

PATIENT REGISTRATION FORM

PLEASE PRINT

Patient Name _____ Age _____ Date of Birth _____

Address _____ City _____

State _____ Zip Code _____ Social Security Number _____

Sex: _____ Female _____ Male

Home Phone Number _____ Work/Cell Phone Number _____

Marital Status ()Single ()Married ()Divorced ()Separated ()Widowed

Driver License Number _____ Employer _____

Employer Address _____ Occupation _____

Spouse's Name _____ Date of Birth _____ Contact Number _____

Spouse's Social Security Number _____ Occupation _____

Emergency Contact (Name of Person to call) _____ Phone _____

Referring or Primary Care Physician _____

Please list to whom the physicians and staff of Heart Care Centers of Florida may speak with regarding your medical care and treatment. (Discuss medical conditions and health care plan, pick up prescriptions, test results, or medical procedure orders, discuss payment/insurance information, all the above.)

1. _____ Relationship _____ Phone# _____

2. _____ Relationship _____ Phone# _____

3. _____ Relationship _____ Phone# _____

4. _____ Relationship _____ Phone# _____

I further understand this authorization will remain in effect unless terminated with a personal dated signature.

Signature of Patient: _____

Signature of Witness: _____

BILLING INFORMATION

Primary Insurance _____

Address _____ Phone# _____

Policy Number/Insured Person ID Number _____ Group# _____

Subscriber's Name _____ Address _____

Relationship to Patient _____ Phone# _____

Date of Birth _____ Gender(M/F) _____ SS# _____

Secondary Insurance _____

Address _____ Phone# _____

Policy Number/Insured Person ID Number _____ Group# _____

Subscriber's Name _____ Address _____

Relationship to Patient _____ Phone# _____

Date of Birth _____ Gender(M/F) _____ SS# _____

Third Insurance _____

Address _____ Phone# _____

Policy Number/Insured Person ID Number _____ Group# _____

Subscriber's Name _____ Address _____

Relationship to Patient _____ Phone# _____

Date of Birth _____ Gender(M/F) _____ SS# _____

I hereby authorize this physician to perform medical services and to bill my insurance company(s) for services. I authorize the release of these reports requested by my physician, insurance company and/or to their designate(s) when necessary to process the claim or for clinical review. This Physician will send the claim to the listed insurance company(s) as a courtesy. I am responsible to understand the parameters of my insurance (i.e., in-network, out-of-network, deductibles, co-pay, and if a preauthorization is needed for ordered tests). I am ultimately responsible for payment.

Signature _____ Date _____

*****If patient is a minor, parent/ guardian signature is required. Thank You.*****

AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____ PHONE: _____

ADDRESS: _____

Covering the period of healthcare from _____ to _____

Information to be disclosed:

<input type="checkbox"/> History and Physical	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Summary List
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Physician Orders	<input type="checkbox"/> EKG
<input type="checkbox"/> Complete Health Record	<input type="checkbox"/> Laboratory Tests/X-Rays	<input type="checkbox"/> Other

If applicable, I also give permission for the following to be disclosed (please initial):

Acquired Immunodeficiency Syndrome (AIDS) or
infected with Human Immunodeficiency Virus (HIV)
 Behavioral Health Services/Psychiatric Care
 Treatment for Alcohol and/or Drug Abuse

Please release to: Heart Care Centers of Florida
7075 N US Highway 1
Suite 200
Port St. John, FL 32927
Phone: 321-636-6914
Fax: 321-636-6916

I understand that I have the right to revoke this authorization at any time. This authorization will expire in 90 days.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures or my health information, I can contact the privacy officer at the phone number listed above.

Signed: _____
(Patient) (Date)

Witness: _____
(Date)

**AUTHORIZATION FOR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Date: _____

I, _____ give
(Printed Name)

Authorization for the physicians and staff of Heart Care Centers of Florida to:

- 1. discuss my medical conditions and health care plan
- 2. pick up prescriptions, test results, or medical procedure orders
- 3. discuss payment/insurance information
- 4. all of the above
- 5. none of the above (if #5 is listed below, this person will not be given ANY information about your protected health information)

With the following family members, friends or caregivers:

*Please circle your choice: 1, 2, 3, 4, 5

<u>Full Name</u>	<u>Relationship</u>	<u>Phone</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I further understand this authorization will remain in effect unless terminated with a personal dated signature.

Signature of Patient: _____

Signature of Witness: _____

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of North Brevard Medical Support's HIPAA Notice of Privacy Practices ("Notice"). The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. In addition, I am aware that the notice may be changed at any time. I may obtain a revised copy of the Notice by notifying the Privacy Officer at North Brevard Medical Support, or by requesting one from the staff at my physician's office.

Please circle one below:

I am accepting a copy at this time.

I am refusing a copy, but I am aware that I can request a copy at anytime from the office.

Signature: _____
(Patient or Representative (Required if the patient is a
minor or an adult who is unable to sign this form))

Relationship of Patient Representative: _____

Print Name: _____

Date: _____

REASON FOR VISIT: _____

Cardiac History: _____ Dates

Previous Angioplasty/Stents: _____

Previous Bypass Surgery: _____

Previous Pacer: _____

Previous Vascular Work: _____

Prior Myocardial Infarction: _____

Other Cardiac Problems: _____

Past Medical History:

Diabetes: _____ High Blood Pressure: _____

Elevated Cholesterol: _____

1- _____ 2- _____

3- _____ 4- _____

5- _____ 6- _____

Past Surgical History:

1- _____ 2- _____

3- _____ 4- _____

5- _____ 6- _____

Social History:

Past or Current Tobacco Use: _____

If 'yes' how many packs for how long : _____

Alcohol Use: _____

I have _____ drinks of _____ (type of drink) _____ daily _____ weekly _____ monthly

Married: _____ Children: _____

Previous or Current Employment: _____

Family History:

Is there any significant family history (parents, brothers, sisters, children etc.) of heart problems? _____

Do you have any of the following symptoms? **If yes**, please **check** the appropriate boxes

Constitutional

- Loss or decrease of appetite
- Recent unplanned weight loss
- Fever
- Night sweats
- Weakness
- Fatigue

Eyes

- Eye disease or injury
- Double vision
- Blurred vision

ENT

- Hearing loss or ringing
- Earaches or drainage
- Chronic sinusitis
- Dizziness
- Nose bleeds
- Mouth sores
- Voice change

Respiratory

- Chronic daily or frequent cough
- Coughing up sputum
- Coughing up blood
- Shortness of breath at rest

Cardiovascular

- Chest pain or angina pectoris
- Palpitations
- Shortness of breath while walking
- Shortness of breath while lying flat
- Swollen feet or ankles or legs
- Pain in the lower leg while walking
- Leg cramps

Gastrointestinal

- Nausea or vomiting
- Frequent diarrhea
- Constipation
- Rectal bleeding or blood in stool
- Abdominal pain
- Heart burn
- Difficulty swallowing

Musculoskeletal

- Joint pain, stiffness, or swelling
- Back pain
- Muscle pain

Genitourinary

- Frequent or painful urination
- Blood in urine
- Decreased force or urine stream
- Incontinence or dribbling
- Female - irregular periods
- Female - vaginal discharge
- Male - testicular masses

Hematology

- Bleeding
- Anemia
- Easy bruising
- Previous transfusion

Psychiatric

- Diagnosed psychiatric disorder
- Depression or anxiety
- Memory loss or confusion

Dermatology

- Rash or itching
- Unusual Mole
- Mole that is changing size and color
- Any lumps or swollen glands
- Breast lumps or nipple discharge

Neurology

- Frequent or recurring headaches
- Numbness of fingers and/or toes
- Tingling of fingers and/or toes
- Tremors
- Weakness of one body side
- Dizzy spells
- Head Injury

Endocrine

- Excessive thirst or urination
- Heat or cold intolerance
- Hot flashes

Print Name: _____

Your Signature: _____ Date: _____ Time: _____

Doctor's Signature: _____ Date: _____ Time: _____

NO SHOW POLICY

North Brevard Medical Support has instituted a policy for "No Showed" appointments. To ensure the care provided by the physicians is not adversely affected with limited availability due to "No Show" appointments, this policy was set in place.

If you are unable to keep your scheduled appointment, we ask that you please call our office at 321-636-6914 to cancel your appointment. Failing to cancel your appointment 24 hours in advance will result in a fee being billed to your account of \$25.00. This fee is not covered by your insurance, and you will be responsible for payment.

Your signature below indicates that you understand the policy and agree to be responsible for missed appointments.

Printed Name: _____ Date: _____

Patient Signature: _____