ALTAMONTE
MEDICAL ASSOCIATES, P.A.

Caring for You. Caring for Our Community.

Patient Welcome & Intake Packet

W

Welcome to Altamonte Medical Associates

Thank you for choosing Altamonte Medical Associates, P.A. We are honored to participate in your healthcare and look forward to serving you with attentive, personalized internal medicine care.

D

Our Physicians

Gary M. Sturn, M.D.
Board Certified Internal Medicine

Stephen N. Sturn, M.D.
Board Certified Internal Medicine

S

Our Services

- ☒ Preventive care
- ☐ Medicare wellness
- ☐ Hypertension care
- ☐ Chronic disease management
- ☐ Internal medicine
- ☐ Diabetes care
- ☐ Thyroid disorders
- ☐ Telemedicine

L

Office Locations

Altamonte Springs Office
631 Palm Springs Drive, Suite 117
Altamonte Springs, FL 32701

Orlando Office
1864 N. Alafaya Trail, Suite B
Orlando, FL 32826

ALTAMONTE
MEDICAL ASSOCIATES, P.A.

Please print clearly.

Patient Registration & Insurance

1 Patient Information

Full Legal Name

Preferred Name

Date of Birth

Cell Phone

Home Phone

Email Address

Preferred Language

Preferred Communication Method

Street Address

City

State

ZIP

Reason for Visit Today

2 Insurance & Emergency Contact

Emergency Contact Name

Relationship / Phone

Primary Insurance

Member ID / Group #

Subscriber Name

Subscriber Date of Birth

Secondary Insurance

Secondary Member ID

Preferred Pharmacy / Phone

Medical History

+ Current Medical Conditions - Check All That Apply

- ☐ High blood pressure
- ☐ Diabetes
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Atrial fibrillation
- ☐ Heart failure
- ☐ Asthma
- ☐ COPD
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Cancer
- ☐ Depression
- ☐ Anxiety
- ☐ Arthritis
- ☐ Stroke/TIA
- ☐ GERD/reflux
- ☐ Other

N Other Medical Conditions / Details

Please list additional conditions or details

P Preventive Screening History

Colonoscopy
Date: _____
Result/comments: _____

Mammogram
Date: _____
Result/comments: _____

Pap smear
Date: _____
Result/comments: _____

Bone density
Date: _____
Result/comments: _____

PSA
Date: _____
Result/comments: _____

Recent vaccines / immunizations
Date: _____
Result/comments: _____

Surgical History

S Surgeries / Procedures

Surgery / Procedure	Year	Hospital / Surgeon

H Hospitalizations / Major Illnesses

Reason	Year	Hospital / Notes

Medications

M

Current Medications

Medication	Dose	Frequency / Instructions	Prescriber

R

Medication Reminder

Please bring medication bottles or an updated medication list to your appointment whenever possible.

Allergies & Family History

A Allergies

Drug / Food / Other Allergy	Reaction

F Family History

Family Member	Medical History

Common conditions to mention: diabetes, high blood pressure, heart disease, stroke, cancer, thyroid disease, autoimmune disease.

Social History & Wellness

S Social History

Occupation _____

Tobacco use: Never / Former / Current - amount _____

Alcohol use: Never / Occasional / Regular - amount _____

Exercise habits _____

Recreational drug use: No / Yes _____

Advance directive: Yes / No _____

W PHQ-2 Depression Screening and Fall Risk

Over the past 2 weeks, how often have you been bothered by:

Question	0 Not at all | 1 Several days | 2 More than half | 3 Nearly every day
Little interest or pleasure in doing things	
Feeling down, depressed, or hopeless	

☐ Have you fallen in the past year?

☐ Do you feel unsteady when standing or walking?

Need help with bathing, dressing, medications, shopping, transportation, or finances? _____

Policies & Signatures

P Practice Policies & Acknowledgements

HIPAA Acknowledgement:	I acknowledge receipt of the Notice of Privacy Practices.
Communication Consent:	I authorize communication by telephone, voicemail, text message, and email regarding appointments, billing, care coordination, and practice communications.
Financial Policy:	Copayments, deductibles, coinsurance, and non-covered services are patient responsibilities.
Records Release:	I authorize exchange of medical information needed for treatment, payment, and healthcare operations.
Telemedicine:	Telemedicine may be offered when clinically appropriate and may not be suitable for all visit types.

Patient / Responsible Party Signature _____ Date _____

AI Artificial Intelligence (AI) Scribe Consent

Altamonte Medical Associates may use AI-assisted medical documentation technology. The AI scribe assists only with documentation and does not diagnose conditions, make treatment recommendations, prescribe medications, or replace your healthcare provider.

☐ I CONSENT to the use of an AI-assisted medical scribe during my visit.

☐ I DO NOT CONSENT to the use of an AI-assisted medical scribe during my visit.

✓ Final Patient Acknowledgement

I certify that the information provided in this packet is accurate and complete to the best of my knowledge.

Patient / Responsible Party Signature _____

Date _____

Financial Responsibility & Office Policies

F Financial Responsibility

We are committed to providing quality healthcare while helping patients understand their financial responsibilities.

- ☐ Copayments are due at the time of service.
- ☐ Deductibles, coinsurance, and non-covered services remain the responsibility of the patient.
- ☐ Insurance verification is not a guarantee of payment.
- ☐ Balances not paid by insurance remain the responsibility of the patient.

A Appointment Policies

- ☐ Please provide reasonable notice if you need to cancel or reschedule an appointment.
- ☐ Missed appointments and late cancellations may be subject to a fee of up to $50.00.
- ☐ This policy applies to office visits and telemedicine visits.
- ☐ Assessment of any fee remains at the discretion of Altamonte Medical Associates, P.A.

B Billing Questions

- ☐ Patients are encouraged to contact the office with billing questions.
- ☐ Accounts more than ninety (90) days past due may be referred to collections at the discretion of Altamonte Medical Associates, P.A.

Patient / Responsible Party Signature _____ Date _____

Telehealth Consent

T Telehealth Services

Telehealth allows patients to meet with their healthcare provider remotely when clinically appropriate.

- ☐ I understand that telemedicine visits may occur through video or telephone communication.
- ☐ Telemedicine services can be a convenient option for many healthcare needs; however, some concerns may require an in-person evaluation.

I Important Information

- ☐ Certain medical concerns may require an in-person examination.
- ☐ Technical interruptions may occasionally occur.
- ☐ My provider may recommend an office visit if clinically appropriate.
- ☐ Telemedicine visits are not appropriate for all appointment types.

P Privacy & Confidentiality

- ☐ Reasonable safeguards will be used to protect my health information.
- ☐ Electronic communications may involve risks beyond the control of the practice.

Patient / Responsible Party Signature _____ Date _____

ALTAMONTE
MEDICAL ASSOCIATES, P.A.

Authorization for treatment of minors ages 16 through 18

Consent to Treat Minor

!

Important

Complete this page only if applicable.

M

Minor Information

Minor Name _____

Date of Birth _____

P

Parent / Guardian Information

Parent / Guardian Name _____

Relationship _____

Primary Phone _____

Alternate Phone _____

A

Authorization

☐ I authorize Altamonte Medical Associates, P.A. to provide medical treatment to the above-named minor.

☐ I authorize emergency treatment when medically necessary.

Parent / Guardian Signature _____ Date _____

Patient Consent & Final Acknowledgment

C Consent & Benefits

- ☐ I consent to medical evaluation and treatment by Altamonte Medical Associates, P.A.
- ☐ I authorize payment of insurance benefits directly to Altamonte Medical Associates, P.A. when applicable.
- ☐ I authorize release of information necessary for treatment, payment, and healthcare operations.
- ☐ I authorize communication regarding appointments, billing, care coordination, and practice communications through telephone, voicemail, text message, and email.

P Patient Responsibilities

- ☐ I will provide accurate and complete health information.
- ☐ I will notify the office if my insurance information changes.

✓ Final Patient Acknowledgment

- ☐ I certify that the information I have provided is accurate and complete to the best of my knowledge.
- ☐ I acknowledge that I have reviewed the policies and consents contained within this packet.
- ☐ I understand that I may request clarification regarding any portion of this packet.

Patient / Responsible Party Signature

Signature _____

Printed Name _____

Date _____ Relationship to Patient (if applicable) _____

Thank you for choosing Altamonte Medical Associates, P.A. Visit AltamonteMedical.com for office information and patient resources.