PATIENT REGISTRATION FORMS

Health Care Services, LLC
Family Medicine and Urgent Care

Patient Last Name **First Name** **Middle Initial**

Social Security Number **Date of Birth** **Age** **Sex**

Mailing Address **City** **State** **Zip**

Email Address **Cell Phone** **Home Phone**

Marital Status (*circle one*): Single / Married / Widowed / Divorced / Separated

Race: _____ **Ethnicity**: Hispanic/Latino *or* Not Hispanic/Latino *or* Other **Language**: _____
Circle one

Primary Physician: _____ **Referring Physician**: _____

Occupation: _____ **Employer**: _____ **Phone**: _____

Pharmacy Name **Phone** **Location**

Workers Compensation or Auto Accident: ____ Yes ____ No **Date of Injury**: _____
Please circle one if applicable

Adjuster: _____ Attorney: _____

IN CASE OF EMERGENCY

Name of Local Friend/Relative: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Would you like us to supply you with an Advance Directive (Living Will)? ____ Yes ____ No
Would you like us to supply you with a Do Not Resuscitate Form (DNR)? ____ Yes ____ No

Patient Name:_____

Past Medical History

O NONE

O Heart Disease	O DVT/ Blood Clots	O Osteoporosis	O Migraine/Headache
O High Blood Pressure	O Stroke	O Arthritis	O Parkinson's Disease
O High Cholesterol	O TIA	O Multiple Sclerosis	O Alzheimer's/Dementia
O COPD/Emphysema	O Anemia	O Neuropathy	O Epilepsy/Seizures
O Asthma	O Thyroid Disorder	O GERD	O Neck/Back Condition
O Diabetes	O Cancer (Type):_____		

O Other (Please List):_____

Past Surgical History

_____

_____

Medication Allergies

_____

Current Medications

Please include Name, Dose and Frequency you take medication

Rx:_____Rx:_____

Rx:_____Rx:_____

Rx:_____Rx:_____

Rx:_____Rx:_____

Rx:_____Rx:_____

Rx:_____Rx:_____

Family History

Father: O Alive O Deceased Age_____ Medical:_____

Mother: O Alive O Deceased Age_____ Medical:_____

Paternal Grand Father: O Alive O Deceased Age_____ Medical:_____

Paternal Grand Mother: O Alive O Deceased Age_____ Medical:_____

Maternal Grand Father: O Alive O Deceased Age_____ Medical:_____

Maternal Grand Mother: O Alive O Deceased Age_____ Medical:_____

Siblings: O Alive O Deceased Age_____ Medical:_____

Children: O Alive O Deceased Age_____ Medical:_____

SELECT THE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING

ALLERGY
- o Rash
- o Runny Nose
- o Scratchy Throat
- o Itchy Eyes
- o Ear Fullness
- o Sinus Congestion

RESPIRATORY
- o Wheezing
- o Short of Breath
- o Chest Pain
- o Chest Congestion
- o Cough

CARDIOLOGY
- o Leg Pain
- o Murmur
- o High Blood Pressure
- o High Cholesterol
- o Dizziness
- o Chest Pain
- o Palpitations
- o Leg Swelling
- o Short of Breath
- o Varicose Veins

CONSTITUTIONAL
- o Chills
- o Weight Gain
- o Loss of Appetite
- o Fever
- o Weakness
- o Weight Loss
- o Fatigue

DERMATOLOGY
- o Hair Loss
- o Itching
- o Rash
- o Mole
- o Lumps
- o Dry/Sensitive Skin
- o Hives
- o Acne
- o Skin Cancer

ENDOCRINOLOGY
- o Weight Gain
- o Fatigue
- o Excessive Thirst
- o Excessive Urination
- o Weight Loss
- o Sleep Disturbance
- o Cold Intolerance
- o Heat Intolerance
- o Diabetes

EAR/NOSE/THROAT
- o Ear Pain
- o Ear Discharge
- o Trouble Swallowing
- o Nasal Discharge
- o Cough
- o Nose Bleeds
- o Hearing Loss
- o Change in Voice
- o Sore Throat
- o Ringing in Ears
- o Sinus Pain

GASTROENTEROLOGY
- o Jaundice
- o Nausea
- o Heartburn
- o Vomiting
- o Abdominal Pain
- o Trouble Swallowing
- o Diarrhea
- o Constipation
- o Blood in Stool
- o Hemorrhoids

HEMATOLOGY/LYMPH
- o Swollen Glands
- o Fatigue
- o Varicose Veins
- o Easy Bruising/Bleeding

MUSCULOSKELETAL
- o Neck Pain
- o Back Pain
- o Joint Stiffness
- o Joint Pain
- o Joint Swelling
- o Leg Cramps
- o Current Fracture
- o Carpal Tunnel

NEUROLOGY
- o Loss of Consciousness
- o Tremor
- o Head Injury
- o Neuropathy
- o Auras
- o Trigeminal Neuralgia
- o Headache
- o Tingling/Numbness
- o Seizures
- o Insomnia
- o Memory Loss
- o Dizziness
- o Gait Abnormality

OPHTHALMOLOGY
- o Eye Pain
- o Double Vision
- o Diminished Vision
- o Eye Irritation
- o Eye Drainage
- o Blurred Vision
- o Seasonal Eye Symptoms
- o Loss of Vision

PSYCHOLOGY
- o Confusion
- o Depression
- o High Stress Level
- o Sleep Disturbance
- o Suicidal Ideas
- o Eating Disorder
- o Mental/Physical Abuse
- o Anxiety

UROLOGY
- o Difficulty Urinating
- o Blood in Urine
- o Frequent Urination
- o Urinary Incontinence
- o Recurrent Infection
- o Bedwetting

SOCIAL HISTORY

Caffeine:
- o No
- o Yes: Cups Per Day____

Exercise:
- o No
- o Yes

Sexually Active:
- o No
- o Yes

Travel Outside US:
- o No
- o Yes

Marital Status:

_____

Occupation:

_____

SMOKING: *Select One*
- o Current Smoker
  Since_____
  Packs Per Day_____
- o Former Smoker
  How Many Years_____
  Packs Per Day_____
  Quit Date_____
- o Never A Smoker

ALCOHOL: *Select One*
- o Yes
  How Much_____
- o No

DRUG USE: *Select One*
- o No Drug Use
- o Former Drug Use
  Drug:_____
- o Current Drug Use

AUTHORIZATION AND AGREEMENT FOR MEDICAL TREATMENT

THE UNDERSIGNED HEREBY MAKES THE FOLLOWING ACKNOWLEDGMENTS AND AGREEMENTS REGARDING THE MEDICAL TREATMENT TO BE PROVIDED TO THE PATIENT WHOSE NAME APPEARS ON THIS FORM HEREOF:

CONSENT TO TREATMENT: I understand that medical treatment is necessary for the patient and that medical care; treatment and procedures will be performed by licensed physicians, and/or other employees of Health Care Services, LLC, herein after "HCS" during normal operating hours. I understand that medical treatment only is being provided. I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results, which may be obtained.
COMPLICATIONS: I understand that it is my responsibility to HCS to immediately report any changes in my condition.
SELECTION OF A PERSONAL PHYSICIAN: I understand that if hospitalization or further treatment is required, HCS will attempt to contact the patient's personal physician to provide service. If the patient does not have a personal physician or the personal physician cannot be contacted, HCS may select any other qualified physician to provide this care.
AGREEMENT TO PAY SERVICES: For and in consideration of the care and treatment provided to the patient not covered by insurance, I promise to pay to HCS, all charges for services rendered to or on behalf of the patient not covered by insurance. In the event the account becomes delinquent and is turned over to a collection agency or an attorney, the patient shall be responsible for any and all additional costs, fees and/or charges incurred for such collection efforts by said agency and/or attorney.
Co-Payment Responsibility: If your insurance policy requires a co-payment, this will be required at the time of service.
RELEASE OF MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS:
I hereby authorize and direct payment to HCS for medical benefits, if any, otherwise payable to me under the terms of my insurance. Furthermore, I authorize HCS and give them power of attorney to endorse/sign my name on any and all checks, drafts or money orders for payment to HCS or to any Doctor who is employed by HCS for services rendered to me as a result of injury or illness for which I have treated by said office.
CHECK APPROVAL: The following information is required prior to accepting personal checks. This form need only be completed once and will be kept on file with your medical records. Please present your driver's license at the front desk. A minimum of $25.00 service charge will be added to your account for any returned check payments in addition to any bank service charges incurred by HCS.
NOTE: All returned checks will be turned over to the state attorney for criminal prosecution. I have read and fully understand the above. The information I have provided is true to the best of my knowledge.
I acknowledge full financial responsibility for services rendered by Health Care Services, LLC or employees, and authorize transfer of all unpaid amounts to my Discover/Visa/Master Card/American Express, or any other credit card I may have used.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Health Care Services, LLC reserves the right to modify the privacy practices posted in the waiting room.
I have received a copy of the Notice of Privacy Practices for Health Care Services .
I HAVE READ THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS, AND FULLY UNDERSTAND THE SAME.

PATIENT NAME: _____

SIGNATURE:_____DATE: _____

MISSED APPOINTMENT AGREEMENT

As a courtesy, our office will do our best to confirm your appointment the day before it is scheduled. If you do not show up at your scheduled appointment time without giving a 24 hour notice, your appointment will be considered a **NO-SHOW**. There will be a $25.00 charge for a **NO-SHOW** appointment for a doctor visit and a $50.00 charge for a **NO-SHOW** diagnostic study appointment. This is our policy and it is your responsibility as the patient to know when your appointment is. Please give us at least 24 hours notice if you are unable to keep your scheduled appointment. This policy is effective as of 01/01/2013. Thank you for your cooperation and understanding.

PATIENT NAME: _____

SIGNATURE:_____DATE: _____

Medical Information Release Form
(HIPPA Release Form)

Patient Name:_____ Date of Birth:____/____/_____

Release of Information

( ) I authorize the release of information including but limited to test results, treatment plan and future appointments. This information may be released to:

( ) Spouse_____
( ) Children_____

( ) Other_____

( ) Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

( ) I give my consent to leave personal information including test results on my voicemail.
( ) Cell Phone_____

( ) Home Phone_____

( ) Other_____

( ) I do not consent to personal information being left on my voicemail. Please leave a message asking me to return your call.

External Medication History

( ) I give my consent for you to perform an external medication history search to help ensure medication accuracy.

( ) I do not give my consent for you to perform an external medication history search.

Patient Signature_____ Date_____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

First Middle Last

Mailing Address: _____ Telephone: _____

_____

The undersigned hereby requests and authorizes the release of records **from** the following:

Physician/Hospital	**Phone**	**Fax**

To the following:

- ☐ Suzann Leslie, D.O. ☐ Theresa Regis,PA-C

- ☐ 506 SW Federal Highway Suite 101, Stuart, FL 34994 Telephone: 772-288-6300 Fax: 772-288-6374
- ☐ 1889 SE Port St. Lucie Blvd. Port St Lucie, FL 34952 Telephone: 772-224-2221 Fax: 772-288-6374

- ☐ Most recent History and Physical/Office Visit/Discharge Summary or specific date(s):_____
- ☐ Most recent lab result or specific date(s): _____
- ☐ Pathology report, specific date(s): _____
- ☐ Radiology and other Diagnostic Reports/test results, specific date(s):_____
- ☐ **Entire Record (All Labs, Diagnostic Reports, Operative Notes, Pathology Reports, Office Notes)**

Certain confidential information may be in your records. Please check below to specifically authorize disclosure of:

- ☐ HIV/AIDS Test Results/Record Notations
- ☐ STD Records (Sexually Transmitted Diseases)
- ☐ Mental Health Treatment Records (excluding **Psychotherapy Notes** – **separate authorization form required for release**)
- ☐ Drug and Alcohol Treatment Records
- ☐ Genetic Testing

Purpose(s) of Request: _____

Pursuant to Florida Law and the Health Insurance Portability and Accountability Act if 1996 (HIPPA) Privacy Rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. Charges are in compliance with Florida law. I understand that once my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIPPA and may no longer be protected by HIPPA. A covered entity (that is, a source of medical information about you) may not condition, treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. I understand that I may revoke this authorization at any time, in writing, to the address listed below, **Medical Records Custodian, 506 SW Federal Hwy. Suite 101, Stuart, FL 34994,** provided that the information has not yet been released.

This authorization expires in six (6) months unless otherwise specified: _____

Patient or Authorized Signature: _____ Date: _____

Relationship to Patient: _____Witness: _____ Date: _____

Explain and/or attach Legal Documentation