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.**

Medical Associates of Brevard
General Surgery/Hanley Skin Cancer Center
Mark Hanley, M.D./Jennifer Hanley, PA-C

PATIENT HISTORY

Date: _____ Reason for visit: _____

Patient Name: _____Date of Birth: _____ Age: _____

Primary Physician: _____ Referring Physician: _____

MEDICAL HISTORY: Circle any which you have been diagnosed with and/or are currently receiving treatment:

Bleeding Tendency	Kidney Trouble	Cancer: _____
Bronchitis/Emphysema	Diabetes	Other: _____
Liver Disease	Gout	**SKIN CANCER: TYPE,**
Tuberculosis	Heart Attack, Date: _____	**LOCATION, & YEAR:**
Heart Disease	Stroke	1._____
High Blood Pressure	Thyroid Disease	2._____
Kidney Stones	Heart Valve Problems	3._____
Sleep Apnea	Blood Clots in lungs or legs	4._____

SURGICAL HISTORY:

Operation	Year	Doctor
1.		
2.		
3.		
4.		
5.		

Last Colonoscopy: _____

MEDICATIONS: (List the name and dosages of all medications you are taking. Please include Aspirin, Hormone/Birth Control, and any Herbal/Dietary Supplements.

_____ _____
_____ _____
_____ _____
_____ _____

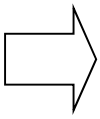
ALLERGIES **ADVERSE REACTION**

_____
_____
_____

Reaction to Anesthesia	No	Yes
IVP Dye/Contrast	No	Yes
Iodine/Shellfish	No	Yes

FAMILY HISTORY:

	ALIVE/ DECEASED	AGE	HIGH BLOOD PRESSURE	HEART DISEASE	STROKE	CANCER	OTHER	NOT KNOWN
FATHER								
MOTHER								
SIBLINGS								



CHILDREN								

PERSONAL/SOCIAL HISTORY:

Alcohol Use: How many alcoholic drinks do you consume per day? _____ per week: _____

Current/former occupation: _____

Do you require antibiotics for dental/surgical procedures _____

Do you use illegal substances? _____

Tobacco Use:

Currently, smoke _____ packs/day for _____ years

Quit in _____ year

Never smoked

FOR WOMEN:

Age period began: _____

Age at the time of birth of your first child: _____

Family History of Breast Cancer: Y N Relation: _____

List past breast biopsies (include right or left side):_____

# of past breast biopsies showing atypia/hyperplasia: _____

Last menstrual period: _____

Have you ever been on birth control? _____

Have you ever been on hormone replacement? _____

REVIEW OF SYSTEMS: Do you have any of the following symptoms or conditions?

CONSTITUTIONAL SYMPTOMS:

Fever	Y	N
Chills	Y	N
Weight Loss	Y	N
Other_____		

EYES:

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other _____		

CARDIOVASCULAR:

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Other _____		

GASTROINTESTINAL:

Abdominal Pain	Y	N
Nausea/vomiting	Y	N
Bleeding	Y	N
Other _____		

MUSCULOSKELETAL:

Back Pain	Y	N
Neck Pain	Y	N
Other _____		

ENDOCRINE:

Thyroid Problems	Y	N
Other _____		
Diabetes	**Y**	**N**

SKIN/BREASTS:

Rash	Y	N
Skin Lumps	Y	N
Breast Lumps	Y	N
Persistent Itch	Y	N
Sunscreen Use	Y	N
Other _____		

EAR/NOSE/THROAT/MOUTH

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other _____		

RESPIRATORY:

Infections	Y	N
Frequent cough	Y	N
Shortness of Breath	Y	N
Other _____		

GENITOURINARY:

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Other _____		

PSYCHIATRIC:

Depression	Y	N
Anxiety	Y	N
Other _____		

HEMATOLOGIC/LYMPHATIC:

Enlarged Lymph Nodes	Y	N
Other _____