

Name (Last, First Middle)		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.			Social Security Number	
Cell Phone		Home Phone		Work Phone		
Address			City		State	Zip
Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Age
<input type="checkbox"/> Employed <input type="checkbox"/> Full-time student <input type="checkbox"/> Part-time student		Employer and Address				
Name of referring doctor(s) – we'll send a report			#		Fax #	
Onset of current problem		Worker's compensation? <input type="checkbox"/>	Motor vehicle accident? <input type="checkbox"/> State _____		Other accident? <input type="checkbox"/>	
In emergency, contact:				Relationship		Phone

PRIMARY INSURANCE CARRIER

Insurance Carrier's Address		City		State	Zip
Insured		Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child			Insured's Phone
ID #		Group #			
Insured's SS #		City		State	Zip
Insured's Date of Birth		Insured's Sex <input type="checkbox"/> M <input type="checkbox"/> F	Insured's Employer		

OTHER INSURANCE CARRIER

Insurance Carrier's Address		City		State	Zip
Insured		Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child			Insured's Phone
ID #		Group #			
Insured's Address		City		State	Zip
Insured's Date of Birth		Insured's Sex <input type="checkbox"/> M <input type="checkbox"/> F	Insured's Employer		

In consideration of the examination to be provided by Drs Porudominsky & Kleinstein: • I understand that the doctor makes no representations about my condition other than those concerning the problem for which he has been retained. • I assign any benefits received from my insurer to Drs Porudominsky & Kleinstein. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is also valid. I authorize release of all information necessary to secure payment. • Should the doctor's testimony be required with regard to my case, I agree to be responsible for a \$250 per hour fee for testimony and preparation. • I agree to pay any deductible or other balance not paid by my insurer. I understand that a monthly charge of 1% (ANNUAL RATE 12%) and collection costs including attorney's fees may be charged on overdue payments.

Patient's Signature _____ Date _____

IMPORTANT: Please answer the medical questions on the back of this page.

Year	Doctor or hospital	Nature of problem

To what drugs are you ALLERGIC? None known

Y N Cigarette smoking: <input type="checkbox"/> past <input type="checkbox"/> present	Y N Swollen glands
Y N Alcohol abuse: <input type="checkbox"/> past <input type="checkbox"/> present	Y N Loss of appetite
Y N Drug abuse: <input type="checkbox"/> past <input type="checkbox"/> present	Y N Unintentional weight loss
Y N Fever or chills	Y N Abdominal pain
Y N Easy bruising or bleeding	Y N Nausea or vomiting
Y N Blood transfusions	Y N Recent change in bowel habits
Y N Dizziness	Y N Rectal bleeding or black stools
Y N Fainting or blackouts	Y N Jaundice (yellowing of skin or eyes)
Y N Double vision	Y N Difficulty voiding
Y N Transient visual loss	Y N Blood in urine
Y N Paralysis	Y N Backache
Y N Numbness	Y N Joint pain, swelling, stiffness
Y N Shortness of breath	Y N Leg pain
Y N Wheezing or asthma	Y N Leg fatigue when walking
Y N Coughing of blood	Y N Leg cramps at night
Y N High blood pressure	Y N Varicose veins
Y N Chest pain	Y N Phlebitis or inflamed vein
Y N Palpitations	Y N Ankle swelling
Y N Heart murmur	Y N Injury
Y N Breast lump or nipple discharge	Y N Men: Loss of sexual activity
Y N Mother, grandmother, aunt with breast cancer	Y N Women: Missed or abnormal period

Reviewed by _____, MD

Patient's Signature _____

IMPORTANT: Please answer the medical questions on the back of this page.

Date _____

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Insured's Date of Birth		Insured's Sex <input type="checkbox"/> M <input type="checkbox"/> F		Insured's Employer	
Insured's Address					
ID #		Group #			
Insured		Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child			
Insured's Phone		Insured's Address			
City		State		Zip	
OTHER INSURANCE CARRIER					

Insured's Date of Birth		Insured's Sex <input type="checkbox"/> M <input type="checkbox"/> F		Insured's Employer	
Insured's SS #					
ID #		Group #			
Insured		Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child			
Insured's Phone		Insured's Address			
City		State		Zip	
PRIMARY INSURANCE CARRIER					

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Name of referring doctor(s) - we'll send a report					
Fax #		#			
Employed <input type="checkbox"/> Full-time student <input type="checkbox"/> Part-time student <input type="checkbox"/>		Employer and Address			
Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Address		City		State	
Zip					
Cell Phone		Home Phone		Work Phone	
Name (Last, First Middle)		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.			
Social Security Number					

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR
TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.

I hereby acknowledge receipt of a written notice of my privacy right and I consent to
Drs. David Porudominsky, Eric Kleinstein, and Pachavit Kasemsap using and disclosing
my protected health information to carry out treatment, payment or health care
operations.

I understand and have been provided with a notice of Privacy Practices, which provides a
more complete description of how my protected health information may be used to
disclosed. I understand that I have the right to review the notice prior to signing this
consent.

I understand that Drs. David Porudominsky, Eric Kleinstein and Pachavit Kasemsap,
reserves the right to change their notice and information practices and that I may obtain a
copy of the revised notice by written request to Bernice Grasso c/o David Porudominsky,
Eric Kleinstein and Pachavit Kasemsap, 2825 N State Rd 7 #300, Margate, FL 33063.

I understand that I have the right to restrict Drs. David Porudominsky, Eric Kleinstein
and Pachavit Kasemsap from using or disclosing my protected health information to carry
out treatment, payment or health care operations; that Drs. David Porudominsky, Eric
Kleinstein and Pachavit Kasemsap bound by restrictions to which it agrees.

I request the following restrictions to how my health information is used or disclosed:

I have the right to revoke this consent by notifying Drs. David Porudominsky, Eric
Kleinstein and Pachavit Kasemsap in writing, except to the extent that Drs. David
Porudominsky, Eric Kleinstein and Pachavit Kasemsap has taken action in the reliance
on my consent

Signature of the patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to patient or
representative's authority to act
for the patient