

PLEASE PRINT

PATIENT REGISTRATION FORM

PLEASE PRINT

Patient Name: \_\_\_\_\_  
 Last First Middle Mr.,Mrs.,Ms.,Miss  
 Address: \_\_\_\_\_  
 Florida Address if not Resident Year round  
 City: \_\_\_\_\_ ST: \_\_\_\_\_ ZP: \_\_\_\_\_ Home Phone#: (\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Permanent Address if not Florida Resident Year round  
 City: \_\_\_\_\_ ST: \_\_\_\_\_ ZP: \_\_\_\_\_ Home Phone#: (\_\_\_\_) \_\_\_\_\_  
 Work Phone #: (\_\_\_\_) \_\_\_\_\_ Patient Cell Phone: (\_\_\_\_) \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patients Social Security#: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F Martial Status: M S W D O  
 How long have you lived in Florida? \_\_\_\_\_ Birthplace: \_\_\_\_\_ Highest Level of Education: \_\_\_\_\_

INSURANCE INFORMATION

**PRIMARY** Insurance Carrier: \_\_\_\_\_ Phone #:(\_\_\_\_) \_\_\_\_\_  
 ID#: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Name of Policy Holder: \_\_\_\_\_ Sex :M / F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Policy Holders Address \_\_\_\_\_ Home Phone #:(\_\_\_\_) \_\_\_\_\_  
 Work Phone #:(\_\_\_\_) \_\_\_\_\_ Policy Holders Employer: \_\_\_\_\_  
 Employers Insurance Plan: Y / N Relationship of Patient to Policy Holder: Self Husband Wife Child Other

**SECONDARY** Insurance Carrier: \_\_\_\_\_ Phone #:(\_\_\_\_) \_\_\_\_\_  
 ID# \_\_\_\_\_ Group#: \_\_\_\_\_ Name of Policy Holder : \_\_\_\_\_ Sex M / F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Policy Holders Employer \_\_\_\_\_ Work Phone#: ( ) \_\_\_\_\_  
 Policy Holders Address: \_\_\_\_\_ Home Phone#:(\_\_\_\_) \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ Is this a Second Insurance through employer, retirement, or Individual policy ?

Is your visit today due to an WORKERS COMPENSATION CASE or AUTO ACCIDENT ? Y N Date of Injury \_\_\_\_\_

Are you employed: Y / N Full Time Part Time Retired Student: FT / PT Position: \_\_\_\_\_  
 Employer or School Name and Address: \_\_\_\_\_  
 Spouse or Emergency Contact: Name \_\_\_\_\_ Spouse Social Security #: \_\_\_\_\_  
 Work #: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Who Referred You to our Office ? \_\_\_\_\_

Any known Drug Allergies ? Y N If Yes What \_\_\_\_\_  
 Do you have a Latex Allergy ? Y N **PLEASE NOTE THIS IS NOT A LATEX FREE ENVIRONMENT.**  
 Do you have a Living Willing / Advance Medical Directive ? Y N Would you like to speak to a staff member about these items ? Y N  
 Primary Language Spoken: English Spanish French Russian Creole OTHER: \_\_\_\_\_  
 Name of your previous physician : \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_

Below is for Office Use Only

DATE	INITIALS	DATE	INITIALS	DATE	INITIALS

**AUTHORIZATION TO PAY BENEFITS TO SAFECARE MEDICAL CENTER, INC.  
AND RELEASE MEDICAL INFORMATION**

**Please read and sign so we may facilitate processing of your insurance claims.**

1. I hereby assign to SAFECARE MEDICAL CENTER, INC all insurance benefits to which I am (or my child is) entitled, including but not limited to Medicare, Private Health Insurance, Medigap and any other form of coverage paying benefits.
2. I hereby authorize SAFECARE MEDICAL CENTER, INC to release all necessary information to secure payment.
3. I understand that I am financially responsible for all charges, whether covered or paid by said insurance. Should SAFECARE MEDICAL CENTER, INC participate with my insurance plan all co-payments and co-insurance payments are due at the time services are rendered. Should SAFECARE MEDICAL CENTER, INC not participate with my insurance plan payment is due **in full** at the time services are rendered until I have made arrangements in advance with SAFECARE MEDICAL CENTER, INC.
4. I understand and agree that, in the event that I fail to make payment for services rendered to my child or myself, SAFECARE MEDICAL CENTER, INC may turn my account and all information over to an attorney or collection agency. I further understand that regardless of insurance coverage, that after default I will be responsible and agree to pay all fee's incurred in the collection of any outstanding balance. This may include but is not limited to, court cost, reasonable attorneys and/or collection agency fees, together with all additional costs and expenses of collections to the present extent of the law.
5. This office reserves the right to charge a monthly billing fee and or interest on all services.
6. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

I hereby state that I have read and fully understand the above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**FILL OUT BELOW ONLY IF YOU HAVE MEDICARE: (required by Medicare)**

Please update my records to reflect the following information:

Are you currently employed? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, are there more than 20 employees in your company? Yes \_\_\_\_\_ No \_\_\_\_\_

If retired, effective date of retirement Month \_\_\_\_\_ Year \_\_\_\_\_

Is your spouse currently employed? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, are there more than 20 employees in the company? Yes \_\_\_\_\_ No \_\_\_\_\_

If retired, effective date of retirement of spouse Month \_\_\_\_\_ Year \_\_\_\_\_

Are you or your spouse covered under any other insurance plan through a current employer? Yes \_\_\_\_\_ No \_\_\_\_\_

If retired, were you or your spouse covered under any other insurance plan while employed? Yes \_\_\_\_\_ No \_\_\_\_\_

**IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS PLEASE COMPLETE THE FOLLOWING:**

Spouse's name: \_\_\_\_\_

Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Name and address of Employer Group Health Plan: \_\_\_\_\_

Is the insurance through a current employer, a retiree program or Medigap Plan? \_\_\_\_\_

Plan ID Number: \_\_\_\_\_ Group/Plan Number: \_\_\_\_\_

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT HISTORY QUESTIONNAIRE NEW PATIENT YEARLY PHYSICAL**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

What is the primary reason for your visit to see the doctor today? \_\_\_\_\_

What symptoms are you experiencing and how long have you had them? \_\_\_\_\_

What treatment have you had towards these symptoms and when? \_\_\_\_\_

Primary language spoken: \_\_\_\_\_

**Medical and Surgical History**

**List hospitalizations, surgeries, and serious injuries**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Social History (check all that apply)**

Marital: Single Married Separated Divorced Widowed

Alcohol: Never Rarely \_\_\_\_\_ drinks/week

Tobacco: Never Quit \_\_\_\_\_ packs/day for \_\_\_\_\_ years

Drugs: Never Have used Use Type: \_\_\_\_\_

Caffeine (coffee/soft drinks) amount per day: \_\_\_\_\_

Prolonged exposure to: Fumes Dust Solvents Noise

Do you feel safe in your home? \_\_\_\_\_

Do you feel sad or cry at time for no reason? \_\_\_\_\_

**Cancer Screening History**

**Please provide the dates and results of the most recent testing.**

Colonoscopy: \_\_\_\_\_

Mammogram: \_\_\_\_\_

Pap smear: \_\_\_\_\_

**Family Medical History**

**Specify current health status or cause of death, age or age at death Medical Problems.**

Father: Alive \_\_\_\_\_ Yes \_\_\_\_\_ No Age at death \_\_\_\_\_

Reason for death: \_\_\_\_\_

Mother: Alive \_\_\_\_\_ Yes \_\_\_\_\_ No Age at death \_\_\_\_\_

Reason for death: \_\_\_\_\_

**Siblings**

Age	Alive	Illness
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Children**

Age	Sex	Health
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Allergies**

\_\_\_\_\_  
 \_\_\_\_\_

**Have you ever had the following?**

Diabetes	Yes	No
Hypertension	Yes	No
Cancer	Yes	No
Heart trouble	Yes	No
Arthritis/gout	Yes	No
Convulsions	Yes	No
Bleeding tendency	Yes	No
Acute infection	Yes	No
Hereditary disease	Yes	No
Gynecologic infections	Yes	No

**Do you presently have any problems in the following areas? If "YES" give an explanation.**

Eyes:	Yes	No	_____
Ears, Nose, Mouth,	Yes	No	_____
Cardiovascular (heart, vessels)	Yes	No	_____
Respiratory (lungs/breathing)	Yes	No	_____
Gastrointestinal (stomach/intesti	Yes	No	_____
Genitourinary (genitals, kidney, )	Yes	No	_____
Musculoskeletal (muscles/joints)	Yes	No	_____
Integument (skin, breasts)	Yes	No	_____
Neurological	Yes	No	_____
Psychiatric	Yes	No	_____
Endocrine (hormones/glands)	Yes	No	_____
Hematological/Immune (blood)	Yes	No	_____
Seasonal allergies (hay fever,	Yes	No	_____

**List your current medications and dosages**

NAME	DOSAGE
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____

**WOMAN ONLY**

Age menstrual period began \_\_\_\_\_ Is it **Regular** or **Irregular**  
 Date of last period \_\_\_\_\_ Do you have Spotting in between **Yes No**  
 Length of period \_\_\_\_\_ days Flow is **Heavy Medium Light**  
 # of pregnancies \_\_\_\_\_ Deliveries \_\_\_\_\_ Aborted \_\_\_\_\_ C section \_\_\_\_\_  
 Have you had a hysterectomy? **Yes No** Do you take hormones? \_\_\_\_\_  
 What contraceptive method to you use? \_\_\_\_\_  
 Onset of menopause (change of life) \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

**CONSENT FORM FOR DIAGNOSTIC AND/OR THERAPEUTIC PROCEDURE**

I hereby consent to and authorize a physician of Safecare Medical Center, and other health Professionals as designated, to perform a physical examination and routine diagnostic procedures upon me. I also consent to and authorize Safecare Medical Center physicians to prescribe a therapeutic regime, which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) ordered by the Safecare Medical Center physician to be performed on me despite the risk involved and complications that might be involved which were explained to me at the time that they were considered.

Signed: X \_\_\_\_\_  
Patient or person authorized to sign for patient

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

Witnesses: \_\_\_\_\_  
\_\_\_\_\_

Por la presente yo autorizo a un medico de Safecare Medical Center, y cualquier otro profesional de salud que designe, para que lleve a cabo un examen fisico y procedimientos de rutina en mi, a fin de diagnosticar la condicion que afecta mi salud. Yo tambien consiento y autorizo a los medicos de Safecare Medical Center para que receten un regimen terapeutico que yo debo seguir. A menos que yo expresamente rehuse, consiento que el o los procedimientos para un diagnostico ordenado por los medicos de Safecare Medical Center, sean llevado a cabo en mi, a pesar de los riesgos y complicaciones que puedan estar asociados con dichos procedimientos, que me fueron explicados en el momento de ser ordenados.

Firma: X \_\_\_\_\_  
Paciente o persona autorizada a firmar para el paciente

Fecha: \_\_\_\_\_ Horas: \_\_\_\_\_ AM/PM

Testigos: \_\_\_\_\_  
\_\_\_\_\_

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

Patient Name \_\_\_\_\_, Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone: \_\_\_\_\_

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**To the Patient – Please read the following statements carefully.**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations. Of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation. Understand that we may decline to treat you or to continue treating you if you revoke this Consent.

**Acknowledgement of receipt of Privacy Practices:** I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my PHI (protected health information to carry out treatment, payment activities and healthcare operations. I also authorize my Healthcare provider to discuss or release my Healthcare information

to \_\_\_\_\_,

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Name/Relationship

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.  
Please Print

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(You have the right to refuse to sign this acknowledgment)

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\_\_\_\_\_**For Office Use Only**-Acknowledgement of receipt of our Notice of Privacy Practices could not be obtained because:  
\_\_\_\_\_**Individual refused to sign**  
\_\_\_\_\_**Communication barriers prohibited obtaining signature**  
\_\_\_\_\_**An Emergency situation prevented us from obtaining signature**  
\_\_\_\_\_**Other** \_\_\_\_\_