TEL: (941) 474-6000
F

John Smith, M.D.

INTERNAL MEDICINE

701 OLD ENGLISH ROAD, P.O. BOX 1309
ENGLEWOOD, FLORIDA 34283

EIN# 59-2034025
UPIN#D498756

OFFICE VISITS	NEW	EST.	FEE
☐ OV LIMITED	99201	99211	
☐ OV EXPANDED	99202	99212	
☐ OV DETAILED	99203	99213	
☐ OV COMPREHENSIVE	99204	99214	
☐ OV COMPRE.HISTORY	99205	99215	
☐			

CPT	OFFICE PROCEDURES
☐ 93000	EKG W/INT
☐ 46600	ANOSCOPY
☐	

CPT	OFFICE PROCEDURES	FEE
	PULMONARY SERVICES:	
☐ 94760	OXIMETRY W/INT	
CPT	**LABORATORY**	**FEE**
☐ 82270QW	BLOOD; OCCULT,FECES	
☐ 86580QW	PPD	
☐		
CPT	**INJECTIONS**	**FEE**
☐ 90659	INFLUENZA VACC.	
☐ G0008	ADMIN. INJECTION, INFL	

CPT	INJECTIONS	FEE
☐ 90732	PNEUMOCOCCAL VACCINE	
☐ G0009	ADMIN. INJECTION, PNEMO	
☐ J3420	B12 INJ/ <=1000MG	
☐ J0780	COMPAZIN PER 10 MGx____	
☐ J1940	LASIX	
☐ 90703	TETANUS TOXOID	
☐ 90746	ADMIN. INJECTION	
☐		
☐		
☐		

DIAGNOSIS

☐ 789.0	ABDOMINAL PAIN	☐ 428.0	CHF AX: (941) 474-4000	[illegible]	HORMONE REPLACEMENT	☐382.9	OTITIS MEDIA
☐ 789.06	ABD. PAIN EPIGASTRIC	☐ 496	COPD	☐ 272.4	HYPERLIPIDEMIA	☐ 462	PHARYNGITIS ACUTE
☐ 787.7	ABNORMAL FECES	☐ 414.00	CORONARY HEART D	☐ 401.9	HYPERTENSION	☐ V70.0	PHYSICAL
☐ 785.3	ABN. HEART SOUNDS	☐ 786.2	COUGH	☐ 242.90	HYPERTHYROIDISM	☐ 486	PNEUMONIA
☐ 477.9	ALLERGIC RHINITIS	☐ 311	DEPRESSIVE DIS	☐ 244.9	HYPOTHYROIDISM	☐ V03.82	PNEUMO VACC
☐ 281.00	ANEMIA PERNICIOUS	☐ 250.00	DIABETES	☐ 487.1	INFLUENZA	☐ V72.81	PRE-OP CARDIOVAS
☐ 300.00	ANXIETY NOS	☐ 787.91	DIARRHEA	☐ V04.8	INFLUENZA VACC	☐ V72.82	PRE-OP RESPIRATORY
☐ 493.90	ASTHMA	☐ 780.4	DIZZINESS	☐782.4	JAUNDICE	☐ 443.9	PVD
☐ 290.10	ATROPHY CEREBRAL	☐ 492.0	EMPHYSEMA	☐ 783.21	LOSS OF WEIGHT	☐ V76.2	SCREENING CERVIX
☐ 281.1	B-12 DEFICIENCY	☐ 780.79	FATIGUE & MALAISE	☐ 724.2	LUMBAGO	☐ 461.9	SINUSITIS NOS
☐ 724.5	BACK PAIN	☐ 780.6	FEVER	☐787.02	NAUSEA ALONE	☐ 785	TACHYCARDIA
☐ 466.0	BRONCHITIS	☐ 535.10	GASTRITIS ATROPHIC	☐ 787.01	NAUSEA & VOMITING	☐ 465.9	URI ACUTE
☐ 429.2	CARDIOVASCULAR DIS	☐ 787.1	HEARTBURN	☐ 310.9	OBS	☐ 599.0	URINARY TRACT INF
☐ 723.1	CERVICALGIA	☐ 599.7	HEMATURIA	☐ 310.1	ORGANIC PERSONALI	☐788.41	URINARY FREQUENCY
☐ 786.50	CHEST PAIN NOS	☐ V05.3	HEPATITIS B VACC	☐		☐	

I hereby authorize the examination and treatment to the Patient named above <u>and authorize my insurance benefits to be paid directly to the above signed physician</u>, realizing I am responsible to pay any unpaid balance or uncovered services and I hereby authorize the release of pertinent, medical information to the insurance carriers.

X______________________________________ X______________________________________

PATIENT/GUARDIAN SIGNATURE **PHYSICIAN SIGNATURE**

NEXT APPOINTMENT: ___________ AT _______ AM PM RETURN:____DAYS___WEEKS___MONTHS___

NOTES: