



PATIENT INFORMATION
(Please Print)

Date of Appointment: _____

Patient's Name: _____
Last
First
MI

Age: _____ Date of Birth: _____ Marital Status: M__ S__ W__ D__ Sep__

Residence Address: _____

City: _____ State: _____ Zip Code: _____

Mailing or Alternate Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) - _____ Business Phone: (_____) - _____

Cell Phone: (_____) - _____ May We Contact You At Work? Yes_____ No_____

Height: _____ Weight: _____ Sex: Male___ Female___ Race: _____

Social Security Number: _____ Driver's License Number: _____

Occupation: _____ Employer: _____

Business Address: _____

Email Address: _____

Husband or (Father if child is a minor): _____
Name
Date of Birth
Social Security Number

Wife or (Mother if child is a minor): _____
Name
Date of Birth
Social Security Number

Their Employer: _____ Business Address: _____

Business Phone: (_____) - _____ Driver's License Number: _____

Closest relative not living with you: _____
Name
Relationship
Phone Number

Emergency Contact other than spouse/parent: _____
Name
Relationship
Phone Number

Referring Physician: _____ Phone: _____

Address: _____
Street
City
State
Zip Code

Primary Care Physician: _____ Phone: _____

Have you or any members of your family been treated here before? Yes___ No___ Name: _____

I heard about Dr. Spence through: Yellow Pages___ Friend___ Physician___ TV___ Radio___ Publication___ Website___

Please Name Publication: _____ Other: _____

If referred by a friend or physician, please list their name so we may thank them: _____

All professional services rendered are charged to the patient.

HISTORY INTAKE

Patient Name: _____

Please answer all of the questions accurately.

Primary Care Doctor: _____

Height _____ Weight _____ Alcohol (type & amount per day) _____
Smoking (type & amount per day) _____ If former smoker, date you quit: _____

Drug allergies: _____

List previous surgeries or major illnesses and dates: _____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals: _____

Family History: Has any blood relative ever had the following (please check all that apply):

Breast Cancer	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>		

Past Medical History: Have you ever had the following (please check all that apply):

Heart Disease	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	AIDS or HIV	<input type="checkbox"/>	Bleeding Tendency	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Malignant Hyperthermia	<input type="checkbox"/>				

Review of system: Do you now or have you had within the past year (please check all that apply):

Weight changes	<input type="checkbox"/>	Swollen feet/ankles	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	Joint or muscle pain	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	Chronic diarrhea	<input type="checkbox"/>	Swollen lymph nodes	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Easy bleeding	<input type="checkbox"/>
Rapid heart beat	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Latex allergies	<input type="checkbox"/>
Increased fever w/ anesthesia	<input type="checkbox"/>				

Women Only:

Age period began _____ Number of pregnancies _____
Date of last mammogram _____ Did you breast feed? _____
Do you do regular breast self-examinations? _____
Do you have a breast lump or discharge? _____

I verify that the above information is true and accurate to the best of my knowledge.

Patient Signature _____ **Date** _____



KENRICK SPENCE, M.D., P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient signature: _____

PRINTED NAME: _____

In connection with the medical services that I am receiving from Dr. Kenrick Spence, M.D., I hereby authorize disclosure of any and/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

- A. Any third party payor covering the medical services of the patient;
- B. Other health care professionals and institutions involved in the delivery of health care to the patient;
- C. The proponent of any legally sufficient subpoena, or in response to a court order;
- D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
- E. Pharmacies; and
- F. As otherwise required by law.

I further consent that photographs may be taken of me, or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him.
2. The photographs shall be taken by my physician or by a photographer approved by my physician.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. This consent is valid from the date executed until revoked in writing by the patient. Please understand that revocation of the consent will not affect any action we took in reliance on consent before we received your revocation and we may decline to treat or continue treating you if you revoke this consent.

I further understand that I have been given special access to the physician's privacy notice and that I have the opportunity to place special restrictions upon the consent (see below). I may request a copy of the privacy notice at any time by contacting:

Contact person: Kitty Norwood; Office of Kenrick Spence, M.D., P.A.
Address: 130 Hillcrest Street, Orlando FL 32801
Telephone: 407-999-2585

Special restrictions: _____

YOU MAY CONTACT ME AT: HOME WORK CELL

YOU MAY LEAVE A MESSAGE AT: HOME WORK CELL

ADDITIONALLY, YOU HAVE MY PERMISSION TO DISCLOSE ANY OR ALL INFORMATION TO:

NAME: _____ RELATIONSHIP: _____

CONTACT PHONE AND ADDRESS: _____

NAME: _____ RELATIONSHIP: _____

CONTACT PHONE AND ADDRESS: _____

NAME: _____ RELATIONSHIP: _____

CONTACT PHONE AND ADDRESS: _____

Signed: _____

Date: _____

Personal Representative (if applicable) _____

Witness: _____

For office use only:

Signed form received

Patient Refused

Emergency

Language barrier prevented acknowledgement or signature

Staff member's name: _____

Date: _____



KENRICK A. SPENCE, M.D., F.A.C.S.
130 HILLCREST STREET
ORLANDO, FL 32801
(407) 999-2585

DIRECTIONS TO THE OFFICE

From the Jacksonville Area

1-95 S Ramp and merge onto US-1S/FL-5S
Take 1-95 South via the exit on the left approximately 88.2 miles
Merge onto 1-4 West via Exit 260B toward Orlando approximately 47.9 miles
Take the Colonial Drive/SR-50 exit #84
Turn left onto Colonial Drive/SR-50 approximately 0.4miles
Turn right on Highland Avenue less than 0.7miles
Turn right onto Hillcrest Street less than 0.1miles
End on left side at 130 Hillcrest Street

From the Altamonte Springs, Maitland Area

Take 1-4 West toward Orlando approximately 7.2 miles
Take the Colonial Drive/SR-50 exit #84
Turn left onto Colonial Drive/SR-50 approximately 0.4miles
Turn right onto Highland Avenue less than 0.7miles
Turn right onto Hillcrest Street less than 0.1miles
End on left side at 130 Hillcrest Street

From the Leesburg Area

Take US 27S/S 14th St/FL-25 S continue to follow US 27 S/FL-25S approx 11.5 miles
Turn left onto the ramp
Merge onto Florida Turnpike S (tolls) approximately 19.1miles
Take SR 408 E (tolls) exit 265 toward Orlando/Titusville
Merge onto SR 408 East/East-West Expressway approximately 9.6miles
Exit 10C toward SR-527/Orange Avenue approximately 0.2miles
Turn slight right onto East Lucerne Circle approximately 0.1miles
Turn right onto Orange Avenue/N. Magnolia and follow approximately 1.3miles
Turn right onto Hillcrest Street less than 0.1miles
End on the right side at 130 Hillcrest Avenue

From the Kissimmee Area

Take W. Osceola Parkway/Dart Blvd approximately 1.5miles
Merge onto Florida Turnpike North via ramp on the left (tolls) approximately 10.5miles
Merge onto 1-4 East via exit #259 toward Orlando approximately 7.3 miles
Take Amelia Street exit #83A approximately 0.2miles
Turn right onto West Amelia Street approximately 0.3miles
Turn left onto N. Magnolia Avenue approximately 0.1miles
Turn right onto Hillcrest Street less than 0.1 miles
End on the right side at 130 Hillcrest Street

From the Satellite Beach, Cocoa Beach and Merritt Island Area

Take 1-95 North approximately 13.8miles
Take the SR 528 West Toll (exit 205) toward Orlando approximately 0.8miles
Merge onto the Bee Line Expressway (SR 528) for approximately 25.5 miles
Take SR 417 Toll North (exit 16) toward Orlando/Sanford approx 1.1 miles
Merge onto Central Florida Greenway/FL 417 North for approx 6.3 miles
Take SR 408 Toll West (exit 33B) toward Orlando for approx 0.3 miles
Merge onto FL 408 Toll West approximately 7.0 miles
Take the Rosalind Avenue exit # 11A approximately 0.1 miles
Turn left onto E. South Street approximately 0.1 miles
Turn right onto S. Rosalind Avenue for approximately 0.9 miles
Turn right onto Hillcrest Street less than 0.1 miles
End on the right side at 130 Hillcrest Street

From the Ft. Lauderdale Area

Take 1-95 North via the ramp on the left for approximately 61.8 miles
Merge onto W. Indiantown Road/FL 706 W via exit 87B toward Okeechobee approximately 0.8 miles
Take Florida Turnpike merge on the Florida Turnpike North for approximately 143 miles
Merge onto 1-4 E via exit 259 toward Orlando for approximately 7.3 miles
Take Amelia Street exit #83A toward US 17/SR 50 for approximately 0.2 miles
Turn right onto West Amelia Street for approximately 0.3 miles
Turn left onto N. Magnolia Avenue approximately 0.1 miles
Turn right onto Hillcrest Street less than 0.1 miles
End on the right side at 130 Hillcrest Street

From the University of Central Florida and Alafaya Area

North on Alafaya Trail toward University Blvd.
Left onto University Blvd. for approximately 2.6 miles
Take the SR 417 Toll S ramp
Merge onto the 417S for 1.8 miles
Take SR-50/Colonial Drive (exit 34)
Turn right onto E Colonial Drive/SR-50 for approximately 6.7 miles
Turn left onto Highland Avenue less than 0.1 miles
Turn right onto Hillcrest Street less than 0.1 miles
End on left side at 130 Hillcrest Street