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.**

INITIAL HISTORY FORM

Name:_____ Date_____

Please answer ALL questions **Review of Systems**

CIRCLE ALL problems, past or present. For problems you need special attention CIRCLE and underline :

Measles, German measles, Chicken Pox Diabetes, Anemia, Heart Disease, High BP, Phlebitis, Blood clots

Mumps, Rheumatic fever Tuberculosis, Meningitis, Pneumonia Stroke, Convulsions, Mental Illness

Hepatitis, Sexually Transmitted Problems Migraine, Gout, Arthritis Breast lumps, Breast Pain, Nipple Secreions

Birth defefects [congenital problems] Asthma, Hay fever, Emphysema Frequent Urinary Infections,

Urine Leakage Eyes, Ears, Nose, Throat

Depression, Anxiety, Suicidal Thoughts Bowel Problems, Hemorrhoids Problems with urinary stream

Skin problems Sexual Problems, Previous Sexual Abuse Frequent Vaginal Infections

Chest Pain, Shortness of Breath, Substance Abuse Period problems, PMS

OTHER COMPLAINTS_____

Serious Injuries [put age in brackets] _____

OPERATIONS:_____

HOSPITALIZATIONS:_____

Pregnancy: Number of times_____ Live birth_____ Miscarriage_____ Abortion_____

Stillbirth_____

First Period [age]_____ Menopause [age]_____ Any chance of you being PREGNANT NOW ?_____

Gynecologist_____ Last Pap_____

Smoke (TOBACCO)**?**_____ Drink Alcohol _____Coffee # of cups_____

Allergies: MEDICATIONS_____

FOODS_____

Medications you take now:

Immunizatons: Childhood shots completed?_____ Last Tetanus booster_____ TB Skin Test_____

Birthplace_____States you've resided in_____Foreign Travel_____

Education [highest level copmpleted]_____

Exercise and Hobbies_____

Family history of any illnesses?_____

_____

Do you have a **LIVING WILL**?_____yes_____no Wear seat belts?_____ Pay attention to your DIET?_____

Date_____ Signature_____[parent, if minor] Witness_____

Dr. Rajive K. Das, M.D.

PATIENT INFORMATION FOR MEDICAL RECORDS

DATE _____ **HOME PHONE** _____ **CELL PHONE** _____

Last Name_____ **First name**_____**Middle**_____

Social security_____**Date of Birth**_____ **Sex**_____

Home address : Street:_____City_____St_____Zip_____

Occupation_____Employed by_____

Employer's Address: Street_____City_____Zip_____

Name of Spouse [or significant other]_____Relatives who may also be Patients_____

Referred by [] Friend_____ [] Relative_____ [] Insurance company Listing_____

Phone Book: [] Small Ad [] Large Ad [] Other _____Driver License #_____

Name and Phone number of friend or relative NOT living with you_____
(in case of emergency or if we have to contact you for a test result and cannot contact you)

_____

METHOD OF PAYMENT **Name of person responsible for the bill**_____ []self [] parent [] spouse [] other___

1. [] CASH, [] VISA, [] MASTER CARD

COPAYS ARE DUE AT TIME OF SERVICE.

PLEASE GIVE THE CARD TO THE RECEPTIONIST **(SO THAT WE MAY MAKE A COPY AND CALL THE INS. COMPANY TO CHECK BENEFITS)**

PRIMARY
INSURED'S NAME_____**DATE OF BIRTH**_____**SSN**_____**Phone**_____

INSURED'S ADDRESS: (IF DIFFERENT THAN PATIENTS) Street_____
RELATIONSHIP to patient: **City**_____**, State**___ **Zip**_____
self; spouse; parent; other

MEMBERS OF YOUR HOUSEHOLD

Relationship	Name	Date of birth

Relationship	Name	Date of birth

MARITAL STATUS

MARRIED SINGLE DIVORCED WIDOW

I certify that the information given by me in applying for payment under my insurance contract [including Title xviii of the social security act] is correct.
I authorize release to my insurance carrier, employer, other pertinent **Physicians, Hospitals, or Laboratories**, any information needed. This includes copies of records, diagnosis, treatment plans, bills, or any pertinent information. By signing this form, I am consenting to RK Das MD's use and disclosure of my **PHI** to carry out **TPO.**
I request that payment of authorized benefits be payable to Rajive K. Das M.D.. I also give permission to Dr. Das's office to submit claims to my insurance carrier, including Medicare.
I understand that I am financially responsible for all charges for services to me including any balance remaining after payment of possible insurance benefits.
This authorization and assignment is to be a continuing one, **remaining in force until revoked in writing** by the undersigned for services begining:
Notice of Consent: If patient is a minor and comes in unattended by parent / guardian and physician deems any medical treatment or procedure the undersigned agrees to it.

Date_____ Signature_____[parent, if minor] Witness_____