FLORIDA EMERGENT CARE

Patient Registration Form

Reason for today's visit: _____ **Describe Pain Level:** (lowest) 1 2 3 4 5 6 7 8 9 10 (highest)

If this is an injury, is it work related? **YES NO** (circle one) Auto Accident? **YES NO** (circle one)

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Male: _____ Female: _____ Date of Birth: _____ SSN: _____ Marital Status: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

CONTACT INFORMATION

Please enter the information below and indicate your preferred means of contact and message permission.

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Email: _____

Please leave a detailed message including patient information at __ home __ mobile __ work __ none

INSURANCE AND RESPONSIBLE PARTY INFORMATION (if different from above)

We will obtain your insurance information from your insurance card. Please provide us with this additional information.

Insurance Subscriber's Name: _____ Subscriber's Date of Birth: _____

Patient's Relationship to Subscriber: _____ Subscriber's SSN: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone Number: Home: _____ Cell: _____ Work: _____

REFERRAL INFORMATION

How did you hear about us? Advertising: _____ Physical Referral: _____ Word of Mouth: _____ Google: _____

Insurance Company: _____ Hospital: _____ Family/Friend is a patient here: _____ Other: _____

Primary Care Physician: _____

FINANCIAL RESPONSIBILITY

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also authorize Florida Emergent Care to release any information required to process my claims. I understand that certain insurance claims may be filed as a courtesy, however, if for any reason the claim is denied, I am responsible for payment. Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and other pay a percentage of the charge. I understand my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance or third party payer within a period not to exceed 60 days.

_____ _____

Patient/Guardian Signature **Date**

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Patient Name: _____ **Date:** _____

MEDICAL HISTORY (please check) ☐ No medical history

__Environmental Allergies
__Anemia
__Angina
__Anxiety
__Asthma
__Atrial Fibrillation
__Blood Clots
__Cancer: _____
__COPD
__Coronary Artery Disease
__Crohn's Disease
__Enlarged Prostate
__Depression
__Diabetes
__Gallbladder Disease
__GERD/ Acid Reflux
__Heart Attack
__Hepatitis
__High Cholesterol
__Hypertension
__Irritable Bowel Disease
__Kidney Disease
__Liver Disease
__Migraine Headaches
__Osteoporosis
__Stomach Ulcers
__Stroke/CVA/TIA
__Seizures
__Tuberculosis
__Thyroid Disease
Smoker? Y N O
Drinker? Y N O

SURGICAL HISTORY (please check) ☐ No surgical history

__Angioplasty
__Appendectomy
__Arthroscopic knee
__Back Surgery
__CABG (Heart Bypass)
__Carpel tunnel release
__Gallbladder
__Gastric Bypass
__Hernia repair
__Hip replacement
__Knee replacement
__Liver Biopsy
__Pacemaker
__Small bowel resection
__Surgical fracture repair
__Other: _____

MALES ONLY (please check)

__Prostate biopsy
__TURP (prostate resection)
__Vasectomy

FEMALES ONLY

Last menstrual period: _____ / _____ / _____
__No periods yet
__No longer having periods
Pregnant? Y N
Nursing? Y N
__Tubal ligation
__Breast Augmentation
__Breast Biopsy
__Breast Reduction
__Cesarean Section
__D & C
__Hysterectomy
__Mastectomy
__Uterine fibroid removal

FAMILY MEDICAL HISTORY (please check) ☐ No family history

__Heart Attacks
__Cancer: _____
__Stroke/CVA/TIA
__Asthma
__Diabetes
__Hypertension
__High Cholesterol
__Other:_____

MEDICATIONS

☐ I do not take any medications
☐ I have a list I will provide for copying

Name of medication	Dose

ALLERGIES

☐ No known drug allergies

FLORIDA EMERGENT CARE

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third party payers (insurance)
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Florida Emergent Care has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I further understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not legally required to agree to my requested restrictions, but if you are in agreement then you are bound to abide by such restrictions.

CONSENT FOR TREATMENT

I _____**,** hereby consent for treatment at this facility for either myself or my minor child (or another person for whom I have medical power of attorney) listed below.

I understand that all treatments or even lack of treatment carries certain risks and benefits. I understand that the doctor at Florida Emergent Care will help me to understand the benefits and common risks of any recommended treatment. It is my responsibility to request further information if there is anything about the risks and benefits that I do not understand. I agree to read any written material provided by the Doctor and/or the pharmacist regarding any medication that I may have now or have had in the past and will notify the Doctor promptly of any changes in my medical condition.

I understand minor procedures involving injections, scraping, cutting, and sewing may lead to some side effects such as pain bruising, bleeding, scarring or infection in spite of our best efforts to prevent those effects. Although these risks of any minor procedures in the office may be reviewed prior to such procedure, this constitutes my acknowledgement of the inherent risks of any such procedure.

Signature of Patient (Parent, Guardian or Spouse):_____**Date:** _____

Individuals we may discuss your health records and care with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Office Use Only

I attempted to obtain the patient's (healthcare surrogate) signature in acknowledgement of Notice of Privacy Practices, but was unsuccessful in doing such as documented below:

Date: _____ Initials: _____ Reason: _____