Lan Luo, M.D. **New Patient Information**

NAME: _____

AGE: _____ DATE OF BIRTH: _____ SS#:_____

STREET ADDRESS: _____

CITY: _____ ZIP CODE: _____

HOME PHONE: _____ CELL/WORK PHONE: _____

EMAIL ADDRESS: _____

EMPLOYER: _____

OCCUPATION: _____

SPOUSE/NEAREST RELATIVE: _____PHONE:_____

SPOUSE'S DATE OF BIRTH (if applicable for insurance):_____

REFERRING OR PRIMARY CARE PHYSICIAN: _____

GENDER: Male _____ Female _____
MARITAL STATUS: _____MARRIED ____ SINGLE____ WIDOWED____DIVORCED
RACE: ____WHITE____ AFRICAN AMERICAN____ASIAN____AMERICAN INDIAN OR ALASKA NATIVE
_____ NATIVE HAWIANN OR OTHER PACIFIC ISLANDER_____ OTHER

ETHNICITY: _____HISPANIC OR LATINO _____NOT HISPANIC OR LATINO

PREFERRED LANGUAGE: ____ENGLISH ____SPANISH ____FRENCH ____GERMAN ____ITALIAN _____OTHER

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I do hereby authorize any physician examining and/or treating me to release to any third payor (such as Insurance company or government agency) any medical and psychiatric information and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis. I do hereby authorize payment directly to any physician examining or treating me for medical benefits, otherwise payable to me for their services, but not to exceed the reasonable and customary charge for these services.

I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me. I permit a copy of these authorization and assignments to be used in place of the original which is on file at the physician's office.

I agree that should the amount of the insurance benefits be insufficient to cover the expenses that I will be responsible for payment of the difference. I will be responsible for the entire amount due for professional services rendered if the expense is not covered by my policy, or if uninsured.

SIGNAURE: _____ DATE: _____

Lan Luo, MD
3310 S.W. 34th St. Ocala, FL 34474-7422
20049 E. Pennsylvania Ave., Unit 1 Dunnellon, FL 34432-6037
Phone: 352-873-9557 Fax: 352-873-1842

CENTRAL FLORIDA HEART CENTER

CONFIDENTIAL

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Ocala Campus
Paddock Park:
3310 S.W. 34th Street
Ocala, Florida 34474
Telephone: (352) 873-0707

Joseph R. Alonso, M.D., FACC
Surexa S. Cacodcar, M.D., FACC
William F. Dresen, M.D., FACC
Tong Liu, M.D., Ph.D., FACC
Lan Luo, M.D., FACC
Ajay Mehta, M.D.
Vijay K. Mittal, M.D., FACC
Kun Xiang, M.D., Ph.D.

West Campus:
7826 SW 60th Avenue
Ocala, Florida 34476
Telephone: (352) 873-7600

Lillian A. Mitchell, M.D.

The Villages Campus:
8550 NE 138th Lane
Lady Lake, Florida 32159
The Villages, FL 32159

Surexa S. Cacodcar, M.D., FACC
William F. Dresen, M.D., FACC
Lan Luo, M.D., FACC

Dunnellon Campus:
20661 Ned Love Ave.
Dunnellon, Florida 34431
Telephone: (352) 873-9557

Lan Luo, M.D., FACC

Citrus Springs:
10489 N. Florida Ave. Unit G
Citrus Springs, Florida 34434

Lan Luo, M.D., FACC

330 South Line Ave.
Inverness, Florida 34452
Telephone: (352) 873-4733

Tong Liu, M.D., Ph.D.

NAME OF PATIENT: _____

DATE OF BIRTH: _____ SS#: _____

I HEREBY AUTHORIZE:

_____

_____

_____

TO RELEASE INFORMATION IN MY MEDICAL RECORDS, INCLUDING (UNLESS NOTED):

- Information about communicable diseases and infections, as defined by statute and Florida Department of Public Health rules (which include venereal disease "VD", tuberculosis "TB", hepatitis B, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS", and AIDS related complex "ARC").
- Alcohol and drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2.
- Mental Health treatment records, psychological services and social services information communications made by me to a social worker or psychologist.

I AUTORIZE SUCH DISCLOSURE TO THE INDIVIDUALS OR ORGANIZATIONS LISTED BELOW IN ACCORDANCE WITH THE CONDITIONS LISTED ABOVE.

Person(s) or Organization(s) to whom disclosure is to be made:

LAN LUO, MD
3310 SW 34TH ST
OCALA, FL 34474
FAX 352-873-1842

This authorization is subject to written revocation at any time except to the extent that action has already been taken in reliance, on the authorization. If not previously revoked, this authorization will terminate six (6) months from the date of this signature.

PATIENT: _____ DATE: _____

WITNESS: _____ DATE: _____

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Tong Liu, M.D., Ph.D.

IMPORTANT REMINDER TO ALL PATIENTS

Is is Dr. Luo's office policy that all new patients and existing patients provide us with a list of current medications.

We also request the name and phone number of the pharmacy where you will receive your prescription refills.

Thank you for your cooperation in assuring us to better care for your health care needs.

NAME OF PHARMACY_____

PHONE NUMBER_____

Thank You,

Dr. Lan Luo and Staff

Central Florida Heart Center

Notice of Privacy Practice and Authorization Form

Today's Date: _____

I, (please print) _____, acknowledge that I have received a copy of Central Florida Heart Center's Notice of Privacy Practices.

In the event that a copy of my personal health information is needed for reasons other than the immediate treatment, I hereby authorize the following family members or friends, acting on my behalf, the release of personal health information to them.

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship _____

I understand that I may amend this authorization at any time.

I also understand that any other requests for personal health information by anyone other than those listed above will require additional authorization by myself in writing.

Patient's Signature: _____

Witness: _____

DR. LAN LUO, MD

INVASIVE AND NON-INVASIVE CARDIOLOGY

PHONE (352) 873-9557 FAX (352) 873-1842

MEDICATION LOG

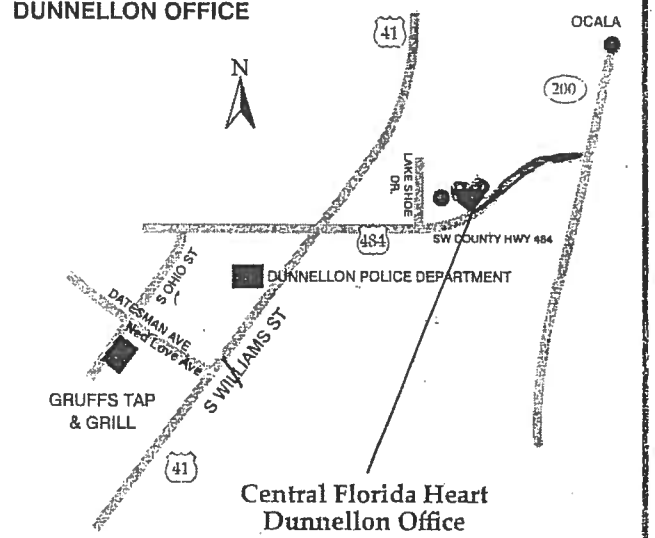
PATIENT _____ DOB _____

START DATE	MEDICATION	DOSAGE	FREQUENCY

CENTRAL FLORIDA HEART CENTER

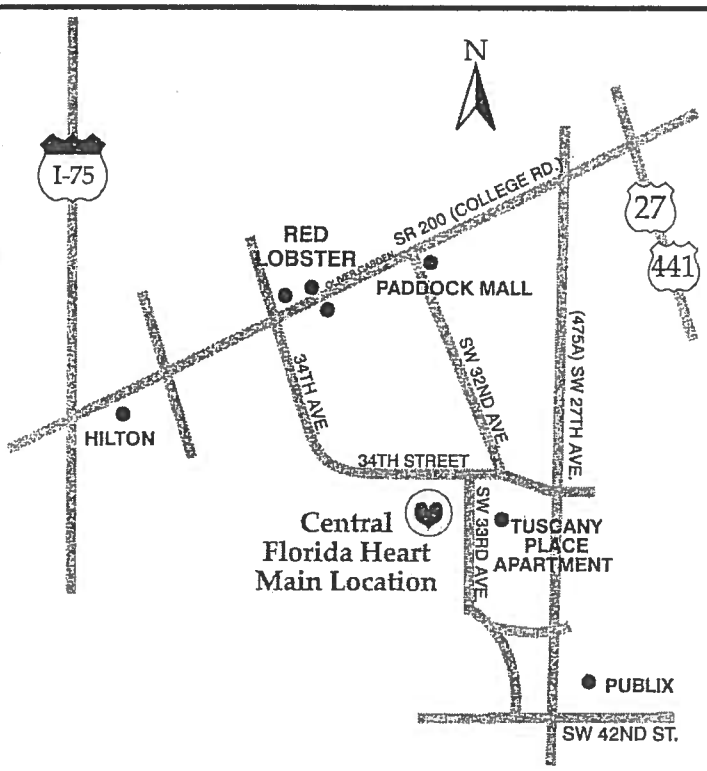
DR. LAN LUO

DUNNELLON OFFICE
20049 East Pennsylvania Ave, Unit 1, Dunnellon, FL 34432
Tel#: 352-873-9557 Fax#: 352-873-1842

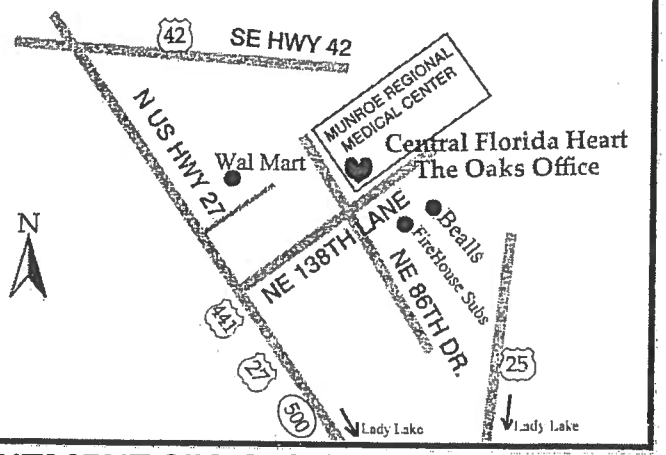


CENTRAL FLORIDA HEART CENTER

MAIN OFFICE
3310 SW 34th Street, Ocala, FL 34474
Tel#: 352-873-9557 Fax#: 352-873-1842



THE OAKS OFFICE
8550 NE 138th Lane, Building 400, Lady Lake, FL 32159
Tel#: 352-873-9557 Fax#: 352-873-1842



CALL TODAY TO SCHEDULE AN APPOINTMENT 352-873-9557