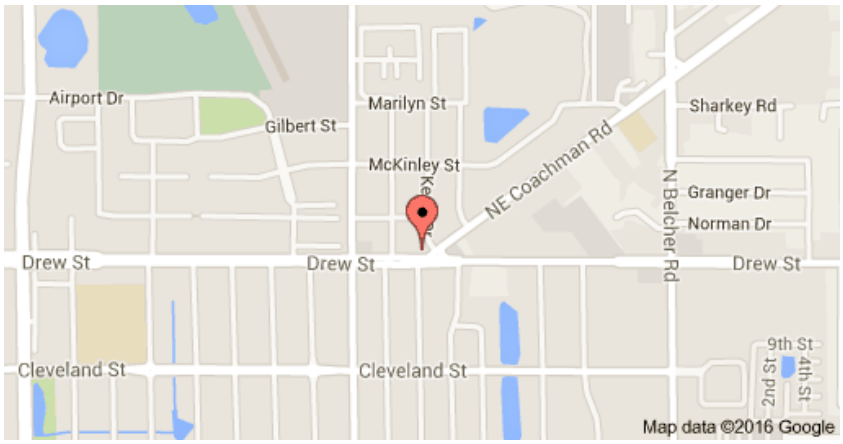
Dennis M. Lox, M.D

2030 Drew Street Clearwater, FL 33765
Phone 727-462-5582 Fax 727-462-5583
www.drlox.com

Dear New Patient,

Thank you for choosing Dennis M. Lox, M.D to participate in your healthcare. We realize that you could have chosen any other office, so we are honored that you have chosen us. While Dr. Lox has cared for thousands of patients since starting his practice in 1990, we treat each of our patients as individuals and attend to their unique needs. Attached is an initial intake questionnaire, designed to make your initial visit much more efficient. Please do your best to complete each section of the questionnaire so that we can have as much information about you as possible.



Our office is located at 2030 Drew Street, Clearwater FL, 33765.
We are on Drew Street, in between N.E Old Coachman Road
& Hercules Avenue.

If you have any questions before your appointment, please feel free to contact our office via telephone; 727-462-5582, via email; info@drlox.com, fax; 727-462-5583.

Again, thank you for choosing Dr. Lox and we look forward to meeting you!

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Today's Date: _____ Social Security Number: _____

Name: _____

Date of Birth: _____ Employer: _____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contact: _____ Phone #: _____

Relationship To You: _____

In the event of an emergency, may we release your medical information to this person? YES NO

May we leave a voicemail on your answering machine to confirm your appointment? YES NO

Primary Care Physician: _____ Phone: _____ Fax: _____

INSURANCE INFORMATION

PRIMARY:

Insurance Carrier: _____ HMO or PPO Referrals Required? YES NO

Member Identification Number: _____ Group Number: _____

Claims Address (PO BOX on back of card): _____

Policy Holder: _____ Relationship: _____ D.O.B: _____

Deductible: _____ Copay: _____

SECONDARY: ☐ **N/A**

Insurance Carrier: _____ HMO or PPO Referrals Required? YES NO

Member Identification Number: _____ Group Number: _____

Claims Address (PO BOX on back of card): _____

Policy Holder: _____ Relationship: _____ D.O.B: _____

Deductible: _____ Copay: _____

Patient Name: _____ **Date of Birth:** _____

Age: _____ **Height:** _____ **Weight:** _____

Chief Complaint:

_____

_____

Are you currently taking any anticoagulants? YES or NO

Current Prescribed Medications: **Allergies:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Social History:

Occupation: _____ **Marital Status:** S M D

Children: Yes No If Yes, How Many: _____ **Tobacco Use:** YES NO

Nutrition: Currently On A Diet? Yes No Explain: _____

Past Medical History:

Have you ever had or currently have cancer? NO YES radiation chemotherapy (please circle)

If Yes, Please Specify: Breast Prostate Other: _____

Radiology: (Most Recent)

XRAY/MRI _____DATE: _____ XRAY/MRI _____DATE: _____

Surgical History

YEAR

Knee L _____ explain: _____
R _____ explain: _____

Shoulder L _____ explain: _____
R _____ explain: _____

Hip L _____ explain: _____
R _____ explain: _____

Back explain: _____

Neck explain: _____

Other: _____

Chronic Medical Problems (Please Circle)

Hypertension Diabetes Gout Asthma Arthritis Renal Disease Thyroid Disease
Coronary Heart Disease COPD

Family History (Please Circle)

Cancer Hypertension Hyperlipidemia Diabetes Coronary Artery Disease Arthritis OA RA
RF Disorders Lupus

How did you hear about Dr. Lox? (Please Circle)

RADIO INTERNET DOCTOR PATIENT TELEVISION OTHER _____

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Authorization for Medical Treatment
And
Assignment of Benefits

Patient Name: _____

Date: _____

I, the undersigned patient, authorize Dennis M. Lox, M.D to carry out such examinations and diagnostic procedures, and to administer such treatments as may be deemed medically necessary or advisable.

I hereby certify that I have read and fully understand the above authorization for medical treatment and diagnostic procedures. (If necessary)

Further, I assign directly to Dennis M. Lox, M.D all medical insurance benefits otherwise payable to me for ALL services rendered. I understand that I am fully responsible for ALL charges, whether or not covered by my insurance. I hereby authorize Dennis M. Lox, M.D to release any of my personal information necessary to secure payment of benefits.
I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS ON MY BEHALF.

_____ _____

Patient Signature

Signature of Legal Guardian/Resp Party
(if under 18)

_____ _____

Patient Printed Name

Printed Name of Legal Guardian/Resp Party

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Authorization to Release Medical Records

Today's Date: _____

Patient Name: _____

Patient Date of Birth: _____ Last 4 Digits of Patient SSN: _____

Doctor / Medical Facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

I authorize the healthcare provider/facility named above to release a copy of my medical records to include all office notes, films and diagnostic test results and forward them to:

Dennis M. Lox, M.D
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Clearwater, FL 33765
Phone: 727-462-5582
Fax: 727-462-5583

_____
Patient Signature

OR

_____
Witness

_____
Signature of Legal Guardian or
Responsible Party (under 18)

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NO SHOW / MISSED APPOINTMENT POLICY

We understand that sometimes you need to cancel or reschedule your appointment and that emergencies DO happen. If you are unable to keep your scheduled appointment, please call our office AS SOON AS POSSIBLE, giving our office at least a 24 hour notice. You can cancel or reschedule appointments by calling **727-462-5582**

To ensure that each and every patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit as scheduled and on time.

Due to a high volume of no call, no shows, we have implemented a new policy for the 2019 year.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel or reschedule your appointment at least 24 hours PRIOR to when you are scheduled.
2. If you do not call to cancel or reschedule your appointment 24 hours in advance, this will be considered a "No Call, No Show" and **you will be billed a fee of $25.00.**
3. Once you have missed 3 appointments, you will be dismissed from our practice.

As a courtesy, our office calls each patient 1-3 days prior to their appointment to remind and confirm appointments. If you are unsure that you will make your appointment, please notify our office staff.

By signing below, I agree that I have read and understand the No Show / Missed Appointment Policy for the office of Dr. Lox. I understand my responsibility to plan appointments accordingly and notify the office appropriately if there is any change or difficulty keeping my scheduled appointment.

_____ _____

Patient Name Date

_____ _____

Patient Signature Staff Signature

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Please complete the following pain diagram.