



AESTHETIC SCIENCE. LASER MEDICINE.

PATIENT REGISTRATION

NAME: _____ DATE: _____

Welcome to Quinn, MD! We are privileged to have the opportunity to include you as one of our patients and will make every endeavor to ensure that your visits with us are enjoyable.

Please take a few moments to answer the following questions so we can be of better service to you now and in the future. Keep in mind, your comments about our services and staff are welcome at anytime during or after your visit.

How did you hear about Quinn, MD?

___ Brochure ___ Folio ___ Times Union ___ TV
___ Internet ___ Yellow Pages Other _____

What information did you receive about the treatment you are seeking before this visit?

How can we improve our communication with you? _____

Address: _____ Home Phone: _____
City, St. Zip _____ Work Phone: _____
Social Security Number: _____ Cell Phone: _____
Date of Birth: _____

Email Address _____
Employer: _____ Occupation: _____

Marital Status: S M D W
Spouse: _____ Work Phone: _____

Nearest Relative: _____ Home Phone: _____
Who should we contact in case of an emergency? _____
Relationship: _____ Phone Number _____

INSURANCE/FINANCIAL INFORMATION

Primary Insurance Company: _____
Policy Holder: _____
Date of Birth: _____ Relationship to Patient: _____
Is this Policy a: HMO PPO PPC POS
Social Security Number: _____ Employer: _____
Secondary Insurance Company: _____
Policy Holder: _____
Date of Birth: _____ Relationship to Patient: _____
Is this Policy a: HMO PPO PPC POS
Social Security Number: _____ Employer: _____
Credit Card you wish to use at this office: VISA MASTERCARD AMERICAN EXPRESS DISCOVER
Card Number: _____ Expiration Date: _____

Person Responsible for this account:
Name: _____ Phone Number: _____
Address: _____ Employer: _____
Who REFERRED you to our office?
Name: _____ Address: _____



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Lifestyle and Medical History Questionnaire Comprehensive Evaluation: Women

Please take the time to complete this comprehensive questionnaire. At Quinn, MD, we view the body as a sum of parts. When one part is adversely affected, other parts will be affected, and perhaps the whole body.

Your responses will aid us in evaluating your current health status and guide us through the various treatment options.

Name: _____ Date: _____
Height: _____ Weight: _____ Age: _____ DOB: _____
Number of Children: _____ Occupation: _____ Employer: _____
Allergies (medication, seasonal, food, cosmetic formulations) _____

List your providers, including family practitioner, OB/GYN, specialists, therapists, acupuncturists:

List any prescription medications, vitamins, minerals, herbal supplements, etc:

<u>Prescription and Non-Prescriptions</u>	<u>Dose</u>	<u>Frequency of Use</u>	<u>Prescriber</u>

<u>Supplements (vitamins, minerals, herbs)</u>	<u>Dose</u>	<u>Frequency of Use</u>

BASIC HORMONE INTAKE

Please note which of the following symptoms are troublesome and/or persist over time

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Cystic ovaries | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Heavy menses | <input type="checkbox"/> Foggy thinking | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Depressed mood |
| <input type="checkbox"/> Fibrocystic breast | <input type="checkbox"/> Irritability | <input type="checkbox"/> Increased body hair | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Thinning skin | <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> Loss of sex drive | <input type="checkbox"/> Bone loss |
- NUMBER SELECTED _____

ADRENAL HORMONE INTAKE

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Aches and pain | <input type="checkbox"/> Morning fatigue | <input type="checkbox"/> Elevated triglycerides | <input type="checkbox"/> Bone loss |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Blood Sugar imbalance | <input type="checkbox"/> Chronic illness |
| <input type="checkbox"/> Evening Fatigue | <input type="checkbox"/> Susceptibility to infections | <input type="checkbox"/> Autoimmune illness | |



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NUMBER SELECTED _____

THYROID HORMONE INTAKE

- ___ Aches and pains ___ Anxiety ___ Brittle nails ___ Depression
- ___ Dry skin ___ Headaches ___ Cold hands and feet ___ Infertility
- ___ Fatigue ___ Foggy thinking ___ Feeling cold all the time ___ Weight gain
- ___ Palpitations ___ Low libido ___ Inability to lose weight ___ Sleep disturbances
- ___ Constipations ___ Thinning hair ___ Menstrual irregularities ___ Elevated cholesterol

NUMBER SELECTED _____

Are you pregnant?___ Breast feeding?___ Menopausal?___ Polycystic Ovary Syndrome?___

Briefly describe your current menstrual cycles:

LMP:_____ Length of cycle in days:_____ Issues (infertility, miscarriage etc):_____

Briefly describe any gynecologic surgeries, including hysterectomy, ligations, IVF, etc:_____

Briefly describe your history of taking hormones, including birth control pills, hormone replacement, infertility agents, etc:_____

Last Pap smear?___ Last Mammography?___ Results?_____

LIFESTYLE FACTORS

Do you have trouble swallowing pills?___ Trouble swallowing multiple pills (3-5/meal)?_____

Are you trying to lose weight?___ Do you exercise?___ Type and frequency:_____

Do you smoke?___ If yes, what type of tobacco and how many per day:_____

Do you drink alcoholic beverages? What type, and how much per day?_____

Do you have trouble with chronic infection? Be specific: _____

Is your blood pressure high?___ Low?___ Level:_____

Is your cholesterol high?___ Low?___ Levels:_____

Do you have achy joints or muscles?___ Swollen or puffy joints?_____

Please list major injuries or surgeries, with their dates:_____

Do you bruise easily?___ Acne?___ Dry skin?___ Hair loss/thinning hair?___

Do you experience any twitching?___ Back pain?_____



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GENERAL MEDICAL

Do you have, or have you had, any of the following diseases or problems? Please specify:

- Rheumatic fever or rheumatic heart disease..... Y N
- Congenital heart lesions..... Y N
- Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Y N
- Cancer, example Uterine, Ovarian, Breast, etc Y N
- Asthma or hay fever..... Y N
- Hives, skin rash, or fever blister..... Y N
- History of lightheadedness or fainting..... Y N
- History of seizures, neurological or psychiatric problems..... Y N
- History of excessive bleeding or scarring..... Y N
- Diabetes, including Insulin Resistance Y N
- Hepatitis or other liver disease..... Y N
- HIV or other blood disorders..... Y N
- Arthritis..... Y N
- Inflammatory rheumatism (painful swollen joints)..... Y N
- Stomach ulcers..... Y N
- Kidney trouble..... Y N
- Tuberculosis..... Y N
- Do you have a persistent cough or cough up blood at any time?..... Y N
- Venereal disease..... Y N
- Personal or family history of blood clots in legs or lungs, or leg swelling?..... Y N
- Other _____

VENOUS AND CIRCULATORY INTAKE

In your legs, do you have any of the following (please check): If no symptoms, please go to the next section.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Aching or throbbing | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Tenderness | <input type="checkbox"/> Burning pain in leg |
| <input type="checkbox"/> Night cramps | <input type="checkbox"/> Tired or heavy legs | <input type="checkbox"/> Ankle/leg swelling | <input type="checkbox"/> Night cramps |
| <input type="checkbox"/> Red/warm areas | <input type="checkbox"/> Varicose veins (bulging) | <input type="checkbox"/> Hard lumps | <input type="checkbox"/> Skin changes |
| <input type="checkbox"/> Ulcers or ulceration | <input type="checkbox"/> Itching | <input type="checkbox"/> Spider veins | <input type="checkbox"/> Other: _____ |

Do you have venous concerns in other areas of your body (hands, feet, breasts, hemorrhoids)? _____

Are your symptoms:

- | | | |
|--|-----|----|
| Related to pregnancy | YES | NO |
| Related to accident/trauma | YES | NO |
| Are you developing new veins? | YES | NO |
| Are your present veins getting bigger? | YES | NO |
| Other _____ | | |

Are your symptoms worse with:

- | | | |
|--------------------|-----|----|
| Prolonged standing | YES | NO |
| Prolonged sitting | YES | NO |
| Menstrual cycle | YES | NO |



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Does your discomfort/leg pain interfere with your activities of daily living? YES NO

Are your symptoms relieved with Rest/Elevation of leg(s) YES NO

FAMILY HISTORY OF VARICOSE VEINS or SPIDER VEINS (please check)

__mother __father __sister __brother __grandmother __grandfather __uncle __aunt __None

PREVIOUS CONSERVATIVE TREATMENT YOU HAVE TRIED:

Have you ever worn compression stockings for your veins? When? YES NO
Did they help your symptoms (leg pain/swelling)? Totally? Partially? YES NO
Do you take pain medications (Advil, Tylenol, aspirin) for your leg pain/veins? YES NO

PREVIOUS TREATMENT HISTORY:

Ligation/Stripping Surgery If so, which leg? when? YES NO
Injection treatments If so, which leg? when? YES NO
Laser Therapy If so, when? YES NO
Other

SKIN CARE HISTORY AND ANALYSIS
COSMETIC SURGERY HISTORY

Have you ever seen a provider for your skin? For what procedures?

Have you had any surgical or non-surgical cosmetic enhancements? List:

Have you had and laser procedures, including hair removal, fotofacial etc? List:

History of Skin Cancer (date, type, location and surgeries):

What is your current skin care regimen? Include brand names and dosages if applicable.

Morning:
Evening:
Other:

Have you used any of the following medications in the last 6 months?

Accutane Retin-A Benzyl Peroxide Topical Antibiotics Diuretics Birth Control Oral Antibiotics

Have you ever had any cosmetic peels? TCA Glycolic Jessner's Microdermabrasion Other

Did you develop hyper-pigmentation due to hormone changes? YES NO

Do you get cold sores or fever blisters on the lips or face? YES NO

How many ounces of water do you drink per day? Other beverages?

How much caffeine do you drink per day? Source of caffeine?



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On a scale of 1-5, how do you rate your skin? 1 is good, 3 is okay, 5 is bad.

- ___ Dry ___ Normal ___ Oily ___ Acne ___ Scarring ___ Blackheads
___ Pimples ___ Sensitive ___ Rosacea ___ Broken Capillaries ___ Whiteheads
___ Fine lines ___ Wrinkles ___ Sagging ___ Crow's feet ___ Brown spots
___ Tightness ___ Flaky ___ Shiny ___ Dehydrated ___ White spots

Describe your lifetime sun exposure in detail. Include use of sunscreen, baby oil, tanning beds, areas lived, history of bad sunburns, etc: _____

Sun History - How does your skin respond to the sun during the first 15 minutes of exposure?

- ___ I Always burns, never tans (Caucasian)
___ II Usually burns, tans with difficulty (Caucasian)
___ III Sometimes burns, tans average (Caucasian, Hispanic, Asian)
___ IV Rarely burns, tans easily (Hispanic, Asian, African American)
___ V Very rarely burns, tans easily (Hispanic, Asian, African American)
___ VI Almost never burns, tans easily (African American)

What do you specifically want to improve or change about your skin? _____

What areas do you want to treat? ___ Face ___ Neck ___ Chest ___ Back ___ Hands

NUTRITION AND DIETARY INTAKE

- Are you a vegetarian? [] YES [] NO
Do you abstain from all meat and poultry? [] YES [] NO
Do you eat chicken, but abstain from red meat? [] YES [] NO
Do you eat dairy? [] YES [] NO
Do you eat soy products? [] YES [] NO
Do you crave sugar? [] YES [] NO
Do you cook your own food? [] YES [] NO
Do you eat organic? [] YES [] NO
Do you eat frozen or canned foods? [] YES [] NO
Do you use a microwave to cook your food? [] YES [] NO



How many times a week do you eat out (including restaurants, prepackaged foods (microwave dinners, “rice-a-roni”), fast foods, star bucks, publix deli, etc)? _____
Where do you get your water intake (bottled, tap etc.): _____

Please describe what you eat and drink on an average day. If you can, provide quantities, calories, information about artificial sweeteners, creamers, condiments, etc.

Breakfast: _____

Snack (if applicable): _____

Lunch: _____

Snack (if applicable): _____

Dinner: _____

Dessert or Snack: _____

Please identify any information about yourself you would like us to know that was not asked previously: _____

Patient Signature: _____
Clinician Signature: _____



Patient Policies: Appointment, Records, Disputes and Informed Consent to Treatment

APPOINTMENTS

All appointment cancellations require at least 24 hours notice unless an emergency (documented) arises. Failure to give a 24-hour cancellation notice, or simply not showing will result in a \$25 office visit assessment. Call 904-296-0900 to cancel. Email notification is not an accepted form of cancellation.

QUINN, MD SIGNATURE SERVICES

Signature Services are the Fraxel Laser, Varicose Vein treatments, Vein Removal procedures, and Laser Hair Removal treatment greater than an hour. All Signature Service cancellations require at least 24 hours notice unless an emergency (documented) arises. Failure to give a 24-hour cancellation notice will result in a \$100 Signature Service assessment. Call 904-296-0900 to cancel. Email notification is not an accepted form of cancellation.

MEDICAL RECORDS POLICIES

For a copy of your medical records, please allow us 10-business days notice. There will be a charge of \$1.00 per page for the first 25 pages and \$0.25 for every page after. You will need a signed medical records release form to proceed.

Payment is due the day of the service unless previous arrangements have been made. Our office often distributes coupons to patients. Only one coupon can be redeemed per visit and it cannot be combined with another pre-arranged discount. Our office is proud to offer financing through CareCredit. This is a no interest payment plan for 12 months. Please see representative for information.

DISPUTES AND INFORMED CONSENT TO TREATMENT

In the event of any dispute between me and Quinn, MD and/or any other person associated with Quinn, MD, I agree to submit a written claim of such dispute to Quinn, MD within one (1) year of this date. I acknowledge and agree that failure to timely make such a claim shall constitute a waiver of any and all rights and remedies related thereto.

Any claim made in accordance with the paragraph above, including, without limitation, claims for Professional Liability, Personal Injury, Contract, Warranty or other breach of duty, or the coverage of this arbitration provision, shall be settled by arbitration pursuant to the Florida Arbitration Code. By agreeing to arbitrate, I am waiving my right to a jury trial. Any such arbitration shall be conducted in Jacksonville, Florida. The arbitration of such issues, including determination of the amount of any damages suffered, shall be to the exclusion of any resolution of such issues in a court of law. The decision of the arbitrators shall be final and binding upon me, my heirs, executors, administrators, successors and/or assigns.

In the event any action is initiated for any breach, fault, or default of any of the terms, conditions, or provisions of this Agreement, then the party in whose favor judgment shall be entered shall be entitled to have and recover from the other party all costs and expenses, including attorneys' fees.

(continues on next page)



All terms and conditions embodied in the Informed Consent to Treatment are to be interpreted and construed according to the laws of the State of Florida; any litigation would be filed in a Florida State Court.

If any part of this Informed Consent to Treatment is deemed to be unenforceable for any reason whatsoever, the remaining portions shall remain in full force and effect. Nothing herein shall be construed to constitute a waiver of, or any other limitation upon, any of the legal and/or equitable rights of Quinn, MD, all of which are hereby expressly reserved.

I understand that consent to arbitration is not a prerequisite to treatment at this clinic, and is voluntarily given by me. I understand there are other clinics where my needs can be addressed, but have chosen Quinn, MD even with all these conditions I have agreed to, and promises I have made.

Patient Signature

Date



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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *April 14, 2003* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Dr. Linda Quinn. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement. Furthermore, we will provide you with a treatment estimate describing or recommending treatment alternatives.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances. We reserve the right to discuss your payment options with the individual financially responsible for your treatment.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. In addition, this may require speaking with your primary care physician, obtaining information from hospitals and/or labs directly relating to your treatment. Your information may also be disclosed to laboratories for the purpose of ordering blood tests.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$1.00 for each page and the staff time including the time



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required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing or request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Dispensed Medications: You have a right to medication counseling by a provider in this office regarding any prescribed or dispensed medications.

HOW TO CONTACT US

Practice Name: Dr. Quinn MD Privacy Officer: Dr. Linda Quinn Telephone: (904) 296-0900

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Privacy Practices.

Print Name: _____ **Signature:** _____ **Date:** _____

Office Use Only

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign. Due to an emergency situation it was not possible to obtain an acknowledgement.
- We were not able to communicate with the patient. Other (please provide specific details) _____

Employee Signature: _____ **Date:** _____

8075 Gate Pkwy West, Suite 101 Jacksonville, FL 32216

Phone 904-296-0900 Fax 904-296-7597

Quinn, MD 904-296-0900
8075 Gate Pkwy West Suite 101 Jacksonville, FL 32216
(904) 296-0900



Directions to the Office

If you are traveling North on I-95:

Exit Butler Boulevard as you come off the exit ramp, stay in the right lane and proceed straight toward the light, which is Belfort Road. You will see signs for Belfort Road. Go straight toward Belfort but stay in the middle lane (the right lane of the lanes going left) and bear left at the light on to Belfort which will take you under the Butler overpass. Once on Belfort, go straight you will see St. Luke's Hospital on your right. You will pass St. Luke's Hospital and continue straight to the next light, Gate Parkway West, turn right. Once on Gate Parkway West, go straight about half quarter mile. The medical complex (Gate Parkway West Professional Center) is on the left. Our office building is to the left next to Gulani Vision Institute.

If you are traveling South on I-95:

Take the Butler Exit turn left off the ramp on to Butler and immediately get into the right lane and take the first exit, which is the Belfort Road. You will see signs for Belfort Road. Go straight toward Belfort but stay in the middle lane (the right lane of the lanes going left) and bear left at the light on to Belfort which will take you under the Butler overpass. Once on Belfort, go straight you will see St. Luke's Hospital on your right. You will pass St. Luke's Hospital and continue straight to the next light, Gate Parkway West, turn right. Once on Gate Parkway West, go straight about half quarter mile. The medical complex (Gate Parkway West Professional Center) is on the left. Our office building is to the left next to Gulani Vision Institute.

If you are traveling West on JTB (from the beach):

Take Southside North, get in the left lane and turn left at Gate Parkway West, go about a mile and a half, you will see the medical complex (Gate Parkway West Professional Center) on the right. Our office building is to the left next to Gulani Vision Institute.

Quinn, MD 904-296-0900
8075 Gate Parkway West Bldg 1 Suite 101 Jacksonville, FL 32222