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 _____

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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 NAME _____

DATE OF BIRTH _____

Ronald A. Turck Jr., M.D.

Board Certified in Neurology

REVIEW OF SYSTEMS

PLEASE CHECK YES OR NO IF IT APPLIES TO YOU

GENERAL	YES	NO
FATIGUE	☐	☐
FEVERS	☐	☐
CHILLS	☐	☐
SWEATS	☐	☐
ANOXERIA	☐	☐
MALAISE	☐	☐

HEM/ONC	YES	NO
HEMOPHILLIA	☐	☐
BLEEDING TENDENCY	☐	☐
BRUISE EASILY	☐	☐
BLOOD CLOTS	☐	☐
WEIGHT LOSS	☐	☐

ENDOCRINOLOGY	YES	NO
COLD INTOLERANCE	☐	☐
HEAT INTOLERANCE	☐	☐
ABNORMAL THIRST	☐	☐
INCREASED APPETITE	☐	☐
EXCESSIVE URINATION	☐	☐
WEIGHT CHANGES	☐	☐

GENITOURINARY	YES	NO
URINARY FREQUENCY	☐	☐
DISCHARGE	☐	☐
DISCOMFORT WHEN URINATING	☐	☐
BLOOD IN URINE	☐	☐
URINARY INCONTINENCE	☐	☐

MUSCULOSKELETAL	YES	NO
JOINT PAIN	☐	☐
SWELLING	☐	☐
STIFFNESS	☐	☐
BACK PAIN	☐	☐
RECENT INJURY	☐	☐

GASTROENTEROLOGY	YES	NO
NAUSEA	☐	☐
VOMITING	☐	☐
DIARRHEA	☐	☐
CONSTIPATION	☐	☐
ABDOMINAL PAIN	☐	☐

RESPIRATORY	YES	NO
COUGH	☐	☐
DIFFICULT BREATHING	☐	☐
EXCESSIVE SPUTUM	☐	☐
BLOOD IN SPUTUM	☐	☐
WHEEZING	☐	☐
SHORTNESS OF BREATH	☐	☐

CARDIOVASCULAR	YES	NO
CHEST PAIN	☐	☐
PALPITATIONS	☐	☐
FAINTING OR PASSING OUT	☐	☐
LABORED BREATHING	☐	☐
SHORT OF BREATH WHEN FLAT	☐	☐
PERIPHERAL EDEMA	☐	☐

EAR/NOSE/THROAT	YES	NO
EAR PAIN	☐	☐
EAR DISCHARGE	☐	☐
TINNITUS	☐	☐
DECREASED HEARING	☐	☐
NASAL OBSTRUCTION	☐	☐
NASAL DISCHARGE	☐	☐
NOSEBLEEDS	☐	☐
SORE THROAT	☐	☐
HOARSENESS	☐	☐
DIFFICULT TO SWALLOW	☐	☐

CONTINUED ON BACK

MAB
MEDICAL ASSOCIATES OF BREVARD

Ronald A. Turck Jr., M.D.

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REVIEW OF SYSTEMS

PLEASE CHECK YES OR NO IF IT APPLIES TO YOU

NEUROLOGY	YES	NO
HEADACHE	☐	☐
POOR BALANCE	☐	☐
TINGLING/NUMBNESS	☐	☐
SEIZURES	☐	☐
TREMOR	☐	☐
MIGRAINES	☐	☐
VERTIGO	☐	☐
SCIATICA	☐	☐
STABBING PAIN IN FEET	☐	☐
BURNING PAIN IN HANDS	☐	☐
BURNING PAIN IN FEET	☐	☐
LOSS OF FEELIN/POWER	☐	☐
LOSS OF CONSCIOUSNESS	☐	☐
CONFUSION	☐	☐
PARALYSIS	☐	☐
WEAKNESS	☐	☐
INSOMNIA	☐	☐
SPEECH ABNORMALITY	☐	☐
VISUAL CHANGES	☐	☐
DIZZINESS	☐	☐
MEMORY LOSS	☐	☐
GAIT ABNORMALITY	☐	☐
SLEEP PROBLEMS	☐	☐

PSYCHOLOGY	YES	NO
DEPRESSION	☐	☐
STRESSORS	☐	☐
SLEEP DISTURBANCES	☐	☐
CONFUSION	☐	☐
MOOD SWINGS	☐	☐
ANXIETY	☐	☐
MANIA	☐	☐
SUICIDAL IDEATION	☐	☐
PARANOIA	☐	☐
HALLUCINATIONS	☐	☐
MENTAL OR PHYSICAL ABUSE	☐	☐
EATING DISORDER	☐	☐

PATIENT SIGNATURE _____ **DATE** _____

Ronald A. Turck Jr., M.D.
Board Certified in
Neurology

MEDICAL ASSOCIATES OF BREVARD

HISTORY INTAKE FORM

Patient Name: _____ DOB: _____

PAST SURGICAL HISTORY

Please list **ALL** of your previous surgeries, including minor surgeries, along with the year and surgeon who did the operation.

1._____
2. _____
3. _____
4. _____
5. _____

PAST MEDICAL HISTORY

Please list **ALL** of your medical problems, including heart, lung, kidney problems, diabetes, cancer, high blood pressure, etc.

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

MEDICATIONS

Please list **ALL** of your medication you are taking, including over –the-counter medicines such as aspirin, etc., along with the **DOSE** and **FREQUENCY** of the medication **(Bring medicine bottle to every appointment or a current list).**

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

ALLERGIES

Please list **ALL** of your allergies to medication **and reaction** you have with the medicine.

1._____ 3._____
2._____ 4._____

Continued on Back

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Neurology

MEDICAL ASSOCIATES OF BREVARD

HISTORY INTAKE FORM *(cont'd)*

SOCIAL HISTORY

Circle One: Right handed or Left handed

Do you smoke? _____ If so, how long and how much? _____

If you were a previous smoker, when did you stop smoking? _____

Do you drink alcohol? _____ If so, how much and how frequent? _____

If you drank alcohol previously, when did you stop and how long did you drink? _____

Do you now use any illegal drugs? _____If yes, please list_____

Have you ever used illegal drugs? _____ If yes, please list_____

FAMILY HISTORY

Is your mother alive? _____ If not, of what and at what age did she die?_____

Is your father alive? _____ If not, of what and at what age did he die?_____

How many brothers _____ and sisters _____ do you have?

How many children? _____ Are they healthy? _____

If not healthy, what disease so they suffer? _____

Please list their medical problems: _____

_____

Has anyone in your family suffered a neurological disease? Please list:

_____

_____

Patient Signature _____ Date: _____