TOTAL PAYMENT AMOUNT:____________cash/cc/ck DATE:____/_____/20___

Largo Clinic
10500 Ulmerton Road, Suite 360
Largo, Florida 33771

Dr.George Kamajian, D.O.

Please fill out highlighted areas

Date:____________________

PATIENT INFORMATION FORM

The following will be kept in strictest confidence

Last Name First Middle	Birthdate:	Age:
Street Address	Gender M F	Birthplace
City State Zip	Home Phone	Work Phone
Employer Occupation	Marital Status S M W D Sep	
Social Security #	Emergency Contact (Name)	
Referred By:	Emergency Contact (Phone)	

Chief Complaint:

Personal History

Do you have or have you ever had any of the following conditions:

YES	NO	CONDITION	YES	NO	CONDITION
☐	☐	AIDS / HIV	☐	☐	Heart Murmur
☐	☐	Alcohol / Drug Problems	☐	☐	Hemorrhoids
☐	☐	Anemia / Low Blood Count	☐	☐	Hepatitis
☐	☐	Arthritis	☐	☐	Hernia
☐	☐	Asthma	☐	☐	High Blood Pressure
☐	☐	Blood Clots	☐	☐	High Cholesterol
☐	☐	Cancer (Type:____________)	☐	☐	Infertility (Difficulty Getting Pregnant)
☐	☐	Cataracts	☐	☐	Kidney / Bladder Problems
☐	☐	Circulation Problems	☐	☐	Liver Disease / Jaundice / Hepatitis
☐	☐	COPD / Emphysema	☐	☐	Mental Trouble / Depression / Anxiety
☐	☐	Diabetes (Sugar)	☐	☐	Pneumonia
☐	☐	Easy Bleeding	☐	☐	Rheumatic Fever
☐	☐	Eating Disoder (Anorexia / Bulimia)	☐	☐	Seizures / Fits / Epilepsy
☐	☐	Eczema	☐	☐	Serious Injury / Serious Accident
☐	☐	Genital Herpes	☐	☐	Sickle Cell Anemia
☐	☐	Genital Infections (Chlamydia / Gonorrhea)	☐	☐	Skin Disorder
☐	☐	Genital Warts / HPV	☐	☐	Stroke
☐	☐	Glaucoma	☐	☐	Thyroid Problem
☐	☐	Gout	☐	☐	Transfusion (Year:_____)
☐	☐	Hay Fever / Pollen Allergy	☐	☐	Tuberculosis (TB)
☐	☐	Headaches	☐	☐	Ulcers
☐	☐	Hearing Loss	☐	☐	Other (specify:______________)
☐	☐	Heart Attack / Heart Disease	☐	☐	Other (specify:______________)

Allergies:

Current Medications:
1.
2.
3.
4.
5.

Surgeries:
1.
2.
3.
4.
5.

Informed Consent

Largo Clinic is a "point of contact" practice. Our focus is on your acute medical or surgical problem at the time you present to this office. It is our intent to provide you with the best medical care possible within the scope of our experience and the physical facilities available in this office. A medical membership at Largo Clinic is prepaid medical, not surgical care with us and does not represent access to any specialist or ancillary services.

Frequently medical diagnosis or surgical procedures require ancillary modalities such as laboratory tests or x-rays to provide you with appropriate care and treatment. Both x-rays and lab testing are available to this practice but are performed outside this facility. Any charges for those tests are your direct and immediate responsibility. Tests typically require a minimum 48 hours turnaround time before they are made available to our office. Based on our experience it is often appropriate to initiate treatment before performing blood test or x-rays. If such tests are ordered and you chose not to follow up in the office or obtain requested studies or testing, our ability to assist you with your health care needs will be severely limited. If your decision not to pursue testing is based on financial issues, please be aware that local hospital emergency departments will see you without any financial caveats.

Medicare Non Provider Status
Dr. George Kamajian has opted out of Medicare as of 2007. This office will continue to see all patients who present for treatment regardless of their insurance status. You, the patient, agrees to accept full responsibility for payment of our office charges. You understand that Medicare limiting charges do not apply to our office charges. You understand that neither you nor this office should submit a claim to Medicare. You understand that Medicare payments will not be made for items or services that otherwise would have been covered by Medicare if no private contract existed. You understand you have the right to obtain Medicare covered items and services from participating Medicare physicians.

This practice is not open on nights or weekends or every day of the business week and we do not admit or see patients in the hospital. We will try to return calls promptly during office hours. Your calls after hours may not be returned until the following business day. **This is a solo practice and there is no physician coverage for emergencies when this office is closed and we do not always respond to after hour phone calls.** Please proceed to the nearest emergency department or call 911 after our regular office hours.

By signing below you acknowledge that you have read the information above and agree to treatment under these guidelines.

AUTHORIZATION AND AGREEMENT FOR TREATMENT

CONSENT TO TREATMENT: I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results obtained.

COMPLICATIONS: Medicine is an inexact science. Every human being is unique. I understand that it is my responsibility to return to the Clinic or report any change in my condition to the clinic.

PRIVACY NOTE: I acknowledge that I have received the privacy notice. The undersigned certifies that he/she has read the above and is the patient, guarantor or the patient's representative duly authorized to execute this agreement and accept its terms. This practice complies with all HIPAA guidelines.

Financial policy: I have read and agree to Largo Clinic's financial policy

By signing below you acknowledge that you have read the information above and agree to treatment under these guidelines.

Signed ______________________________ **Date**____________

George K. Kamajian, D.O.
Largo Clinic & Dr K's Med Spa

Discharge Instructions for Acute Medical or Surgical Conditions

You understand that you have been seen in a walk in clinic and that we are not your primary physician. There is no coverage for this medical practice after hours or when the office is closed. If your symptoms become worse you should immediately return to this facility or the emergency department of the nearest hospital.

Your preliminary (tentative) diagnosis(es) is(are):

Please proceed immediately to the nearest emergency department for evaluation and possible admission. If you do not, you may **die** or be **permanently disabled**. ☐

Please comply with the following instructions:

1.	Antibiotic:	__________ times per day for _______ days	
2.	Pain medication		
3.	Fever Control	Tylenol	Motrin
4.	Splint / Crutches	days	weeks
5.	Diet:	clear	regular
6.	Compresses	ice	heat _____times per day for __days
7.	Extremity	elevate	non weight bearing for ____ days
8.	Referred to	Pinellas Health	Specialist
9.	Imaging	X-Ray/CT scan/MRI ordered:	accepted / declined
10.	Labs ordered:	CBC/CMP/Cultures:_______	accepted / declined
11.	Suture removal	5 / 7 / 10 / 14 days	

Additional Medications/Orders:

I understand the following information has been provided to me: *Purpose of care, alternative forms of care, risk of recommended care including medication, risk of alternative care, risk of not undergoing care. I acknowledge that I have had the opportunity to discuss this information with Dr. Kamajian and understand the potential risks and benefits.*

Next follow up appointment: ____days/weeks

Patient Signature: ____