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 _____________________________________

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.

Dr. Gayed: Medical History Form | Date:

Patient Name:____________________________________ **Date of Birth:** _____/_____/_____

Current Medications

Medication Name:	Dosage:	Frequency:

***Please continue medications on back of page.**

Allergies: Drug and Environmental.

Surgeries and Hospital History: *From birth to present*

Surgery/Reason for Hospital Visit:	Date:

Chronic Medical Conditions: (*i.e.* Asthma, high blood pressure, diabetes, etc)

Dr. Gayed: Medical History Form | Date:

Family History:

Member:	Age:	Alive/Deceased	Medical Conditions:
Father:			
Mother:			
Sister:			
Brother:			
Others:			

Have any immediate family members ever been diagnosed with cancer? Yes / No

If yes, which family member and what type: ____

____

Immunization History:

Influenza: Yes / No	Year Received:
Pneumovax23 / Prevnar13: Yes / No / Both	Year/s Received:
Shingrix / Zostavax: Yes / No / Both	Year/s Received:
Tetanus: Yes / No	Year Received:
Other / Misc:	

Health Maintenance:

Colonoscopy: Yes / No Year:	Facility or Doctor:
DEXA (Bone Density) Yes / No Year:	Facility or Doctor:
Mammogram: Yes / No Year:	Facility or Doctor:

Social History:

Do you currently or have you ever smoked or use any tobacco products? Yes / No. Circle all that apply: Cigarettes / Cigars / e-Cigarette / Chewing Tobacco. How much? ____________ Start date/age: _____________

When did you quit (Age or date)? ________________.

Do you currently or have you previously drink alcohol? Yes / No. Type: Beer / Liqueur / Both. How many drinks per: Day / Week / Month / Year: ______________. Have you had any history of alcohol abuse? Yes / No. Start date: _____________ Quit Date: ______________.

Do you currently or have you ever used recreational drugs. (*I.e.* Marijuana, cocaine, Methamphetamines, etc)

Yes / No. Please note any recreational drugs used, the start date, and end date if applicable: ________________

____