New Patient Registration

MAB
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 ◯ 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 _____

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/Portal ◯ 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/Portal ◯ 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

HISTORY INTAKE FORM

Patient Name: _____ DOB: _____

PAST MEDICAL HISTORY

Please list <u>all</u> of your medical problems, including heart, lungs, kidney problems, diabetes, cancer, blood pressure, etc.

1._____ 4. _____

2._____ 5. _____

3._____ 6. _____

DATE OF LAST:

PAP SMEAR: _____ *COLONOSCOPY:* _____

MAMMO: _____ *DEXA SCAN:* _____

PSA (MEN): _____*COVID HX:* _____

PAST SURGICAL HISTORY

Please list <u>all</u> of your previous surgeries including minor surgeries along with the year.

1._____

2._____

3._____

MEDICATIONS

Please list <u>all</u> of your medications including over counter medications and vitamins including dosage and frequency.

1._____ 5. _____

2._____ 6. _____

3._____ 7. _____

4._____ 8. _____

ALLERGIES

Please list all allergies to medications and <u>reaction</u> you have with the medication.

1._____ 3. _____

2._____ 4. _____

IMMUNIZATIONS

Covid: _____ Flu: _____

Shingles: _____ Pneumonia: _____

Tdap: _____

Are you up to date on all your immunizations including your childhood immunizations? _____

FAMILY HISTORY

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

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

How many brothers _____ and sisters_____ do you have?

Please list their medical problems: _____

_____

If anyone in your family suffered cancer or neurological disease:_____

_____

SOCIAL HISTORY

How many children do you have? _____ Are they healthy? _____

If not healthy, what diseases do they suffer?_____

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

If you were a previous smoker, when did you quit?_____

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

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

Do you now or have you ever used any illegal drugs? _____

Patient Signature: _____ **Date**: _____