Marital Status: Single, Widow, Married, Civil Partner** **PLACE OF BIRTH** ________________

**INSURANCE: Provide bookkeeper with your insurance cards and ID to scan into record. It is further the responsibility of patient to keep our office**

**Primary Insurance Name:** ________________________ **Policy #** ______________________

**Secondary Insurance Name:** ________________________ **Policy #** ____________________

**Emergency Contact Name:** ______________________________ **Relationship:** ____________

**Phone number of Emergency Contact :)** ____________________________

I hereby give consent to Daniel W. McGrane MD PA to provide whatever treatment the assigned physician or practitioner may deem necessary to the above named patient.

I understand that I am responsible for payment in full for all services provided to me at the time of service. I hereby assign insurance benefits, otherwise payable to me, to be paid directly to DANIEL W. MCGRANE MD PA for Professional Physician Practitioner fees and authorize release of information for insurance purposes. I understand I am responsible for any charges not covered by my insurance policy.

I hereby request payment of authorized Medical benefits and /or other insurance benefits, otherwise payable to DANIEL W. MCGRANE MD PA to be paid directly to DANIEL W. MCGRANE MD PA for any services furnished to me by DANIEL W. MCGRANE MD PA. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If item 9 of the HCFA – 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance "CO PAY' and non-covered services. The Copay and the deductible are based upon the charge determination of the Medicare carrier where Daniel W. McGrane MD PA is a participating provider.

I have read the above statements, understand and agree

Patient Signature ________________________________________________ Date ____________

Daniel W. McGrane, MD PA

Diplomat American Board of Internal Medicine

**PATIENT HEALTH STATUS UPDATE**

1. **Patient Name** ______________________ **Birth Date** ______________
2. **Today's Date** __________ **SS#** ______________________
3. **Welcome to the medical practice of Daniel W. McGrane MD PA. It is a pleasure to act as your primary health care provider. Please complete this form to the best of your ability, understanding your past history is very important to providing your health care.**
4. **PROVIDE A LIST OF CURRENT MEDICATIONS OR BRING ALL MEDICATION BOTTLES TO THE NURSE.**

**5. MEDICAL TESTING HISTORY:**

| Test Type | Date of last test |
|---|---|
| Blood test | |
| Colonoscopy | |
| EKG | |
| Eye Examination | |
| Stress Test | |
| Shingles Vaccination | |
| Flu Vaccine | |
| Pneumonia Vaccine | |

***6.* YOUR PAST MEDICAL HISTORY & SURGERIES**

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |

7. **Do you use Tobacco? YES NO If you have quit smoking, when?** __________
8. **Do you consume any alcohol? YES NO If YES how many glasses per week?** ________

***9. FAMILY HISTORY: Please list below any medical problems within your immediate family:***

| *10. HISTORY* | *11. RELATIONSHIP* |
|---|---|
| | |
| | |
| | |

Daniel W. McGrane, MD PA,
6725 Cedar Ridge Drive
Zephyrhills, Florida 33542
(813) 788-7662

# DANIEL W. MCGRANE, MDPA

## Privacy Instructions

Patient Name: ______________________
Date of Birth: ______________________

We take your privacy very seriously. Please let us know how we may contact you to remind you about appointments, discuss lab test results and other matters.

| | Specify your Phone Number | Ok to Leave Detailed Message | Leave Message with our practice name and callback Number Only | Do Not Call |
|---|---|---|---|---|
| Home | ( ) - | ☐ | ☐ | ☐ |
| Work | ( ) - | ☐ | ☐ | ☐ |
| Cell | ( ) - | ☐ | ☐ | ☐ |
| Fax | ( ) - | ☐ | ☐ | ☐ |
| Other | ( ) - | ☐ | ☐ | ☐ |

Daniel W. McGrane, MDPA Specialists will be reaching out to our patients via email regarding our IQHealth Patient Portal. We may also contact you in the event of any breach of confidentiality or security and email is the fastest way to advise you.

Email Address: ______________________________________

☐ I authorized Daniel W. McGrane, MDPA Specialists to notify me via email for the IQHealth patient portal and in the event of a data breach.

**Others we may speak with**

Please give us guidance regarding speaking with any family or friends when we call, or if they contact us regarding your care and/or payment for your care. It is OK for Daniel W. McGrane, MDPA Specialists to speak with:

| Name | Relationship | Phone | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please check all that apply to the above listed people:

☐ Schedule Appointments ☐ Cancel Appointments ☐ Discuss Billing Issues

☐ Discuss Medical Issues ☐ Obtain/Transfer Medical Records

I have received the HIPAA Notice of Privacy Practices and have provided the above instructions.

Patient Signature: ______________________________________ Date: ____________________

Parent/Guardian Signature: ________________________________ Date: ____________________

***For Office Use Only***

Daniel W. McGrane, MDPA Specialists made a good faith effort to obtain the above information.

☐ Individual refused to sign.
☐ An emergency situation prevented us from obtaining this acknowledgement.
☐ Other ______________________________________

Staff Signature: ______________________________________ Date: ____________________

Daniel W. McGrane, MD PA
Diplomat American Board of Internal Medicine

**PATIENT HEALTH STATUS UPDATE**

List any allergies:

______________________________________________
______________________________________________
______________________________________________
______________________________________________

**Medications** – Please list all medicines that you use (include dose and frequency)

______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

List all hospitalizations (starting with the most recent) the year and for what conditions:

______________________________________________
______________________________________________
______________________________________________
______________________________________________

Women:

Date of last menstrual cycle: _______
Date of last Pap smear: ___________
Date of last Mammogram: _________
Do you perform regular?
Self-breast exams? _______________

Men:

Date of last prostate exam: _______
Have you had a PSA test? ________
If so, date of last test: __________

REQUEST FOR RELEASE OF MEDICAL INFORMATION TO:

# Daniel W. McGrane, MD PA

**Diplomat American Board of Internal Medicine**

To: Dr.________________________________________

Address: ________________________________________

________________________________________

**FAX**: ________________________

Phone Number: ________________________

Email: ________________________

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Patient Name: ________________________________________

Date of Birth: ________________________________________

Social Security Number: ________________________________________

I request for you to please release to Daniel W. McGrane MD PA, 6725 Cedar Ridge Drive, Suite #4 Zephyrhills, Florida 33542. Please send all Medical information from my health record and /or all other records for the purpose of continuity of care.

Signed: ________________________________________
(Patient) (Date)

Signed: ________________________________________
(Witness) (Date)

SPECIAL AUTHORIZATION for release of HIV test results and or AIDS diagnosis and treatment (If less than 18 year of age, parent or guardian must sign). Check the box if this information is to be released.

__________ HIV antibody test/o AIDS diagnosis treatment, as per Florida Statute 381.004

Signed: ________________________________________
(Patient) (Date)

Signed: ________________________________________
(Witness) (Date)

***Fax: 813-788-7464***

6725 Cedar Ridge Drive
Zephyrhills, FL 33542
Phone: 813-88-7662

Daniel W. McGrane MD
Amanda Sturgeon, A.R.N.P

Lives with:

| | |
|---|---|
| ☐ Self | ☐ Mother |
| ☐ Children | ☐ Roomate(s)/Friend(s) |
| ☐ Family | ☐ Siblings |
| ☐ Father | ☐ Significant other |
| ☐ Foster family | ☐ Spouse |
| ☐ Grandparents | ☐ Other: |

Number of children:

Living situation:
- ○ Home/Independent
- ○ Home with assistance
- ○ Homeless/Shelter
- ○ Hospice
- ○ Law Enforcement/Detention Center
- ○ Nursing home
- ○ Psychiatric Facility
- ○ Rehabilitation Facility
- ○ Other:

Home equipment:

| | |
|---|---|
| ☐ CPAP/BiPAP | ☐ Respiratory treatments |
| ☐ Elevator | ☐ Special bed |
| ☐ Feeding tube | ☐ Ventilator |
| ☐ Glucose monitoring | ☐ Walker/Cane |
| ☐ IV therapy | ☐ Wheelchair |
| ☐ Monitoring | ☐ Other: |
| ☐ Oxygen | |

## Exercise and Physical Activity

Times per week:
- ○ Never
- ○ 1-2 times/week
- ○ 3-4 times/week
- ○ 5-6 times/week
- ○ Daily
- ○ Other:

Duration (average number of minutes):

Self assessment:
- ○ Poor condition
- ○ Fair condition
- ○ Good condition
- ○ Excellent condition
- ○ Other:

Exercise type:

| | |
|---|---|
| ☐ Aerobics | ☐ Swimming |
| ☐ Bicycling | ☐ Walking |
| ☐ Organized team sports | ☐ Weight lifting |
| ☐ PE class | ☐ Yoga |
| ☐ Running | ☐ Other: |