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.**

PATIENT'S NAME:_____ **DATE:**_____

REASON FOR TODAY'S VISIT:

WHEN DID THE SYMPTOMS START?_____

THE SYMPTOM INTENSITY IS: **Mild** **Moderate** **Severe**

THE SYMPTOMS ARE: **Intermittent** **Constant**

WHAT MAKES THE SYMPTOMS WORSE?_____

WHAT MAKES THE SYMPTOMS BETTER?_____

CURRENT MEDICATIONS AND DOSAGES. PLEASE INCLUDE SUPPLEMENTS AND NASAL SPRAYS.

HAVE YOU HAD ANY REACTIONS TO MEDICATIONS: Yes No

PLEASE TELL US THE MEDICATION AND WHAT REACTION YOU HAD (RASH, SWOLLEN TONGUE, STOPPED BREATHING, VOMITING, ABDOMINAL PAIN, DIARRHEA)

PLEASE LIST ALL PREVIOUS MEDICAL CONDITONS, PREVIOUS SURGERIES AND DATES, AND HOSPITALIZATIONS AND DATES

FAMILY MEDICAL HISTORY

THYROID PROBLEMS **No Father Mother Brother Sister**

HEARING LOSS **No Father Mother Brother Sister**

HEART DISEASE **No Father Mother Brother Sister**

SOCIAL HISTORY

DO YOU DRINK ALCOHOL? Yes Never Quit (year quit _____)

WHAT ALCOHOL CONTAINING BEVERAGE DO YOU DRINK? BEER WINE OTHER_____

HOW OFTEN DO YOU DRINK ALCOHOL? OCCASIONALLY WEEKENDS DAILY

DO YOU SMOKE? Yes Never Quit (year quit _____)

CIGARETTES CIGARS MARIJUANA CHEWING TOBACCO SNUFF PAN OTHER_____

HOW MUCH DO YOU SMOKE? _____ PACK(S) PER DAY,

HOW MANY YEARS DID YOU SMOKE OR HAVE BEEN SMOKING?_____Years

DO YOU USE ANY RECREATIONAL DRUGS? Yes Never Quit (year quit _____)

If Yes or Quit, please list drugs used:_____

OCCUPATION:_____

If retired, what was the last thing you did before you retired?_____

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED ENGAGED

ARE YOU (THE PATIENT) EXPOSED TO SECOND HAND SMOKE? Yes No

DO YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS?

CONSTITUTIONAL SYMPTOMS

Fevers Yes No

Night Sweats Yes No

Weight Loss Yes No

EYES

Pain Yes No

Blurred vision Yes No

Double vision Yes No

Loss of vision Yes No

CARDIOVASCULAR

Chest pain Yes No

Heart failure Yes No

RESPIRATORY

Difficulty breathing Yes No

COPD/emphysema Yes No

Asthma Yes No

GASTROINTESTINAL

Heartburn Yes No

Difficulty swallowing Yes No

INTEGUMENTARY

Rash Yes No

PSYCHIATRIC

Depression Yes No

Impaired memory Yes No

EAR NOSE THROAT MOUTH

Hearing loss Yes No

Ringing in ears Yes No

Ear pain Yes No

Ear discharge Yes No

Dizziness Yes No

Ear infections Yes No

Surgery in the ears Yes No

Sore throat Yes No

Had tonsils out Yes No

Hoarseness Yes No

Mouth lesions Yes No

Snoring Yes No

Stop breathing at night Y N

Tired during day Yes No

ENDOCRINE

Thyroid disease Yes No

Diabetes Yes No

ALLERGIC/IMMUNOLOGIC

Sneezing Yes No

Runny nose Yes No

Nasal congestion Yes No

Facial pain Yes No

Nosebleed Yes No

Lost sense of smell Yes No

GENITOURINARY

Frequent urination Yes No

Stones Yes No

MUSCULOSKELETAL

Joint pain Yes No

Back pain Yes No

HEMATOLOGIC/LYMPHATIC

Bleed easily Yes No

Enlarged glands Yes No

NEUROLOGIC

Headaches Yes No