ADVOCATE MD

Patient Registration Form

Patient Name: _____ Date of Birth:_____

Local Address: _____

City: _____ State: _____ Zip Code: _____

Out of State Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone Number:_____ Mobile Phone Number: _____

How would like to receive appointment reminders? □ Home Phone Voice □ Cell Phone Voice □ Text

Sex: □ Male □ Female Marital Status: _____

Social Security Number: _____ Occupation: _____

Emergency Contact: _____Phone Number:_____

E-mail:_____

By listing my e-mail address above, I certify that I am allowing AdvocateMD to contact me via e-mail for appointment reminders, health related alerts, health fairs and events and the AdvocateMD e-magazine. I understand that I may receive notification of a health related alert based on my personal health information; but this information is not shared with any outside parties. If at any time you do not want to receive this information or need to change the e-mail address on file, please contact the office. WE TREAT YOUR EMAIL WITH HIPAA STANDARDS – IT IS NOT SHARED AND IS NOT FOR SALE.

Race: _____ Preferred Language (If other than English): _____

Ethnicity: □ Non-Hispanic □ Hispanic □ Other:_____

Pharmacy Name/Address/Phone: _____

How did you hear about our practice? □ Web/Internet □ Newspaper/Magazine □ Health Fair/Event □ Friend □ Physician □ Other:_____

Name of Current or Prior Primary Care Physician:_____

Were you referred by another Physician? If so, Name:_____

Primary Insurance Company Name:_____

Guarantor Name (if different from above): _____

Policy #: _____ Effective Date: _____

Secondary Insurance Company Name:_____

Guarantor Name (if different from above): _____

Policy #: _____ Effective Date: _____

Authorization and Agreement – I hereby authorize my insurance benefits to be paid directly to Florida Medical Specialists, LLC a division of AdvocateMD. I acknowledge that I am responsible to pay non-covered services, benefits paid directly to me, and services which are not paid by my insurance in a timely manner. I hereby authorize the release of my medical records to my insurance carrier, other treating physicians, and my attorney in response to subpoena duces tecum, or to my representative.

Patient Signature: _____ Date: _____

Legal Guardian/POA: _____ Relationship: _____

ADVOCATE MD

Medical History

Today's Date: _____

Patient Name: _____ Date of Birth:_____

Allergies to medications, x-ray dyes, or other substances: □ Yes □ No
If yes, please list and explain: _____

_____

Past medical history and review of symptoms:
Please list and date all operations/surgery: _____

_____

Hospitalizations other than surgery: _____

_____

Reason for Visit: _____
Please check the circle next to any medical conditions you have been diagnosed with in the past:

O Asthma/Wheezing	O Epilepsy	O Mental Disease
O Arthritis/Gout	O Gallbladder Disease	O Skin Disease
O Blood Disorder(s)	O Glaucoma/Blindness	O STD's (VD)
O Bronchitis/Pneumonia	O Heart Disease	O Stroke/TIA
O Cancer	O Hemorrhoids	O TB/TB Exposure
O Colitis	O Hepatitis or Jaundice	O Thyroid Disease
O COPD	O High Cholesterol	O Transfusion – Date:_____
O Diabetes	O Hypertension	O Ulcers
O Drug/Alcohol Addiction	O Kidney Disease	O Other:_____

Do you use tobacco? O YES – Pack per day _____ O NO
Do you drink alcohol? O YES – Drinks per day_____ O NO
Do you drink caffeine (coffee, tea, colas)? O YES – Drinks per day_____ O NO
Are you sexually active? O YES O NO
Do you practice birth control? O YES O NO
Do you believe you have been at risk for acquiring AIDS? O YES O NO
Number of sexual partner in last year?_____ 2 years?_____
Have you ever been hurt by your intimate partner? O YES O NO
How do you resolve conflict with your intimate partner?_____
When was your last physical exam?_____
Last cholesterol check? _____where?_____ when?_____
Do you have an Advance Directive? O YES O NO
Health Surrogate? O YES O NO
Living Will? O YES O NO
Power of Attorney? O YES O NO

Patient Name: _____ Date:_____

Female Questionnaire

Gynecologic & Obstetric History
Age at onset of periods_____ Frequency_____ Length of period_____
#Pregnancies_____ #Birth_____ #Miscarriages_____ #Abortion_____
Last Period_____ (Normal)_____ Prolonged or Abnormal Bleeding_____
History of abnormal pap? O YES – Date:_____ O NO
Pelvic pain/pain with intercourse? O YES O NO
Abnormal discharge? O YES O NO
When was your last PAP Smear?_____
Do you examine your breasts for lumps monthly? O YES O NO

Male Questionnaire

Do you have erection difficulties? O YES O NO
Do you check your testicles for lumps monthly? O YES O NO
When was your last scrotal/testicular exam?_____ Rectal/prostate exam?_____

Immunization History

Tetanus O YES – Date:_____ O NO Hepatitis B O YES – Date:_____ O NO Hepatitis A O YES – Date:_____ O NO	Other: O YES – Date:_____ O NO Please list: _____

Family History

Are you adopted? O YES O NO
Father (age)_____ O Living O Deceased Mother (age)_____ O Living O Deceased
Brothers_____ Sisters_____ Sons_____ Daughters_____
Has any family member (including parents, grandparents and siblings) ever had the following?

O TB/TB Exposure	O Stroke/TIA	O Thyroid Disease
O Diabetes	O Mental Disease/Suicide	O Epilepsy
O High cholesterol	O Drug/Alcohol Addiction0	O Kidney Stones
O Hypertension	O Glaucoma/Blindness	O Gallbladder
O Heart Disease	O Bleeding Diseases	O Ulcers
O Cancer (type) _____	O Gout	O Other:_____

Medications/Prescriptions including Vitamins or Herbal Supplements

Drug	Dose	How Often

Please list any other concerns you would like to discuss with your doctor:_____
_____
_____

Patient Signature: _____ Date: _____

Legal Guardian/POA: _____ Relationship: _____

ADVOCATE MD

Authorization for Use / Disclosure of Protected Health Information (PHI)

Patient Name:_____ DOB:_____

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called PHI, Protected Health Information, under a federal health privacy law, as described below.

I, authorize AdvocateMD, to release and obtain my private health information to/from (check all that applies):

□ My Spouse/partner	Name of spouse/partner: _____
□ My Primary Care Physician/staff	Name of Physician: _____
□ My Pharmacy	Name of Pharmacy: _____
□ My parent/child(ren)	Name(s): _____
□ My Personal Representative	Name of Representative: _____
□ Other	Name: _____
□ None of the above	

May our office leave a message on your machine? □ Yes □ No

Are there any restrictions on PHI to be disclosed? □Yes □ No

If yes, please describe:

_____

_____

The PHI will be disclosed to confirm appointments, to render to caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am a patient with AdvocateMD. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention *Privacy Officer at, PO Box25487, Sarasota, FL 34277.* I understand that my revocation will not affect any actions taken by AdvocateMD prior to receiving my revocation. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use of disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective for 1 year from the date signed, at which time this authorization to obtain and release this protected health information expires.

_____ _____

Patient Signature or Authorized Representative Date

_____

Patient Name Printed

Notice of Privacy Practices

I acknowledge that I was provided with a copy of (or the opportunity to review) the AdvocateMD Notice of Privacy Practices.

_____ _____

Patient Signature Personal Representative Print Name/Signature

AdvocateMD Employee Use ONLY: I have made a good faith effort to obtain a written acknowledgement of receipt of AdvocateMD Notice of Privacy Practices, but was unable to do so because □ Patient unable to sign □ Patient refused to sign □ Other

_____ _____

Employee Name Date

ADVOCATE MD

Assignment of Benefits & Financial Policy

ASSIGNMENT OF BENEFITS

If you have no insurance: I agree to pay my medical expenses, in full, when I am seen by the doctor. If for any reason there is a balance owed on my account, I agree to pay promptly upon receipt of the monthly statement.

If you have Medicare: I request that payment of authorized Medicare benefits be made on my behalf to the rendering physician for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information (including HIV, alcohol, and mental health) needed to determine these benefits or the benefits payable for related services. I agree to pay any portion of my charges that my Medicare carrier determines to be my responsibility.

If you have HMO, PPO, or commercial insurance: I authorize any holder of medical information about me to release to my insurance company or its agents any information (including HIV, alcohol, and mental health) needed to determine benefits payable for related services. I agree to comply with the terms of my insurance coverage, including payment of my co-payment at the time of service rendered and payment of any portion of charges that my insurance carrier determines to be my responsibility, upon receipt of my monthly statement.

If you have Medigap insurance (Medicare Supplement): I request that payment of authorized Medigap benefits be made either to me or on my behalf to the rendering physician for any services furnished me by that provider. I authorize any holder of medical information about me to release to my Medigap carrier any information (including HIV, alcohol, and mental health) needed to determine these benefits or the benefits payable for related services.

STATEMENT OF FINANCIAL RESPONSIBILITY

All insurance forms processed by this office, prior to payment in full, are assigned to this practice. Your cooperation in complying with the terms of this assignment will be appreciated. If your visit is related to an auto accident or work-related injury, this information must be provided prior to seeing the physician and all claim and billing information must be furnished prior to the appointment. Patients who cancel an appointment without a 24 hour notice may be subject to an administrative fee depending upon the length of the scheduled appointments (this fee also applies to diagnostic testing.) I, the UNDERSIGNED, have read the above and realize that all medical charges incurred by me, or my dependents are my financial responsibility. All court fees, attorney fees, or other fees necessary to collect this account, should it become delinquent, are payable by me.

_____ _____

Patient Signature or Authorized Representative Date

_____

Patient Name Printed

Patient General Consent to Treatment

I, hereby consent to the administration and performance of general treatments including pelvic, prostate and rectal exams, retrieval and review of medication history, use of prescribed medication, performance of medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgement 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. A photocopy of this consent shall be considered as valid as the original.

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

Patient Signature: _____ Date: _____

Legal Guardian/POA: _____ Relationship: _____

ADVOCATE MD

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Birth Date: _____

Previous Name: _____ Social Security: ###-##-_____

I request and authorize my healthcare information to be Release to:

AdvocateMD

_____

_____

This request and authorization applied to:

☐ All Healthcare Information – Please include ONLY
2 years of office notes/consult notes, labs and diagnostic imaging

All Available Records for -

EKG or ECG
Colonoscopy
Mammogram
Bone Density/DEXA
Immunization Records
Ultrasound Results – ECHO/Carotid US/Lower Extremity US
Cervical Cancer Screening Results
Dilated Eye Exam

☐ Healthcare information relating to the following treatment, condition or dates:_____

_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simples, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.

☐☐Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐☐Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature:_____ Date:_____

THIS AUTHORIZATION EXPIRES WHEN THE PATIENT IS

NO LONGER UNDER THE CARE OF THE FACILITY REFERENCED ABOVE

ADVOCATE MD

Circle of Care

Patient Name: _____ Date:_____

Please list all the providers that you have seen within the past 2 years. If you have not been to a specialist, please write N/A. If you are continuing to see this physician – please indicate the frequency you typically see the doctor (if known).

Cardiologist (Heart Doctor): _____ # of Office Visits per year:_____

Practice Name:_____ Phone Number: _____

Neurologist (Nerve Doctor): _____# of Office Visits per year:_____

Practice Name:_____ Phone Number: _____

Psychiatrist (Mental Health Doctor): _____ # of Office Visits per year:_____

Practice Name:_____ Phone Number: _____

Gastroenterologist(Digestion Doctor): _____# of Office Visits per year:_____

Practice Name:_____ Phone Number: _____

Pulmonologist (Lung Doctor):_____ # of Office Visits per year:_____

Practice Name:_____ Phone Number: _____

Nephrologist (Kidney Doctor):_____ # of Office Visits per year:_____

Practice Name:_____ Phone Number: _____

Dermatologist (Skin Doctor): _____# of Office Visits per year:_____

Practice Name:_____ Phone Number: _____

Endocrinologist (Endocrine System Doctor): _____# of Office Visits per year:_____

Practice Name:_____ Phone Number: _____

Oncologist (Cancer Doctor): _____# of Office Visits per year:_____

Practice Name:_____ Phone Number: _____

Ophthalmologist (Eye Doctor): _____# of Office Visits per year:_____

Practice Name:_____ Phone Number: _____

Urologist (Urinary Doctor): _____# of Office Visits per year:_____

Practice Name:_____ Phone Number: _____

Podiatrist (Foot Doctor): _____# of Office Visits per year:_____

Practice Name:_____ Phone Number: _____

Rheumatologist (Rheumatoid Doctor): _____# of Office Visits per year:_____

Practice Name:_____ Phone Number: _____

Patient Name: _____ Date:_____

Colon Cancer Screening

- Last Colonoscopy (Every 10 years)
  - I had one on DATE:_____
  - I have never had one
  - I have one scheduled DATE: _____
    Physician's Name:_____ Phone Number:_____
- Last Sigmoidoscopy (Every 5 years)
  - I had one on DATE:_____
  - I have never had one
  - I have one scheduled DATE: _____
    Physician's Name:_____ Phone Number:_____
- Last Fecal Occult Blood Test (Annually)
  - I had one on DATE:_____
  - I have never had one
  - I have one scheduled DATE: _____
    Physician's Name:_____ Phone Number:_____

Breast Cancer Screening

- Last Mammogram (Every 24-27 months)
  - I had one on DATE:_____
  - I have never had one
  - I have one scheduled DATE: _____
    Facility or Physician's Name:_____ Phone Number:_____

Diabetic Patients

- Last Eye Exam (Annually)
  - I had one on DATE:_____
  - I have never had one
  - I have one scheduled DATE: _____
    Physician's Name:_____ Phone Number:_____
- Last Foot Exam (Annually)
  - I had one on DATE:_____
  - I have never had one
  - I have one scheduled DATE: _____
    Physician's Name:_____ Phone Number:_____

Have you ever had a Flu Shot?

- Yes, DATE: _____ Location: _____
- No

Have you ever had a Pneumonia Vaccine?

- Yes, DATE: _____ Location: _____
- No

Have you ever had a Shingles Vaccine?

- Yes, DATE: _____ Location: _____
- No

Patient Signature: _____ Date: _____

Legal Guardian/POA: _____ Relationship: _____