Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ______________ (First) __________ (MI) _____ Previous Name ______________

Address Line 1 ______________________________

City, State ______________ ZIP __________

Home Phone __________ Cell No. __________ Work Phone __________ Ext. ______

Primary Care Provider (PCP) ______________ Referring Provider ______________

Rendering Provider Name (this practice) ______________ E-Mail Address: ______________

Date of Birth MM ______/DD ______/YYYY ______ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ☐ ________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name ______________

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name ______________ First Name ______________

Phone Number ______________ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient ______________ ☐ Guardian

Address Line 1 ______________________________

City, State ______________ ZIP __________

Home Phone __________ Work Phone __________ Ext. ______

Referring Provider Name ______________________________

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) ______________ (First) ______________ (MI) ______

Guarantor Account Number ______________ Date of Birth MM ______/DD ______/YYYY ______

Social Security Number _____-_____-_____ Telephone ______________

E -Mail Address ______________ Sex ☐ F – Female ☐ M - Male

Address Line 1 ______________________________

City, State ______________ ZIP __________

Employer ______________ Employer Phone Number ______________

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number ______________ (_____)__________

Name of Insured ______________ Patient Relationship to Insured ______________

Subscriber ID (Policy Number) __________ Group ID __________ Copay Amount __________

Effective Date __________ Termination Date __________ Date of Birth MM ______/DD ______/YYYY ______

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number ______________ (_____)__________

Name of Insured ______________ Patient Relationship to Insured ______________

Subscriber ID (Policy Number) __________ Group ID __________ Copay Amount __________

Effective Date __________ Termination Date __________ Date of Birth MM ______/DD ______/YYYY ______

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature ______________________ ***Date*** __________

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Medical History Form

Date:______________________

Name:	Age:	Birthdate:
Address:		
Home Phone:	Work Phone:	
Emergency Contact Person:	Emergency Contact Number:	
Occupation:		

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Name of Spouse/Domestic Partner:

Children's Name and Ages:

Allergies to Medications, X-ray Dyes, or other Substance? ☐ **No** ☐ **Yes**
(Please List & Explain):

Past Medical History and Review of Symptoms

Please List and Date all Operations/Surgery: ______________________

Hospitalizations other than Surgery: ______________________

Please circle the number if you have had a problems with or are currently complaining about any of the following:

1. High Blood Pressure
2. Diabetes
3. High Cholesterol
4. Cancer
5. Heart Disease
6. Chest Pain/Tightness
7. Palpitation
8. Shortness of Breath
9.Lightheadedness
10. Ankle swelling
11. Asthma/Wheezing
12. Persistent Cough
13. Bronchitis/Pneumonia/TB
14. Abdominal Pain
15. Indigestion/Heartburn
16. Nausea/Vomiting
17. Constipation
18. Diarrhea
19. Change in bowel habits
20. Blood in Stool
21. Hemorrhoids
22. Colitis
23. Gallbladder disease
24. Hepatitis or Jaundice
25. Frequent Urination
26. Leakage of Urine
27.Kidney Disease
28. Kidney Stone
29. STD's (VD)
30. Unusual Fatigue
31. Fever/Chills/Sweats
32. Abnormal Weight Loss
33. Anemia
34. Blood Disorder(s)
35. Transfusion (w/ date)
36. Headache
37. Hay Fever/Sinuses
38. Thyroid Disease
39. Head/Neck Radiation
40. Swallowing Problems
41. Skin Disease/Itching
42. TIA/Stroke
43. Visual Disturbance
44. Gait/Balance Problem
45. Severe Memory Problem
46. Arthritis/Gout
47. Back Problems
48. Alcohol or Drug Abuse
49. Anxiety/ Depression
50. Inability to Sleep

Described all circled numbers: ______________________

51. Do you require assistance in bathing/dressing? ☐ Yes ☐ No
52. Do you require assistance to walk about? ☐ Yes ☐ No
53. Do you use devices such as walker,cane,wheelchair,hospital bed or oxygen? ☐ Yes ☐ No
54. Do you exercise regularly? ☐ Yes ☐ No
55.Do you always wear setbelt? ☐ Yes ☐ No
56. Have you worked with asbestos or other hazardous material? ☐ Yes ☐ No
57. Do you use tobacco? ☐ Yes ☐ No
58. Do you drink alcohol? ☐ Yes ☐ No (Drinks per day ______) ☐ Quit
59. Do you use recreational drugs? ☐ Yes ☐ No ☐ Quit
60. How much caffeine(coffee,tea, colas)? __________________
61. When was your last physical exam? ______________________
62. Last cholesterol check? ______________________ where? ______________________ when? ________________

63. Last Stool check for blood? ________ ☐ Negative ☐ Positive

64. Last Colonoscopy? ________ 65. Eye Exam? ________

66. Do you believe you have been at risk for acquiring AIDS? ☐ Yes ☐ No

67. Do you want to be tested for AIDS? ☐ Yes ☐ No

68. Are you sexually active? ☐ Yes ☐ No

69. Do you practice birth control? ☐ Yes ☐ No

70. Number of partners in last year? ________ 2 years? ________ 5 years? ________

71. Have you ever been hurt by your intimate partner? ☐ Yes ☐ No

72. How do you resolve conflict with your intimate partner? ________

Female Questionnaire:

Gynecologic and Obstetric History

Age at onset of periods ________ Frequency ________ Length of period ________

Pregnancies ________ Birth ________ Miscarriages ________ Abortion ________

Last Period ________ (Normal) ________ Prolonged or Abnormal Bleeding ________

Prolonged or Abnormal Bleeding ________ ☐ Yes(Describe) ________ ☐ No

History of abnormal pap? ☐ Yes ☐ No

Pelvic pain/pain with intercourse? ☐ Yes ☐ No

Abnormal discharge? ☐ Yes ☐ No

When was your last PAP Smear? ________ Breast Exam? ________ Mammogram? ________

Do you examine your breast for lumps monthly? ☐ Yes ☐ No

Male Questionnaire:

Do you have erection difficulties? ☐ Yes ☐ No

Do you check your testicles for lumps monthly? ☐ Yes ☐ No

When was your last scrotal/ testicular exam? ________ Rectal/prostate exam? ________

Immunization History

Tetanus	☐ Yes	Date:	☐ No	Pneumovax	☐ Yes	Date:____	☐ No
Hepatitis B	☐ Yes	Date:	☐ No	Flu	☐ Yes	Date:____	☐ No
Hepatitis A	☐ Yes	Date:	☐ No	Other	☐ Yes	Date:____	☐ No

Family History

Father ☐ Living ☐ Died (at age) Mother ☐ Living ☐ Died (at age)

Siblings Number ________ Number Living ________

Have you or any family member(including parents, grandparents and siblings) ever had the following:

☐ TB/TB exposure	☐ Stroke/TIA	☐ Thyroid Disease
☐ Diabetes	☐ Mental Disease/Suicide	☐ Epilepsy
☐ High Cholesterol	☐ Drug/Alcohol Addiction	☐ Kidney stones
☐ Hypertension	☐ Glaucoma/Blindness	☐ Gallbladder
☐ Heart Disease	☐ Bleeding Diseases	☐ Ulcers
☐ Cancer(type)	☐ Gout	☐ Other

Medications(Prescriptions, OTC, Vitamins, Herbs, etc.)

Drug/Dosage ________ Drug/Dosage ________ Drug/Dosage ________

Drug/Dosage ________ Drug/Dosage ________ Drug/Dosage ________

Drug/Dosage ________ Drug/Dosage ________ Drug/Dosage ________

Drug/Dosage ________ Drug/Dosage ________ Drug/Dosage ________

Drug/Dosage ________ Drug/Dosage ________ Drug/Dosage ________

Drug/Dosage ________ Drug/Dosage ________ Drug/Dosage ________

Please list any other concerns you would like to discuss with your doctor. ________

Do you have an Advance Directive? ☐ Yes ☐ No Living Will? ☐ Yes ☐ No

Health Surrogate? ☐ Yes ☐ No Power of Attorney? ☐ Yes ☐ No

Patient General Consent to Treat

I, the undersigned, hereby consent to the following;

- Administration and performance of general treatments
- Use of prescribed medications
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after the specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Healthcare America Medical Group may include consent at other satellite offices under common ownership.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize Healthcare America Medical Group to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Healthcare America Medical Group

I acknowledge that I have been given Healthcare America Medical Group Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. (Patient Initial) ________________.

I, the undersigned, authorize Healthcare America Medical Group to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________________ ________________

Patient (or responsible party) Signature **Date**

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

DON'T LOSE YOUR RIGHT TO DECIDE!

You cannot remove all uncertainty about your future healthcare needs but by having an advance directive you can have the peace of mind that comes from making your wishes known in advance.

Declaration to Decline Life-Prolonging Procedures (Living Will)

- ☐ I have made a Living Will
- ☐ I do **NOT** have a Living Will

Health Care Surrogate

- ☐ I have designated a Health Care Surrogate
- ☐ I have **NOT** designated a Health Care Surrogate

Durable Power of Attorney

- ☐ I have appointed a Durable Power of Attorney for Health Care decisions
- ☐ I have **NOT** appointed a Durable Power of Attorney for Health care decisions.

Signature of Patient/Representative ______________________ Date ______________

If you have any further questions, you can contact your family attorney, local hospital, or local medical association for additional information.

CHAPTER 745, FLORIDA STATUTES

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **HEALTHCARE AMERICA MEDICAL GROUP**, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **HEALTHCARE AMERICA MEDICAL GROUP** Notice of Privacy Practices for a more complete description of such uses of disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **HEALTHCARE AMERICA MEDICAL GROUP**, reserves the right to revise its Notice of Privacy Practice at anytime. A revised Notice of Privacy Practice may be obtained by forwarding a written request to **HEALTHCARE AMERICA MEDICAL GROUP**, Privacy Officer at 3501 Cortez Road West, Bradenton, FL 34210.

With my consent, **HEALTHCARE AMERICA MEDICAL GROUP**, may call my home or any designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **HEALTHCARE AMERICA MEDICAL GROUP**, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked **Personal** and **Confidential.**

With my consent, **HEALTHCARE AMERICA MEDICAL GROUP** may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **HEALTHCARE AMERICA MEDICAL GROUP**, restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **HEALTHCARE AMERICA MEDICAL GROUP**, to use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, **HEALTHCARE AMERICA MEDICAL GROUP** may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

______________________________ ______________________________
Patient Name Date

____
Print Name of Patient/ Legal Guardian

Patient Consent to Receive Mail and/or Telephone Message

____
Please Print (Last name) (First Name) (Middle Initial)

1.Send appointment information to your home? Yes __________ No ______________

2.Send test result to your home? Yes __________ No ______________

3. Leave information on your home answering machine or voice mail for the following:

Appointment Information Yes __________ No ______________

Billing Information Yes __________ No ______________

Medical Information Yes __________ No ______________

4. Leave information on your work answering machine/voice mail for the following:

Appointment Information Yes __________ No ______________

Billing Information Yes __________ No ______________

Medical Information Yes __________ No ______________

I give permission to share appointment information with the person named below:

Name ____

I give permission to share medical information including biopsy and lab results with the person listed below:

Name: ____

I give permission to share billing information with the person named below:

Name: ____

Signature of Patient: ______________________ Date: ________________