MAB
MEDICAL ASSOCIATES OF BREVARD

NASA PRIMARY CARE

1555 W NASA Blvd, Unit B1
Melbourne FL 32901
Ph: 321-341-1700 Fax: 321-622-6295
www.nasaprimarycare.com

New Patient Registration

Patient Information

Patient Name

_____
First MI Last

DOB ___/___/_____ SS# _____

Marital Status_____ ◯ MALE ◯ FEMALE

Address _____

_____

Home Phone _____ Cell _____

Work Phone _____

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 ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

◯ Check if same as patient's address

Employer _____

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New Patient Registration

HIPAA Release

Patient Name

First MI Last

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.

Emergency Contact:

Name Relationship

Phone #

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.

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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.
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 of 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.

NOTE: You will electronically sign for this Financial Policy agreement on the signature pad in your doctors' office to be stored in your electronic medical chart.

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 Carequality 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.**

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or Referring Doctor:	**Date of Last Physical Exam:**

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Shingrix
	☐ Influenza	☐ COVID-19

Medical History

Surgeries

Year	Reason	Hospital

Hospitalization

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)							
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)							
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)							
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)							
Diet	Are you following a specific diet plan?				☐	Yes	☐	No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola				
	# of cups/cans per day?							
Alcohol	Do you drink alcohol?				☐	Yes	☐	No
	How many drinks per week?							
Tobacco	Do you use tobacco?				☐	Yes	☐	No
	☐ Cigarettes – pks. /day	☐ Chew - #/day	☐ e-cigarettes?	☐ Cigars - #/day				
	☐ # of years	☐ Or year quit						
Drugs	Do you currently use recreational or street drugs?				☐	Yes	☐	No
	Have you ever given yourself street drugs with a needle?				☐	Yes	☐	No
Personal Safety	Do you have frequent falls?				☐	Yes	☐	No
	Do you have vision or hearing loss?				☐	Yes	☐	No
	Do you have an Advance Directive or Living Will?				☐	Yes	☐	No
	Would you like information on the preparation of these?				☐	Yes	☐	No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your physician?				☐	Yes	☐	No
Occupation								
Sexually Active	With Men/ Women / N/A (Circle all that apply)							

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**		
Mother					
Sibling					
			Grandmother *Maternal*		
			Grandfather *Maternal*		
			Grandmother *Paternal*		
			Grandfather *Paternal*		

When did you have the following investigations?
Mammogram
Pap
Colonoscopy
DEXA/Bone Density

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

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Patient Authorization for Release of Medical Records

Patient's Name: DOB:

Address:

Please check all information that applies:

Chart Notes: ☐

Imaging: ☐

Lab results: ☐

Other: ☐ _____

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

Select one of the following choices:

This authorization will end on the following date: _____

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: _____ DOB: _____

Name of Patient: _____