Patient Registration Form 8/12/2014

Janis Black, D.O.

Family Health Center at Port St. John
3740 Curtis Blvd, Suite 108
Cocoa, FL 32927

PATIENT INFORMATION *(Person seeing the Doctor today)*

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 *(Person responsible for any balances not covered by insurance; also called "Guarantor")*

Name of Person responsible for bill	Home Address *(Complete: street, city, state, zip)*	Home Phone Number

INSURANCE INFORMATION *(Person whose insurance is used for today's Doctor visit; also called "Subscriber")*

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

_____

_____

_____

_____

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. _____

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
M Grandfather										
M Grandmother										
P Grandfather										
P 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
Deanna Pichler, PA-C
3740 Curtis Blvd, Suite 108
Port St John, FL 32927
(321)633-5500 Fax (321)633-5566

LAB PREFERENCES

As your healthcare provider we may collect specimens that will need to be sent out to a laboratory for testing. We kindly ask that our patients be informed on which area laboratories participate with their insurance plan as we have a large volume of patients with many different types of insurance.

Your personal selection of a laboratory helps avoid error so that you are not left responsible for any charges due to your specimen being sent to the incorrect laboratory. If you are unsure about which laboratories accept your insurance please call the number listed on the back of your insurance card.

By signing below I am accepting that I understand it is my responsibility to know which laboratories are contracted with my insurance; it is also my responsibility to notify Dr. Black's office if this changes at any time. I have verified that the laboratory I have chosen below accepts my insurance and I understand that if it does not I will be responsible for any fees incurred from testing. As with all insurance, if my insurance company chooses not to pay for any tests performed I will be financially responsible.

The laboratory I wish for my specimens to be sent to is:

- ○ Family Health Center at Port St. John in house lab
- ○ Lab Corp
- ○ Health First
- ○ Quest Diagnostics
- ○ Wuesthoff
- ○ Parrish Medical Center
- ○ I am self pay and have no preference for which laboratory my specimens are sent to
- ○ I am self pay – however I do prefer the laboratory I have chosen

Patient's Printed Name:_____

Patient's Signature:_____ **Date:**_____

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of Dr. Janis G. Black's HIPAA Notice of Privacy Practices ("Notice"). The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. In addition, 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.

Please initial below:

___ I am accepting a copy at this time.

___ I am refusing a copy, but I am aware that I can request a copy at anytime.

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

Print Name:_____ **Date**_____

Signature:_____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____ Phone Number:_____

The following information/records **WILL NOT** be disclosed without the patient's authorization or the patient's Power of Attorney or Healthcare Surrogate's Authorization:

- Acquire Immunodeficiency Syndrome (AIDS)
- Infection with Human Immunodeficiency Virus (HIV)
- Behavioral Health Services and/or Psychiatric Care
- Treatment for Alcohol and/or Drug Abuse

I authorize Dr. Black and her staff to share my personal medical information, such as appointment times, test results, medication issues, etc. and other details in relation to my care, with the following person(s):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand that I have the right to revoke this authorization in writing at any time. Unless revoked, this authorization will not expire. If I have questions about the disclosure or my health information, I can contact Dr. Black's office staff at: 321-633-5500.

Patient Signature: _____Date: _____

Witness Signature:_____Date:_____

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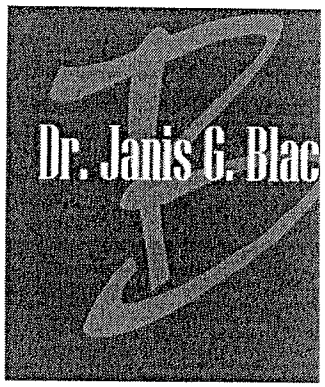

"NO SHOW" AND "LATE CANCELLATION" POLICY FORM

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 patient by wasting appointment times that would otherwise be used by 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 results in a fee being billed to your account in the amount of $25.00. You may cancel your appointments by calling our office at 321-633-5500.

This fee is for patients who miss their scheduled appointment or do not cancel within the 24 hour period. These fees are not covered by your insurance and you will be responsible for payment. Your signature below indicated that you understand the policy, and agree to be responsible for missed appointments.

Patient Name_____ Date _____

Patient Signature_____

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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 & Physical _____Progress Notes _____Labs/X-Ray Reports
_____Medication List _____Immunizations _____Other

In compliance with Florida Statues which require special permission to release otherwise privledged information, please release records pertain to: (Patient MUST Initial) :_____Mental Health
_____HIV Test Results _____Alcohol Treatment
_____AIDS/AIDS related Illness _____Developmental Disabilities _____Drug Treatment

Purpose of need for disclosure: (Check all that apply)

_____Further Medical Care _____Payment of claim _____Legal _____School/Academic
_____Application for insurance _____Disability Claim _____Persona l____Other

Please release this information to:

Family Health Center at Port St. John
3740 Curtis Blvd Suite 108
Port St. John Florida 32927
Ph: (321) 633-5500 Fax: (321) 633-5566

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

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

Patient Signature_____Date_____
Witness Signature_____Date_____

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ADVANCE DIRECTIVES

(For Compliance with 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 an Advance Directive in any of these forms, have you provided the 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:_____