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.

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.**

MAB
MEDICAL ASSOCIATES OF BREVARD

Name _____ Date: _____ SSN ____/_____/_____

Address _____ AGE _____ DOB_____/_____/_____

_____ ☐ MALE ☐ FEMALE

Home Ph. (_____)_____-_____ Cell Ph. (_____)_____-_____ ☐ MARRIED ☐ SEPERATED ☐ DIVORCED

Business Ph. (_____)_____-_____ ☐ SINGLE ☐ WIDOWED

Referring Physician _____ Occupation_____

Family Physician _____ Do you have a Living Will? ☐ yes ☐ no

Family History:

Family member	Age (if living)	Health Good	Poor	List any illnesses	If deceased, cause of death	Age at death
Father						
Mother						
Brothers or sisters						

Personal History: (Women: Don't list pregnancies.)

	Hospitalization (1)	Hospitalization (1)
Type of illness		
Month/Year Hospitalized		
Name of Hospital		
City and State		

Risk Factors:

Do you smoke? _____ How much? _____ per day

Did you smoke previously? _____

Do you drink alcohol? _____ How often? _____

Do you use recreational drugs? _____

Cholesterol level (if known) _____

Do you have high blood pressure? _____

Do you have family history of heart disease? _____

Do you have diabetes? _____

When did you last have the following?

Chest x-ray_____ EKG_____

Cardiac Catheterization _____

Mammogram _____

Present Medications (please include mg and dosage)

1.	mg
2.	mg
3.	mg
4.	mg
5.	mg
6.	mg
7.	mg
8.	mg
9.	mg
10.	mg

Drug Allergies:

1.
2.
3.
4.

Signature_____ Date_____

EYES

eyesight worsening	O Yes	O No
seeing double	O Yes	O No
cataracts	O Yes	O No

EARS

hearing difficulties	O Yes	O No
buzzing in ears	O Yes	O No

MOUTH

dental problems	O Yes	O No
easy bleeding gums	O Yes	O No

NOSE

frequent congestion	O Yes	O No
frequent nosebleeds	O Yes	O No

HEAD

frequent headaches	O Yes	O No
painful sinuses	O Yes	O No

NECK

neck pain	O Yes	O No
neck stiffness	O Yes	O No
neck lumps/swelling	O Yes	O No

THROAT

horse voice	O Yes	O No
difficulty swallowing	O Yes	O No

LUNGS

wheezing	O Yes	O No
shortness of breath	O Yes	O No
coughing up sputum	O Yes	O No
coughing up blood	O Yes	O No
history of tuberculosis	O Yes	O No
pain when breathing	O Yes	O No

HEART

attacks of racing heartbeat	O Yes	O No
chest pain or heaviness	O Yes	O No
dizzy spells	O Yes	O No
swollen feet or ankles	O Yes	O No
leg cramps when walking	O Yes	O No
history of heart murmur	O Yes	O No
shortness of breath	O Yes	O No
difficulty sleeping	O Yes	O No

OTHER SYMPTOMS

DIGESTIVE

difficulty swallowing	O Yes	O No
pain on swallowing	O Yes	O No
heartburn	O Yes	O No
vomiting	O Yes	O No
stomach pains	O Yes	O No
vomiting blood	O Yes	O No
diarrhea	O Yes	O No
black stools	O Yes	O No
constipation	O Yes	O No
yellow jaundice	O Yes	O No

URINARY TRACT

frequent urination	O Yes	O No
getting up at night to urinate	O Yes	O No
wetting pants on coughing	O Yes	O No
burning on urination	O Yes	O No
hx of kidney stones	O Yes	O No
hx of urinary tract infections	O Yes	O No

MUSCULOSKELETAL

painful joints	O Yes	O No
swollen joints	O Yes	O No
back pain	O Yes	O No
shoulder pains	O Yes	O No
muscle aches	O Yes	O No
swollen/painful big toe	O Yes	O No
joint stiffness	O Yes	O No

SKIN

skin itching/redness/rash	O Yes	O No
bruising easily	O Yes	O No

NEUROLOGICAL SYSTEM

fainting spells	O Yes	O No
lightheadedness	O Yes	O No
seizures/convulsions	O Yes	O No
tremors	O Yes	O No
sudden loss of vision	O Yes	O No
loss of memory	O Yes	O No

GENERAL

recent weight gain	O Yes	O No
recent weight loss	O Yes	O No
loss of appetite	O Yes	O No
tiring easily	O Yes	O No
night sweats	O Yes	O No
fevers	O Yes	O No
shaking chills	O Yes	O No
excessive thirst	O Yes	O No

Name: Signature: Date:

MEDICAL ASSOCIATES OF BREVARD

CARDIOLOGY

PAD Questionnaire

Name:_____Date of Birth_____Date_____

Do you smoke or have you ever smoked?	YES	NO
Do you have high blood pressure or are you on blood pressure medication?	YES	NO
Do you have high cholesterol or are you on medication to lower your cholesterol?	YES	NO
Have you ever had, or have been told you had a heart attack or stroke?	YES	NO
Have you ever had an angioplasty or stent placed in the heart or leg?	YES	NO
Have you ever noticed your walking pace has slowed?	YES	NO
Are you a diabetic or have you ever been told you are borderline diabetic?	YES	NO
Do your legs ever feel tired causing you to stop and rest?	YES	NO
When you walk, do you ever have to stop because you have pain or cramping in your calves or thighs?	YES	NO
Do you ever experience cramping, tightness, pain, "charleyhorses," in the legs or feet when lying down that improves when you stand up?	YES	NO
Do you have any infections or sores that are not healing on your feet or toes?	YES	NO
Is the skin on your legs or feet pale, reddish, or purple?	YES	NO
Is the skin on your legs or feet cool to the touch?	YES	NO
Have you been told you have poor circulation in your legs, intermittent claudication or peripheral arterial disease?	YES	NO
Have you ever had any testing done to your legs for peripheral artery disease?	YES	NO

Additional comments?

_____

_____

_____

Signiture:_____