



# Pavankumar Patel, MD

5200 Babcock Street Suite 106 A&B  
Palm Bay, FL 32905  
Ph: 321-373-7700 Fax: 321-256-5512

# New Patient Registration

## Patient Information

### Patient Name

First MI Last

DOB / / SS#

Marital Status  MALE  FEMALE

Address

Home Phone Cell

Email Address

Employer

Occupation

Name of Spouse

Address:

Check if same as patient's address

### Race

- American Indian or Alaska Native  Asian
- Native Hawaiian  Black or African American  White
- Other Pacific Islander  Prefer not to answer

### Ethnicity

- Hispanic/Latino  Non-Hispanic/Latino
- Prefer not to answer

### Preferred Language

- English  Spanish  French  Indian (includes Hindu & Tamil)  Other

Preferred Pharmacy

Location

Family Doctor

Phone

## Insurance Information

Primary Insurance Co

Policy #:

*Policy holder information, if not same as patient:*

Name

DOB / / SS#

Secondary Insurance Co

Policy #:

*Policy holder information, if not same as patient:*

Name

DOB / / SS#

## Complete below if patient is a minor

Father's Name (or Guardian)

DOB / / SS#

Home Phone Cell

Work Phone

Address:

Check if same as patient's address

Employer

Mother's Name (or Guardian)

DOB / / S S #

Home Phone Cell

Work Phone

Address:

Check if same as patient's address

Employer



# Pavankumar Patel, MD

5200 Babcock Street Suite 106 A&B

Palm Bay, FL 32905

Ph: 321-373-7700 Fax: 321-256-5512

## New Patient Registration

### HIPAA Release

**Patient Name**

\_\_\_\_\_  
First MI Last

**Emergency Contact:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone # \_\_\_\_\_

Do you have a Living Will?  Yes  No

Do you have an Advance Directive?  Yes  No

*If you answered yes to either, please provide us a copy.*

**I authorize Medical Associates of Brevard LLC to discuss my healthcare information with the below:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone # \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone # \_\_\_\_\_

**Preferred appointment reminder notification:**

- Home Phone  Cell  Cell Text  Work phone
- Mail  E-Mail  None
- With the person(s) authorized above

**Preferred medical information notification:**

***I authorize Medical Associates of Brevard LLC to leave a detailed message which may contain personal health information via:***

- Home Phone  Cell  Cell Text  Work phone
- Mail  E-Mail  None
- With the person(s) authorized above

**Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine.**

***Your HIPAA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.***



**Pavankumar Patel, MD**

5200 Babcock Street Suite 106 A&B  
Palm Bay, FL 32905  
Ph: 321-373-7700 Fax: 321-256-5512

**Patient Authorization for Release of Medical Records**

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Please check all information that applies:**

**Chart Notes:**

**Imaging:**

**Lab results:**

**Other:**  \_\_\_\_\_

**Releasing Authority:**

**Facility / Provider Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Fax Phone:** \_\_\_\_\_

I give my authorization to release the above protected information to MEDICAL ASSOCIATES OF BREVARD, LLC.

**Select one of the following choices:**

- 1. This authorization will end on the following date: \_\_\_\_\_
- 2. This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use/or disclosure. Describe the event below:

**Signature of Patient:** \_\_\_\_\_

**DATE:** \_\_\_\_\_



# Patient Health History Questionnaire

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male  Female

Reason For Visit: \_\_\_\_\_

## MEDICAL HISTORY

- Diabetes (Specify) Type 1 or Type 2     Hypertension     High Cholesterol
- Stroke     Heart Attack     Heart Failure     Kidney (Specify) \_\_\_\_\_
- Problems     Osteoporosis     Osteoarthritis     Gout
- Thyroid disease (specify) \_\_\_\_\_  Liver Problems     Rheumatoid Arthritis
- Enlarged Prostate     Prostate Cancer     Cancer (specify) \_\_\_\_\_
- Other: \_\_\_\_\_

## SURGERIES (Include Dates)

- Heart Stent/ Angioplasty \_\_\_\_\_  Cardiac Bypass \_\_\_\_\_  Thyroidectomy: Partial / Total
- Prostate Surgery \_\_\_\_\_  Appendectomy \_\_\_\_\_  Tonsillectomy \_\_\_\_\_
- Hernia Repair \_\_\_\_\_  Gall Bladder Surgery \_\_\_\_\_  Hysterectomy \_\_\_\_\_
- Tubal Ligation \_\_\_\_\_  Vasectomy \_\_\_\_\_
- Cataract Surgery \_\_\_\_\_  Breast Surgery \_\_\_\_\_
- Other: \_\_\_\_\_

## SCREENING TEST DATES

- Diabetic Eye Exam \_\_\_\_\_  Diabetic Foot Exam \_\_\_\_\_
- Bone density test / DEXA \_\_\_\_\_  Thyroid Scan \_\_\_\_\_
- Thyroid Biospy \_\_\_\_\_  Thyroid Ultrasound \_\_\_\_\_
- Prostate test / PSA \_\_\_\_\_  PAP smear \_\_\_\_\_
- Colonoscopy \_\_\_\_\_  Mammogram \_\_\_\_\_

## FAMILY MEDICAL HISTORY

	Age	Illnesses	Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			
Other			

### SOCIAL HISTORY

1. Use of alcohol:    Never    Rarely    Moderate    Daily
  
2. Use of tobacco:  Never    Previously, but quit ( Cigarettes  Cigars  Pipes  Chewing tobacco  Snuff)  
                             How many years? \_\_\_\_\_ How Many Pack Per Day? \_\_\_\_\_
  
3. Use of drugs:  Never    Type/frequency \_\_\_\_\_

### ALLERGIES / REACTIONS TO MEDICATIONS, FOOD OR ENVIRONMENTAL

DRUG NAME:	REACTION / COMMENTS





**Pavankumar Patel, MD**

5200 Babcock Street Suite 106 A&B

Palm Bay, FL 32905

Ph: 321-373-7700 Fax: 321-256-5512

## YOU MUST READ BELOW FOR IMPORTANT INFORMATION AND NOTICES

### Financial Policy

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of-pocket, deductibles and noncovered services. Patients who fail to show for their scheduled appointment or did not notify the office within 2 business days of their scheduled appointment time, shall be subject to a **"No Show/Cancellation" fee of \$75.00 for New Patients and 50\$ for an established patient. We reserve the right to discharge you after 2 NO SHOWS.**

I authorize the payments from my insurance company(s) according to my medical benefits be made payable to **Medical Associates of Brevard LLC** for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all Medical Associates of Brevard as well as to my insurance company(s).

**LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.**

### Notice of Privacy Practices

I acknowledge that I have received a copy of the **Provider Notice of Privacy Practices** for Medical Associates of Brevard LLC. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

**NOTE: You will electronically sign for this Notice of Privacy Practices on the signature pad in your doctors' office to be stored in your electronic medical chart.**

### Consent to Obtain External Prescription History

I authorize Medical Associates of Brevard LLC and its physicians and staff to view my external prescription history via the electronic medical records system Medent, and the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

**MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.**

**NOTE: You will electronically sign for this Consent to Obtain External Prescription History on the signature pad in your doctors' office to be stored in your electronic medical chart. You will have the option to give consent or deny this access upon electronically signing.**

### Community Chart Consent

I give consent to Medical Associates of Brevard LLC to access the Community Chart in order to access and share my medical records if available through other entities operating under the Care quality Interoperability Framework, including Surescripts. This includes demographic information as well as other relevant clinical documentation.

**NOTE: You will electronically sign for this Community Chart Consent on the signature pad in your doctors' office to be stored in your electronic medical chart. You will have the option to give consent or deny this access upon electronically signing.**