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.

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.**

A Multi-Specialty Group Practice

ANJU GROVER, M.D.
NITIN JAIN, M.D.

Board Certified Internal Medicine

LATE CANCELLATION, LATE RESCHEDULING AND NO SHOW POLICY

We understand that situations arise when you must cancel or reschedule your appointment. It is therefore requested that, if you must change your appointment, you provide more than 24 hours' notice. This will enable another person who is waiting for an appointment to be seen. If you cancel or reschedule your appointment with less then the 24 hours' notice, we are unable to offer that appointment time to another patient.

Office appointments which are canceled or rescheduled with less than 24 hours' notice may be subject to a **$25.00 cancellation fee**.

Patients who do not show up for their appointment will be considered a **NO SHOW** and may be subject to a **$25.00 no show fee**. Patients who no show two (2) or more times in a 12-month period may be dismissed from the practice and will be denied any future appointments.

The late cancellation, late rescheduling and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communication. Questions about late cancellation, late rescheduling and no show fees should be directed to the Billing Department at (321) 254-6338.

Please sign that you have read, understand and agree with this policy.

____________________________   ______________________

Patient Names (Please Print)   Date of Birth

____

Signature of Patient or Patient Representative

2010 W. Eau Gallie Blvd. • Unit 106 • Melbourne, FL 32935 • Phone (321)254-6338 • Fax (321) 254-6341

ADULT HEALTH QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

PATIENT NAME: ______________________________

PATIENT DATE OF BIRTH: __________ **TODAY'S DATE:** __________

What would you like to talk to your doctor about today? ______________________________

____

MEDICAL HISTORY

Please list any medication allergies or reactions:

____

____

Please check to indicate if you have ever had the following conditions:

- ☐ Diabetes
- ☐ Kidney disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Arrythmia
- ☐ High blood pressure
- ☐ Hepatitis
- ☐ Depression
- ☐ Coronary Artery Disease
- ☐ Asthma
- ☐ Thyroid disease
- ☐ Emphysema
- ☐ Congestive Heart Failure
- ☐ Heart attack
- ☐ Seizures
- ☐ Sexually transmitted disease – type: ______________
- ☐ Eye problems – type: ______________
- ☐ Cancer – type: ______________
- ☐ Other, please explain: ______________________________

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery / reason for hospitalization / location	*Date*

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

____

____

When was your last physical?

____

Please list all medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage if possible.

Medication Name	*Dosage*

What pharmacy do you use for prescription medications?

____

Are you currently receiving care from any other doctors, chiropractors, or other health care professionals? If yes, we would like to know whom so that we can coordinate your care:

Provider's name	*Condition they are treating you for*

Please note dates of your most recent immunizations:

	Approximate Date		*Approximate Date*
Tetanus		Influenza	
Pneumonia		Hepatitis B	
Other: ________		Other: ________	

If you have had any of the following tests done, please note when the tests was done and what the results were, if known:

Test	*Approximate Date*	*Result*
Cholesterol		
Pap smear/pelvic		
Mammogram		
Blood in stool		
HIV		
Colonoscopy		
Hepatitis C		

FAMILY HISTORY

Check any of the diseases that run in your family **and** please note who had it:

	None	Mother	Father	Sister	Brother	Grandmother (mother's side)	Grandfather (mother's side)	Grandmother (father's side)	Grandfather (father's side)	Child	Other (Please explain)
Alcoholism or Drug Use											
Cancer											
Cancer Type											
Diabetes											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Osteoporosis											
Mental Illness											
Stroke											
Thyroid Disease											
Other											

Other Comments:

____

____

____

____

HEALTH HABITS

Do you smoke or use any tobacco products?.. ☐ Yes ☐ No ☐ Quit

Number of cigarettes each day? ____________

For how many years? ____________

Other forms of tobacco used? ____________

Do you drink alcohol?.. ☐ Yes ☐ No ☐ Quit

How much? ____________

How often? ____________

Have you ever felt that you should cut down on your drinking?................................ ☐ Yes ☐ No

Have you regularly used other drugs?.. ☐ Yes ☐ No

If yes, are you still using them?.. ☐ Yes ☐ No

PERSONAL HISTORY

Are you currently married or living with a significant other?...☐ Yes ☐ No

Who lives with you at home?________________________

Are you employed?...☐ Yes ☐ No

If yes, what kind of work do you do?______________________________

If no, is this by choice?___ Disability?____ Other reasons?________________

Do you exercise more than 2 times per week?..☐ Yes ☐ No

Do you often feel sad or depressed?.. ☐ Yes ☐ No

Do you feel there is something seriously wrong with your body?.................................... ☐ Yes ☐ No

Are you having money problems which limit your access to food, shelter or medical care?......... ☐ Yes ☐ No

In the last year, have there been any major changes in your life like marriage, divorce, death of a family member or close friend, illness or injury, or change in job situation?.........................☐ Yes ☐ No

SEXUAL HISTORY

Are you sexually active? ....☐ Yes ☐ No

With: ☐ Men ☐ Women ☐ Both

Do you feel you are at risk for HIV/AIDS? ....☐ Yes ☐ No

Do you have children? ....☐ Yes ☐ No

How many children do you have? ________

Do you use any form of birth control? ....☐ Yes ☐ No

If yes, which type / brand? ____

WOMEN ONLY

Have you ever been pregnant? .... ☐ Yes ☐ No

How many times? __________________

How many miscarriages? _____________

How many abortions? ________________

How many children do you have living? ________________________

Do you have menstrual periods? ....☐ Yes ☐ No

If no, at what age did they stop? _______________

If yes, are your periods regular? _______________

OTHER COMMENTS:

____

____

____

____