New Patient Registration

MEDICAL ASSOCIATES OF BREVARD

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 _____

MAB
MEDICAL ASSOCIATES OF BREVARD

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.

MEDICAL HISTORY FORM

PATIENT NAME:_____ DATE OF BIRTH:_____

BRIEFLY DESCRIBE THE PROBLEM THAT BRINGS YOU TO THE OFFICE TODAY:
(FOR EXAMPLE: RIGHT HEEL PAIN, INGROWN NAIL LEFT BIG TOE, INJURY LEFT ANKLE)

PLEASE CIRCLE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

ANEMIA	HIGH BLOOD PRESSURE	DEPRESSION AND/OR ANXIETY
ASTHMA	HIGH CHOLESTEROL	STROKE / TIA
PERIPHERAL VASCULAR DISEASE (POOR CIRCULATION)	KIDNEY DISEASE ON DIALYSIS?	STOMACH ULCERS
BLEEDING DISORDERS		REFLUX DISEASE (GERD)
USE BLOOD THINNERS COUMADIN/WARFARIN PRADAXA	LUNG DISEASE COPD EMPHYSEMA	ARTHRITIS DEGENERATIVE (OSTEOARTHRITIS) RHEUMATOID
BACK PROBLEMS CERVICAL LOW BACK PAIN SCIATICA HERNIATED DISCS OTHER:	HEART DISEASE HEART ATTACK CONGESTIVE HEART FAILURE CORONARY ARTERY DISEASE ATRIAL FIBRILLATION MITRAL VALVE PROLAPSE PACEMAKER OTHER:	CANCER TYPE: TREATMENT:
DIABETES - YEAR DIAGNOSED:	EPILEPSY/SEIZURES	
GOUT	THYROID PROBLEMS	LIVER DISEASE: HEPATITIS OR JAUNDICE
BLOOD CLOTS	FIBROMYALGIA	PSORIASIS
WOUND HEALING PROBLEMS	MRSA INFECTION	NEUROPATHY/NERVE PROBLEMS

☐ NO KNOWN MEDICAL PROBLEMS
ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:

PRIOR FOOT OR ANKLE PROBLEMS?: IF SO, DESCRIBE:

PLEASE LIST ALL PRIOR SURGERIES WITH DATES: ☐ NO PRIOR SURGERIES
☐ HEART (STENTS OR BYPASS) DATE:
☐ VASCULAR/LEGS- (STENTS OR BYPASS) DATE:
☐ PRIOR FOOT OR ANKLE SURGERY, PLEASE DESCRIBE:

ANY OTHER SURGERIES:
_____
_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, BIRTH CONTROL PILLS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

_____
_____
_____

REFERRAL SOURCE:_____ **PRIMARY DOCTOR**:_____

PLEASE LIST ALL ALLERGIES: ☐ NO KNOWN ALLERGIES

☐ PENICILLIN ☐ SULFA ☐ CODEINE ☐ NSAIDS ☐ ASPIRIN ☐ LATEX ☐ ADHESIVE TAPE ☐ IODINE

ANY OTHER ALLERGIES NOT LISTED ABOVE:

_____

PLEASE LIST ANY HOSPITALIZATIONS IN LAST 2 YEARS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE
_____		_____	
_____		_____	

SOCIAL HISTORY:

FOR CHILDREN: GRADE IN SCHOOL _____ SPORTS/ACTIVITIES _____

FOR ADULTS: OCCUPATION: _____ EMPLOYER: _____

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE _____ PACK(S)/DAY FOR _____ YEARS

ALCOHOL CONSUMPTION: ☐ NEVER ☐ OCCASIONAL ☐ MODERATE ☐ DAILY
☐ HISTORY OF ALCOHOL ABUSE

EXERCISE: ☐ NEVER ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

FAMILY HISTORY:

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER, TYPE _____
☐ HEART DISEASE ☐ STROKE ☐ RHEUMATOID ARTHRITIS
☐ OTHER (PLEASE INCLUDE ANY FOOT OR ANKLE PROBLEMS) _____

VITALS: HEIGHT (INCHES) _____ WEIGHT (POUNDS) _____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF APPLICABLE) DATE