WEST ORANGE FAMILY MEDICAL CARE
1002 S. DILLARD STREET STE. 102
WINTER GARDEN, FL 34787
PHONE: (407) 877-3577 FAX: (407) 798-7793
MICHAEL MERCADO, MD
RAFAEL PERFECTO, MD

PATIENT INTAKE FORM

PLEASE PRINT AND ANSWER AS THOROUGHLY AS POSSIBLE. IF QUESTION DOES NOT APPLY PLEASE WRITE N/A

Today's Date:_____
NAME:_____ DATE OF BIRTH:_____
GENDER: MALE / FEMALE SSN:_____ AGE:_____
HOME PHONE:_____ CELL:_____
STREET ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____
EMAIL:_____ MARITAL STATUS:_____
OCCUPATION:_____ CURRENTLY EMPLOYED: YES / NO

ETHNICITY:_____ PREFERRED LANGUAGE:_____
RACE: ASIAN___ BLACK___ HISPANIC___ WHITE___ OTHER_____

NEXT OF KIN
NAME:_____ RELATIONSHIP:_____
ADDRESS:_____ PHONE NUMBER:_____
_____

ALTERNATE EMERGENCY CONTACT
NAME:_____ PHONE NUMBER:_____
MOTHERS MAIDEN NAME FOR SECURITY QUESTION:_____

INSURANCE INFORMATION
PRIMARY INS:_____ ID#:_____
NAME OF INSURED:_____ INSURED SSN:_____
EMPLOYER:_____ GROUP #:_____

SECONDARY INS:_____ ID#:_____
NAME OF INSURED:_____ INSURED SSN:_____
EMPLOYER:_____ GROUP #:_____

*PHARMACY NAME:*_____
ADDRESS:_____ PHONE:_____
MAIL ORDER:_____
ADDRESS:_____ PHONE:_____

NAME:_____ DATE OF BIRTH:_____

PLEASE LIST ALL SPECIALIST THAT APPLY TO YOU

CARDIO:_____ PHONE:_____
ENDO:_____ PHONE:_____
Ear Nose & Throat:_____ PHONE:_____
GASTRO:_____ PHONE:_____
HEMATOLOGY:_____ PHONE:_____
NEPHRO:_____ PHONE:_____
NEURO:_____ PHONE:_____
OPHTHAL:_____ PHONE:_____
OPTOMETRIST:_____ PHONE:_____
ORTHOPEDIST:_____ PHONE:_____
OB/GYN:_____ PHONE:_____
PAIN MANAGEMENT:_____ PHONE:_____
PODIATRY:_____ PHONE:_____
PSYCHIATRIST:_____ PHONE:_____
PSYCHOLOGIST:_____ PHONE:_____
PULMONOLOGY:_____ PHONE:_____
RHEUMOTOLOGY:_____ PHONE:_____
UROLOGY:_____ PHONE:_____
VASCULAR:_____ PHONE:_____

LIST ANY ALLERGIES TO MEDICATIONS, FOODS, SHELLFISH, IODINE, CONTRAST DYE, ETC.

ALLERGY	*MILD, MODERATE, OR SEVERE*	*ALLERGY*	*MILD, MODERATE, OR SEVERE*

PAST MEDICAL HISTORY: PLEASE MARK Y OR N IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS

ANGINA		ANXIETY DISORDER		THYROID DISORDER	
CANCER		GERD/REFLUX, ULCERS		BLEEDING DISORDER	
SEIZURES		KIDNEY DISEASE		DEPRESSION	
HIGH BLOOD PRESSURE		OSTEOARIHRISTIS		HIGH CHOLESTEROL	
NEUROPATHY		STROKE		DIABETES	
RHEUMATOID ARTHRITIS		CONGESTIVE HEART FAILURE		ASTHMA, COPD, ENPHYSEMA	
LIVER DISEASE		MULTIPLE SCLEROSIS		OSTEOPOROSIS	
HEART ATTACK		PACE MAKER/ DEFIBRILLATOR		OTHER (LIST BELOW)	

PLEASE CLARIFY, IF NECESSARY, ANY OF THE ABOVE SELECTIONS:_____

_____

NAME:_____ DATE OF BIRTH:_____

PAST SURGICAL HISTORY: HAVE YOU HAD PREVIOUS SURGERY?

TYPE OF SURGERY	*APRROXIMATE DATE*	*SURGEON*

FAMILY MEDICAL HISTORY: PLEASE LIST MEDICAL CONDITIONS AND/OR CAUSE OF DEATH FOR MEMBERS

FATHER-AGE_____ STILL ALIVE?_____ IF NOT, AGE HE EXPIRED_____

MOTHER-AGE_____ STILL ALIVE?_____ IF NOT, AGE SHE EXPIRED_____

CANCER_____

HIGH BLOOD PRESSURE_____

STROKE_____

HEART DISEASE_____

DIABETES_____

OTHER CONDITIONS:_____

SIBLINGS: HOW MANY SIBLINGS DO YOU HAVE?_____

CONDITIONS?_____

SOCIAL HISTORY

ALCOHOL USE: YES/NO

HOW OFTEN DO YOU HAVE A DRINK CONTAINING ALCOHOL?_____

HOW MANY STANDARD DRINKS CONTAINING ALCOHOL DO YOU HAVE ON A TYPICAL DAY?_____

HOW OFTEN DO YOU HAVE 6 OR MORE ALCOHOLIC DRINKS ON A TYPICAL DAY?_____

TOBACCO USE: YES/ NO HOW MANY CIGARETTES DO YOU SMOKE DAILY?

DO YOU USE ANY RECREATIONAL DRUGS? YES/ NO

HOW OFTEN DO YOU USE RECREATIONAL DRUGS?

STRESS AT HOME_____ ENVIRONMENTAL STRESS AT HOME_____

TOXIN EXPOSITION_____

HOW MANY DAYS OF MODERATE TO STRENUOUS EXERCISE, LIKE BRISK WALK, DID YOU DO IN THE LAST 7 DAYS?_____

HOW MANY MINUTES A DAY?_____

NAME:_____ DATE OF BIRTH:_____

PLEASE LIST MOST RECENT STUDIES

STUDY	*DATE OF STUDY*	*BODY PART (IF APPLICABLE)*	*RADIOLOGY OR LABORATORY USED*
PHYSICAL			
PAPSMAER			
MAMMOGRAM			
DEXA SCAN			
COLONOSCOPY			
ENDOSCOPY			
EKG			

MEDICATION LIST

MEDICATION NAME	*DOSE OF MEDICATION*	*FREQUENCY*

*PRIMARY COMPLAINT (REASON FOR YOUR VISIT)*_____

_____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AM CONSENTING TO MEDICAL EVALUATION, MEDICAL TESTING, TREATMENT, WELLNESS RECOMMENDATIONS, AND POSSIBLE REFERRAL TO SPECIALIST AS DEEMED NECESSARY BY ANY AND ALL OF THE BOARD CERTIFIED PRIMARY CARE PROVIDERS EMPLOYED AT WEST ORANGE FAMILY MEDICAL CARE, PA.

_____ _____

PATIENT/ GUARDIAN SIGNATURE **DATE**

WEST ORANGE FAMILY MEDICAL CARE PATIENT CARE POLICIES

1. Dr. Michael G. Mercado is the Directing Physician at WOFMC and although he may not directly care for you, he is at all times available as a medical consultant for any highly-trained and experienced Nurse Practitioner or Physician Assistant entrusted to autonomously provide medical care to patients at WOFMC.

2. The entire staff at WOFMC works together as a team and is committed to providing our patients with a comfortable environment to receive compassionate, competent, and individualized medical care. If there is a situation that does not meet your expectations, we will do our best to correct it, however we do ask for your calm and respectful treatment to each staff member at all times.

3. Medical care is provided by appointment only. Every request you may have related to your medical care requires "Face to Face" time with a provider who can document your encounter and plan of care to be implemented. This includes prescription renewals, Home Care, and any DME provision. Home Care agencies take care of skilled and intermittent needs. Home Care does not provide care to homebound sick or elderly patients who are chronic but stable.

4. If you become sick and need an urgent or same day visit, please be assured we will make every effort to have you seen by a provider. You will receive treatment for that illness ONLY.We do our best to keep your wait time as short as possible, but in our effort to be thorough and attentive with every patient and some of our patients are severely ill and require more critical medical care; we apologize if you are not seen at the time of your appointment.

5. We require you bring in ALL your medications with you to every visit so we have an accurate accounting of your treatments. We request you have your medications refilled at the time of your visit. When you or your pharmacy contacts our office for refills outside of an office visit, we still have to consult your chart to ensure your refill is appropriate. Prescribing for patients who are in the office takes priority and your refill request could take up to 1 (one) week to complete.

6. Please be aware, in order to prescribe any NARCOTIC medication all patients are required to have a previous medical record on file. If you require a prescription of a controlled medication for pain, muscle spasm, cough, insomnia, anxiety, ADD/ADHD in the course of your medical treatment, it will be prescribed by Dr. Mercado only. Documented test results, reports of symptoms and physical findings must support the use of a controlled substance, and only when all other methods of treatment have failed. Urine testing will be done randomly at your cost and surveillance reports of controlled substance use as tracked by the pharmacies and the State of Florida will be reviewed. Do Not call the office at any time for refill of controlled meds, as you will require an office visit. Lost or stolen meds or prescriptions will not be replaced.

7. You will find that your insurance company will not pay for certain medical procedures. Medical equipment, specialty prescriptions, brand name drugs, or even some generic meds or that a deductible or co-pay does not fit your budget> WOFMC providers will choose medications or treatments that are formulary with your Insurance carrier. Ifyou consider a medication or treatment to be life-saving, exclusive of all other options, you will be referred to a specialist. Pre-authorizations or any letter of appeal are generally NOT done in this office.

8. WOFMC staff considers patient confidentiality to be a serious matter and therefore we have many layers of electronic security that help keep your medical history private. In the event the entire Practice Fusion database becomes hacked, our office will inform you as soon as humanly possible and put you in touch with the administrative offices of Practice Fusion, a cloud based electronic medical record keeping system.

9. For the convenience of our patients, WOFMC offers a line of natural patented nutritional supplements and skin care products developed and distributed by Mannatech, Inc. Mannatech's products contain stabilized Aloe Vera in addition to other high quality ingredients. While our providers, in the course of interpreting your lab results, may recommend certain vitamins or minerals, our patients are under NO obligation to purchase those supplements from our office. Any interested patient will be referred to Lilian Mercado, our Wellness Coach. Most importantly, the offering of the products in our office is NEVER intended to treat conditions or cure illness. We care only to potentially provide you with availability of high quality nutritional products you would seek out for yourself in the retail market.

PATIENT/ GUARDIAN SIGNATURE **DATE**

*DATE:*_____ *NAME:*_____ *DOB:*_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I have read and reviewed WOFMC practice policy and I understand that my protected health information may be used for TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS. I also understand the circumstances under which the practice may use this information, and I have the right to withhold consent in writing if I do not want information released for purposes other than these legal requirements.

Designated Individuals Authorization Form

I wish to be contacted in the following manner (check all that apply)

____ Home Telephone #:_____ ☐ **Ok to leave detailed message** ☐ **Leave message with call back number only**	**____Work Telephone #:**_____ ☐ **Ok to leave detailed message** ☐ **Leave message with call back number only**
_____ Cell Phone #: _____ ☐ **Ok to leave detailed message** ☐ **Leave message with call back number only**	**____Written Communication** ☐ **Ok to leave detailed message** ☐ **Leave message with call back number only**

Communication with Family and Others Involved in your care

Please list up to 2 (TWO) family members or others who may be involved in coordinating you care. Also, please indicate that kind of information may be shared with each individual.

NAME and DOB	RELATIONSHIP TO PATIENT	ALL	APPT	MEDICAL	BILLING/ PAYMENT

I understand that I may cancel this designation at any time by signing the revocation section. I understand that any cancellation can only apply to future disclosures and cannot cancel actions taken or disclosures made while the designation was in effect.

SIGNATURE:_____ DATE:_____

PRINTED NAME:_____ DOB:_____

PATIENT SELF DETERMINATION ACT QUESTIONAIRE (Please checkmark your answer)

DECLARATION TO DECLINE LIFE-PROLONGING PROCEDURES (LIVING WILL)

____ I **HAVE** made such a declaration and will provide the office with a copy.
____ I have **NOT** made such a declaration.

HEALTH CARE SURROGATE

____ I **HAVE** a designated a healthcare surrogate and will provide the office with documentations.
____ I have **NOT** designated a health care surrogate.

DURABLE POWER OF ATTORNEY

____ I **HAVE** appointed a durable power of attorney for health care decisions and will provide documentation.
____ I have **NOT** appointed a durable power of attorney for health care decisions.

PATIENT SIGNATURE:_____ **DATE:**_____

WEST ORANGE FAMILY MEDICAL CARE FINANCIAL POLICY

Thank you for choosing our office as your health care provider.We are committed to your treatment being successful. Please understand that the payment of your bill is considered part of your treatment, to provide you with staff and facility in which to serve you. The following is a statement of our financial policy which we require you read and sign prior to any treatment.

All patients must complete our Patient Intake forms, Patient Care Policy form, and HIPAA form before seeing any of our providers at West Orange Family Medical Care.

- Full payment of visit, insurance deductibles, or co-pays are due at the time of service.
- We accept cash, checks, Visa, Master Card, and American Express for payment.
- We offer an extended payment plan with prior approval by the Office Manager, after the initial visit.
- The providers are not aware of payment arrangements, except to the extent that they are sensitive to provide treatments that are covered by your insurance or affordable to you otherwise.

Insurance and Covered Services

We will bill your insurance company after your deductible has been met. If payment is not made by your insurance, the patient becomes fully responsible for payment. If your insurance company has not paid your account service within 45 days of billing, the balance will automatically transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and are not considered reasonable and necessary under the Medicare program and/or other medical insurance, you will be informed in advance of service rendered, as much as we are aware.

Participating Provider with your Insurance Plan

All co-pays and deductibles are due prior to treatment. In the event your insurance coverage changes to a plan where we do not participate, refer to the paragraph above.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and our charges are considered "usual and customary for our geographical area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

FEE SCHEDULE for Forms

Please be aware it may take up to 2 weeks for any form to be completed. To ensure accuracy and avoid possible delays, the patient is responsible for completing all fields that pertain but not limited to: Employee information, medical facts, performance impediment, amount of level needed, etc. It is also necessary that the patient attach a summary of his/her condition explaining why the forms are being required. In addition, if there are any fields left blank for any reason, you must include an explanation as to why you feel you cannot input an answer. Without this information, you may hinder your form(s) readiness for pick up.

PAYMENT IS DUE AFTER FORM(S) HAVE BEEN COMPLETED. YOU WILL NOT RECEIVE, HAVE FAXED, OR MAILED ANY FORM(S) UNTIL PAYMENT HAS BEEN MADE.

Disability Forms (short and long term)	$45.00 and up
FMLA FORMS	$50.00
Letter explaining diagnosis or travel letter	$25.00
Form(s) for court of any kind	$25.00
Jury duty excuse, work or school excuse, Handicap form(s) for DMV	$0

Michael Mercado, MD

PATIENT SIGNATURE:_____ DATE:_____

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PATIENT INTAKE FORM

PLEASE PRINT AND ANSWER AS THOROUGHLY AS POSSIBLE. IF QUESTION DOES NOT APPLY PLEASE WRITE N/A

Today's Date:_____
NAME:_____ DATE OF BIRTH:_____
GENDER: MALE / FEMALE SSN:_____ AGE:_____
HOME PHONE:_____ CELL:_____
STREET ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____
EMAIL:_____ MARITAL STATUS:_____
OCCUPATION:_____ CURRENTLY EMPLOYED: YES / NO

ETHNICITY:_____ PREFERRED LANGUAGE:_____
RACE: ASIAN___ BLACK___ HISPANIC___ WHITE___ OTHER_____

NEXT OF KIN
NAME:_____ RELATIONSHIP:_____
ADDRESS:_____ PHONE NUMBER:_____
_____

ALTERNATE EMERGENCY CONTACT
NAME:_____ PHONE NUMBER:_____
MOTHERS MAIDEN NAME FOR SECURITY QUESTION:_____

INSURANCE INFORMATION
PRIMARY INS:_____ ID#:_____
NAME OF INSURED:_____ INSURED SSN:_____
EMPLOYER:_____ GROUP #:_____

SECONDARY INS:_____ ID#:_____
NAME OF INSURED:_____ INSURED SSN:_____
EMPLOYER:_____ GROUP #:_____

*PHARMACY NAME:*_____
ADDRESS:_____ PHONE:_____
MAIL ORDER:_____
ADDRESS:_____ PHONE:_____



West Orange Family Medical Care, PA

Diplomate, American Board of Family Medicine
Michael G. Mercado, M.D., FAAFP, CMD

_____ Print Patient full name

_____/_____/_____ Birth date

_____ Street address

_____-_____-_____ Social Security Number

_____ City/State/Zip

(_____)_____-_____ Home phone number

I, _____, do hereby authorize WEST ORANGE FAMILY MEDICAL CARE, P.A. to receive:
patient name

_____ Discharge Summary
_____ History & Physical
_____ Progress Notes
_____ Operative Notes
_____ Pathology Reports
_____ Laboratory Reports
_____ Radiology Reports
_____ ECG/EEG/Cardiac Cath
_____ Emergency Reports
_____ Entire Chart
_____ Other _____

ATTN: YOU MUST FILL OUT THE BELOW SECTION OR WE WILL NOT BE ABLE TO COMPLY WITH YOUR REQUEST. (please check one)

_____I do _____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

RECEIVE INFORMATION FROM: _____
Name of Company/Agency/facility/Person

Phone #: _____ _____
Street Address

Fax #: _____

_____
City/State/Zip

PURPOSE OF DISCLOSURE:

____ Referral to specialist ____ Insurance ____ Workers Comp ____ Change of Doctor/Provider
____ Legal Investigation ____ Disability determination ____ Self ____ Continuing care
Other (please specify) _____

Please provide the best telephone number in the event we need to contact you (home, work or cell)
(_____) _____-_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished many not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individual or guardian or Personal Representative of patient's estate — Date

CANCELLATION/NO SHOW POLICY 2025

EFFECTIVE JANUARY 1, 2025, THERE WILL BE A $25.00 NO SHOW FEE TO ANY PATIENT THAT DOES NOT CANCEL THEIR APPOINTMENT 24 HOURS PRIOR TO THEIR SCHEDULED APPOINTMENT TIME.

EFFECTIVE JANUARY 1, 2025, THERE WILL BE A $75.00 NO SHOW FEE TO ANY PATIENT THAT DOES NOT CANCEL THEIR PROCEDURE 24 HOURS PRIOR TO THEIR SCHEDULED PROCEDURE TIME.

_____

PATIENT NAME PRINTED DATE

_____

PATIENT SIGNATURE