

# Patient Registration Form 8/12/2014

**Janis Black, D.O.**

PATIENT INFORMATION <small>(Person seeing the Doctor today)</small>				
Last Name		First Name		Middle Initial
Home Address (Street, Apt #)			City	State Zip
Mailing Address (if different from home)			City	State Zip
Home Phone Number		Cell Phone Number		Social Security Number
Date of Birth	Gender (M-F)	Emergency Contact (Name of Person to call)		Emergency Phone Number
Patient Employer (Company Name)	Work Address (Complete: street, city, state, zip)			Work Phone Number
Referring Doctor (Doctor who referred you to us. If not referred, please write "none" or your Primary Care Physician)				Patient Marital Status
BILLING INFORMATION <small>(Person responsible for any balances not covered by insurance; also called "Guarantor")</small>				
Name of Person responsible for bill		Home Address (Complete: street, city, state, zip)		Home Phone Number
INSURANCE INFORMATION <small>(Person whose insurance is used for today's Doctor visit; also called "Subscriber")</small>				
Name of First (Primary) Insurance Company		Address of First (Primary) Insurance Company (back of ins card)		Insurance Company Phone Number
Group Number	Policy Number or Insured Person ID Number			Relationship to Patient
Subscriber Name (Policy holder of insurance)		Subscriber's Home Address (Complete: street, city, state, zip)		Subscriber's Home Phone Number
Subscriber Date of Birth	Gender (M-F)	Social Security Number	Name of Company where Subscriber works	
Name of Second Insurance Company		Address of Second Insurance Company		Insurance Company Phone Number
Group Number	Policy Number or Insured Person ID Number			Relationship to Patient
Subscriber Name (Policy holder of insurance)		Subscriber Home Address (Complete: street, city, state, zip)		Subscriber Home Phone Number
Subscriber Date of Birth	Gender (M-F)	Social Security Number	Name of Company where Subscriber works	

\*\*\* Please note: We do not file liability insurance; visits related to accidental injuries must be paid in full. You will be given a receipt to file the liability claims with the insurance for reimbursement.

\*\*\* List any person with legal Power of Attorney for you. A copy of the Power of Attorney must be provided for your chart.

\_\_\_\_\_  
(Name of Person with Power of Attorney)

\*\*\*\*I authorize Family Health Center at Port St John to access and view my prescription history from external sources Signature \_\_\_\_\_

AUTHORIZATION: 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 and referring physician any information needed including diagnosis and records of any treatment or examination rendered to me to process this claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable or authorize Family Health Center at Port St John to submit a claim to my insurance, including Medicare, for payment on my account. I understand that I will receive monthly statements reflecting my balance and that the FINAL PAYMENT of these accounts remains my responsibility.

\_\_\_\_\_  
(Patient / Legal Guardian's Signature)

\_\_\_\_\_  
(Date)

## Patient Information Form

Please fill out form completely (check no or does not apply), please do not leave questions blank, unless indicated. The more information you provide enables the physician to provide better care.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Email Address: \_\_\_\_\_ May we email you with Appt reminders? \_\_\_\_\_

Occupation: \_\_\_\_\_ Retired? \_\_\_\_\_

Birth date: \_\_\_\_\_ Birthplace: \_\_\_\_\_ Lived outside of US?: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Who referred you to see the doctor today? \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

### Past Medical History

**Allergies** Do you have any food or drug allergies? If so, please list below and describe.

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

Have you had any reactions to IVP dye used for X-ray studies? \_\_\_yes \_\_\_no

**Medications** For any additional medications please continue on back of form.

Name of Medication	Dose	Instructions	Prescribing Physician
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Herbs, supplements, vitamins:

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

### **Surgeries:**

Year	Surgery	Hospital	Doctor

Have you ever been advised to have a surgical operation that was not done? \_\_\_Yes \_\_\_No

If yes, explain. \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever had radiation or chemotherapy? \_\_\_Yes \_\_\_ No If yes, please explain.

Start Date      End Date

Month	Year	Month	Year	Area Treated	Hospital	Doctor

Blood Transfusions \_\_\_Yes \_\_\_No When \_\_\_\_\_

Illnesses (rheumatic fever, polio, TB, hepatitis, meningitis, malaria) \_\_\_\_\_

**Do you see a Specialist** (Cardiologist, OBGYN, Pulmonologist, Urologist, etc.)

Specialty	Doctor's name	Phone/fax	City, State	Last visit

**Family History**

Relation	Age	High Blood Pressure High Cholesterol Heart Disease/Stroke Heart Attack	Diabetes	Cancer (What kind and age at Diagnosis)	Lung Disease COPD Emphysema	Seizures Neurological Disorders	Mental Illness Suicide Depression Alcoholism	Rheum Arthritis Lupus	Other Medical Concern	Age at Death
<u>M</u> Grandfather										
<u>M</u> Grandmother										
<u>P</u> Grandfather										
<u>P</u> Grandmother										
Father										
Mother										
Brothers										
Sisters										
Children										
Other relatives										

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Personal History**

**Do you use any medical devices?** Check all that apply.    \_\_\_glasses \_\_\_ hearing aids  
\_\_\_walker \_\_\_wheelchair \_\_\_oxygen \_\_\_Cpap \_\_\_Other\_\_\_\_\_

What medical equipment company do you use? \_\_\_\_\_

**Smoking:**

Do you currently smoke cigarettes? \_\_\_Yes \_\_\_No If not, did you previously? \_\_\_Yes \_\_\_No

If you stopped, when was it? \_\_\_\_\_ How many years have you smoked? \_\_\_\_\_

During the entire time, what is the average number of packs per day smoked? \_\_\_\_\_

Do you smoke a pipe or cigars? \_\_\_Yes \_\_\_No. If yes, how long? \_\_\_\_\_

Do you or did you use snuff/chewing tobacco? \_\_\_Never \_\_\_Past \_\_\_Current-How Long\_\_\_\_\_

**Alcohol:**

Do you drink any alcoholic beverages? \_\_\_Current \_\_\_Former What kind? \_\_\_\_\_

How much? \_\_\_1-2 \_\_\_2-3 \_\_\_4+ How often? \_\_\_\_\_ Daily, Weekly, Weekends, Rarely.

Has it ever interfered with your personal or professional life? \_\_\_Yes\_\_\_No If yes,explain  
\_\_\_\_\_

Have you ever been treated for this? \_\_\_\_\_

**Drug Use:**

Have you ever used illegal/recreational drugs? \_\_\_Current \_\_\_Past \_\_\_Never

If yes, what kind? \_\_\_\_\_ how often? \_\_\_\_\_

Have you ever had formal treatment for this? \_\_\_\_\_

Have you ever been addicted to or abused prescription medication? \_\_\_\_\_

**Women only:**

Last Menstrual Period : \_\_\_\_\_ Might you be pregnant? Yes\_\_\_ No\_\_\_ Unsure\_\_\_

Contraceptive Method None\_\_\_ Pills \_\_\_ Condoms \_\_\_ Surgical \_\_\_ Menopause \_\_\_ Other \_\_\_

Number of times pregnant: \_\_\_\_\_ # of Deliveries: \_\_\_\_\_ # of Children \_\_\_\_\_

Last Pap Smear: \_\_\_\_\_ Performed By Dr: \_\_\_\_\_ Results: \_\_\_\_\_

Prior abnormal Pap? \_\_\_\_\_ When? \_\_\_\_\_ Last Mammo? : \_\_\_\_\_

Action taken for abnormal pap? Repeat exam \_\_\_ Cryotherapy \_\_\_ Cone \_\_\_ LEEP \_\_\_ Other \_\_\_

**Testing:**

Colonoscopy or Other Bowel or Digestive Studies? (Why, When, Results, When to Repeat?) \_\_\_\_\_

Stress Test/Cardiac Cath/EKG/Heart Studies? (Why, When, Results, Actions Taken/Advised?) \_\_\_\_\_

Have you ever had a DEXA scan (Bone Density Scan) done? \_\_\_\_\_

**Vaccines:**

Flu Vaccine? \_\_\_\_\_ Pneumonia Vaccine? \_\_\_\_\_

Shingles Vaccine? \_\_\_\_\_ Tetanus Vaccine? \_\_\_\_\_

Have you completed your Hepatitis B series? \_\_\_\_\_

**Patient Portal**

Have you been given information about our patient portal? \_\_\_\_Yes \_\_\_\_No

Would you like more information about our Patient Portal where you can login and access your lab results, appointment times, and visit summaries? \_\_\_\_Yes \_\_\_\_No

Our office would be happy to provide you with more information about our new Patient Portal and provide you will your login information, please ask our staff.

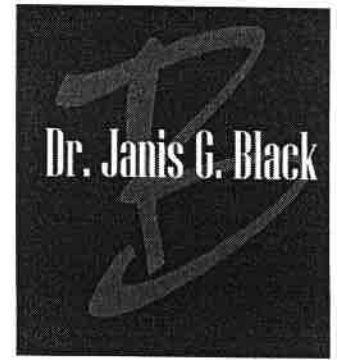
**What Three things would you like to discuss with Dr. Black today?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Thank you for completing this information it will enable us to give you the best possible care.**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Family Health Center at Port St John  
Dr. Janis G. Black  
Tanya Schrupf, DC, APRN  
Tamara Edelstein, APRN  
3740 Curtis Blvd, Suite 108  
Port St John, FL 32927  
(321)633-5500 Fax (321)633-5566



**No Show, Late Cancellation, and Unconfirmed Appointment Notice**

Due to the high demand for appointments and the number of no shows and late cancellations, The Family Health Center at Port St. John has had to institute a policy regarding these broken appointments.

No shows and Late Cancellations waste the doctors' limited appointment availability. They adversely affect the care provided to our patients by wasting appointment times that would otherwise be used by sick patients or patients who are requesting to be seen sooner.

If you are unable to make your appointment, you will need to cancel by calling the office at least 24 hours in advance of your scheduled appointment time so that the time-slot can be used for another patient. Failing to do so may result in a fee being billed to your account in the amount of \$25.00. This fee is not covered by insurance and the patient is responsible for paying this before their next appointment. You may cancel your appointments by calling our office at 321-633-5500. If it is after business hours you must leave a detailed message about your cancellation.

Our office makes two attempts to confirm your appointment by calling 48 hours prior and again 24 hours prior. You are responsible for verbally confirming your appointment with our office. If you are unable to call until after hours, please leave a detailed message confirming your appointment. Failing to do so may require us to reschedule your appointment to a later date.

Consecutive no shows or late cancellations will result in discharge from the practice, as we are unable to properly provide the quality of care that is necessary when appointments are not kept.

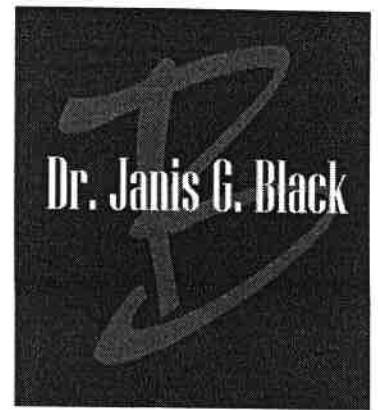
Your signature below indicates that you understand the policy, and agree to be responsible for no show appointments, late cancellations, and unconfirmed appointments.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

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

Witness \_\_\_\_\_ Date \_\_\_\_\_

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Acknowledgement of receipt of HIPAA notice of privacy practices.

I have received a copy of Dr. Janis Black's HIPAA Notice of Privacy Practices. The notice describes how medical/protected health information may be used and disclosed. I understand that I should read it carefully, I am aware that the notice may be changed at any time. I may obtain a revised copy of the notice by requesting one from Dr. Black or her staff.

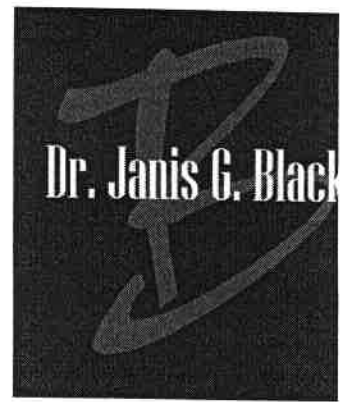
Initial below:

\_\_\_\_\_ I am accepting a copy at this time.

\_\_\_\_\_ I am refusing a copy, but am aware that I can request a copy at any time.

If you have any questions regarding our HIPAA Policy please feel free to ask our staff.

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## Authorization to disclose health information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize the Family Health Center at Port St. John to share my personal health information, such as test results, medications, appointment times, and other details in relation to my care, with the following person(s)”

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

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

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

I understand that certain information relating to my health such as HIV/AID status, behavioral health services and psychiatric care, and drug and alcohol treatments will not be disclosed without my written permission.

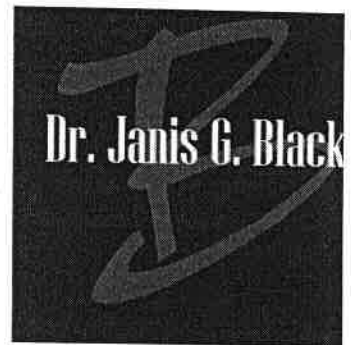
I also understand that I have the right to revoke this authorization at any time. Unless revoked, this authorization will not expire. If I have any questions about the disclosure of my health information, I can contact Dr. Black’s office at (321)633-5500.

\_\_\_\_\_  
Patient signature Date

\_\_\_\_\_  
Witness signature Date



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**Authorization to release health information**

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I Authorize: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**To release the following health records:**

\_\_\_\_ Complete health record      \_\_\_\_ Consultation reports      \_\_\_\_ EKG/Cardiac Testing  
\_\_\_\_ History and Physical      \_\_\_\_ Progress Notes      \_\_\_\_ Labs/X-ray Reports  
\_\_\_\_ Medication list      \_\_\_\_ Immunizations      \_\_\_\_ Other

In compliance with Florida Statutes which require special permission to release otherwise privileged information, please release records pertaining to: **(PATIENT MUST INITIAL)**

\_\_\_\_ HIV/AIDS results      \_\_\_\_ Substance abuse/treatments      \_\_\_\_ Developmental disabilities

**Purpose of need for disclosure:**

\_\_\_\_ Further Medical Care      \_\_\_\_ Payment of Claim      \_\_\_\_ Legal      \_\_\_\_ School  
\_\_\_\_ Application for Insurance      \_\_\_\_ Disability Claim      \_\_\_\_ Personal      \_\_\_\_ Other

**Please release this information to:**

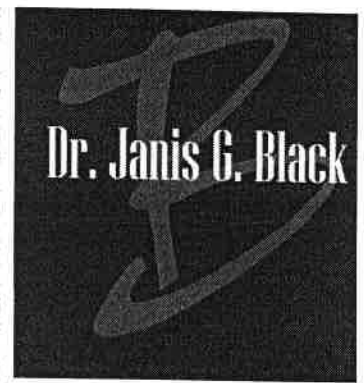
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Phone: (321) 633-5500 Fax: (321) 633-5566**

I am aware that the release of information carries the potential for an authorized re-disclosure and the information may not be protected under federal confidentiality laws. I may contact the number above with any questions or concerns regarding my health information.

I understand that this authorization expires in 90 days and that I may revoke it at any time.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Witness Name \_\_\_\_\_ Date \_\_\_\_\_

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**Advance Directives**  
(For Compliance The Patient Self Determination)

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Have you executed an Advance Directive? \_\_\_\_\_ Yes \_\_\_\_\_ NO

If yes, is this directive in the form of:  
(Circle your answer)

- A LIVING WILL
- A DURABLE POWER OF ATTORNEY
- A HEALTHCARE SURROGATE

If you have executed Advance Directives in any of these forms, have you provided this office with a copy for your medical records? \_\_\_\_\_ Yes \_\_\_\_\_ No

If you would like more information regarding Advance Directives, please ask our staff.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

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