Women's Healthcare of Boca Raton

Please fill out this registration form as completely as possible.
Return this form with your insurance card(s) and drivers license to the receptionist.

Date ___/___/___

PATIENT

Patient Name _____

Local Address _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Work ( ) _____ Ext _____

2nd Address _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Cell ( ) _____

Marital Status _____ Sex M F Date of Birth ___/___/___

Social Security # ___-___-___ Drivers Lic # _____

Employed by _____ Position _____

Address _____

Family Physician (PCP) _____ Phone ( ) _____

SPOUSE/OTHER (if applicable)

Name _____ Date of Birth ___/___/___

Employer _____

Address _____

Work Phone ( ) _____ Cell ( ) _____

INSURANCE

Primary Plan _____ (HMO,PPO,POS,EPO,OTHER _____)

ID# _____ GROUP# _____

Name of Insured _____ Relationship to Patient _____

Insured Social Security # ___-___-___ Insured Date of Birth ___/___/___

Secondary Plan _____ (HMO,PPO,POS,EPO,OTHER _____)

ID# _____ GROUP# _____

Name of Insured _____ Relationship to Patient _____

Insured Social Security # ___-___-___ Insured Date of Birth ___/___/___

EMERGENCY CONTACT INFORMATION

Name of Insured _____ Relationship to Patient _____

Home Phone ( ) _____ Work ( ) _____ Ext _____

Cell ( ) _____ Pager Cell ( ) _____

REASON FOR YOUR VISIT TODAY

_____

_____

_____

_____

SOCIAL ISSUES

Tobacco ____No ____Yes

packs per day _____

Alcohol ____No ____Yes

Amount _____

List Medications currently taking

_____

_____

_____

_____

_____

_____

Allergies to medications or food

_____

_____

Do you have advance directives (Living Will)? ____No ____Yes

Primary Language Spoken _____

PHARMACY

Name _____

Location _____

_____

Phone ( ) _____

Do we have permission to:

Leave a message on your answering machine at home? _____

Leave a message at your place of employment to return our call? _____

Discuss your medical condition with any member of your household? _____

If yes, whom? _____ Relationship _____

Payment is due at the time services are rendered as well as any copays or deductibles due in connection with your insurance plan.

FINANCIAL AGREEMENT:

I have presented my insurance information to the physicians of Premier Women's Healthcare, and or their staff, and to the best of my knowledge, it is accurate and correct. I agree to be responsible for any applicable co-payments and or deductibles. If the insurance information upon verification is inaccurate, incorrect, expired or otherwise not in effect at this time, I will be personally responsible for the charges for medical services.

I hereby authorize payment for services medical and/or surgical, rendered to me by Premier Women's Healthcare, not paid by me, to be paid directly to Premier Women's Healthcare. If my current policy, due to policy provisions, prohibits payment directly to the doctor then I hereby also instruct my insurance company to make check payable to both myself and Premier Women's Healthcare. I further understand and agree that regardless of any insurance status I am ultimately responsible for the balance of my account, including deductible, co-insurance, and other amounts deemed not payable due to policy provisions.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Premier Women's Healthcare to release any information acquired during the course of my care or examination to my insurance company and/or physician(s) involved in my care. I hereby authorize any other holders of medical records or other information to release such records to Premier Women's Healthcare.

INSURANCE NOTICE:

Under Florida law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgement arising from claims of medical malpractice. This notice is pursuant to Florida law.

Acknowledgement of receipt of notice of privacy practices: I have been presented with a copy of the notice of privacy practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I authorize the release of any medical information necessary to process my claims. I also authorize payment of medical benefits to physician or supplier of service as indicated on claim. In the event it is necessary to refer my account to a collection agency or an attorney, I agree to pay all collection costs, including attorney fees and court costs.

I WISH TO PLACE THE FOLLOWING RESTRICTIONS ON DISCLOSURE OF MY HEALTH INFORMATION

_____

_____

Patient signature _____ **Date** _____

(INTERNAL USE ONLY) If patient/patients' representative refused to sign acknowledgement, please document date and time notice was presented to patient and sign below

Presented on (date and time): _____

By (Name and title): _____

MEDICARE PATIENTS ONLY:

If you have a supplemental policy and it is a Medigap policy to which your Medicare carrier automatically "crosses over", we are requested to keep a separate signature on file.

I request authorized Medigap benefits be made on my behalf for any services furnished to me by Premier Women's Healthcare. I authorize any holder of medical information to release the above Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on Medigap or Insurance Card _____ Date

PATIENT NAME : _____

EMAIL : _____

(please print)

Do we have permission to :

Confirm appointments via email? _____

Send results to you via email? _____

I decline any contact via email:_____

(patient signature)

Notice of Privacy Practice Acknowledgement

Women's Healthcare of Boca Raton

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

Patient: _____ Date: _____

REVIEW OF SYSTEMS

Do you now have any problems related to the following systems? Circle Yes or No

Constitutional Symptom

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other	Y	N

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other	Y	N

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other	Y	N

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/Tingling	Y	N
Other	Y	N

Endocrine

Excessive thirst	Y	N
Too hot/Too cold	Y	N
Tired/sluggish	Y	N
Other	Y	N

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other	Y	N

Cardovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other	Y	N

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other	Y	N

Muscoskeletal

Joint pain	Y	N
Knee pain	Y	N
Back pain	Y	N
Other	Y	N

Ear/ Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problem	Y	N
Other	Y	N

Genitourinary

Urine Retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other	Y	N

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other	Y	N

Hematologic/Lymphatic

Swollen glands	Y	N
Blood Clotting Problem	Y	N
Other	Y	N

Psychiatric

Are you unhappy with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other	Y	N