Pavankumar Patel, MD MPH
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 _____

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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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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: _____

Patient Health History Questionnaire

Last Name: _____ First Name: _____

_____Date of Birth: _____ Male O Female O

Reason For Visit: _____

MEDICAL HISTORY

O Diabetes (Specify) Type 1 or Type 2 O Hypertension O High Cholesterol

O Stroke O Heart Attack O Heart Failure O Kidney (Specify) _____

O Problems O Osteoporosis O Osteoarthritis O Gout

O Thyroid disease (specify)_____ O Liver Problems O Rheumatoid Arthritis

O Enlarged Prostate O Prostate Cancer O Cancer (specify) _____

O Other: _____

SURGERIES (Include Dates)

O Heart Stent/ Angioplasty _____ O Cardiac Bypass_____ O Thyroidectomy: Partial/Total

O Prostate Surgery_____ O Appendectomy_____ OTonsillectomy_____

O Hernia Repair_____ O Gall Blader Surgery_____ OHysterectomy_____

O Tubal Ligation_____ O Vasectomy_____

O Cataract Surgery_____ O Breast Surgery_____

O Other: _____

SCREENING TEST DATES

O Diabetic Eye Exam _____ O Diabetic Foot Exam _____

O Bone density test / DEXA_____ O Thyroid Scan_____

O Thyroid Biospy_____ O Thyroid Ultrasound _____

O Prostate test / PSA _____ O PAP smear _____

O Colonoscopy_____ O Mammogram _

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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 _____

MEDICATIONS: List prescribed and over-the-counter medications

DRUG NAME:	DOSE & DIRECTIONS:	REASON:

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FAMILY MEDICAL HISTORY

	Age	Illnesses	Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			
Other			

ALLERGIES / REACTIONS TO MEDICATIONS, FOOD OR ENVIRONMENTAL

DRUG NAME:	REACTION / COMMENTS

CURRENT CARE TEAM

PROVIDER NAME:	SPECIALIZES

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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. 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.**