Sample Family Medicine

5596 W Sample Road
Margate, FL 33073
(954)-968-4000

PATIENT INFORMATION

Name: (L/F/M) _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: M ____ F ____

Marital Status: M ____ S ____ D ____ W ____ Spouse Name: _____

Telephone #: _____ Can we leave a message at this number regarding appointments/results? Yes ___ No ___

Cell Phone #: _____ Can we leave a message at this number regarding appointments/results? Yes ___ No ___

Email Address: _____ Can we leave a message at this address regarding appointments/results? Yes ___ No ___

Patient's Place of Employment: _____ Occupation: _____

Work Telephone #: _____ Can we leave a message at this number regarding appointments/results? Yes ___ No ___

Emergency Contact: _____ Relationship: _____

Telephone #: _____ Primary Language: _____

How did you hear about us? _____

INSURANCE INFORMATION

Insured's Name: _____ Insured's SS #: _____ Date of Birth: _____

Insurance Company: _____ Policy #: _____ Group #: _____

Insurance Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Telephone #: _____ Effective Date: _____ Termination Date: _____

ADVANCE DIRECTIVE

A. Do you have a Health Care Surrogate? Yes: _____ No: _____

   Name of Health Care Surrogate: _____ Relationship: _____ Telephone #: _____

B. Do you have a Living Will? Yes: _____ No: _____

   Person that a representative can speak to regarding my conditions: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize that the information contained in my chart, on my registration form, is correct. I understand this information is necessary for the processing of my claims and to ensure proper medical care. I authorize Sample Family Medicine, LLC and its physicians to treat me. I authorize the release of my medical or any other information necessary to process any claims. I also request payment of governmental benefits either to myself or to the party who accepts assignment and payments of medical benefits to Sample Family Medicine, LLC by my insurance company for services provided. I agree that I am responsible for all charges which are not authorized as covered by my insurance company or government agency.

Signature: _____ Date: _____

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HEALTH HISTORY QUESTIONNAIRE

All questions in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.)	**DOB:**
Previous or referring doctor:	**Date of last physical exam:**

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Vaccine	**Year of Last**	**Test / Exam**	**Year of Last**	**Test / Exam**	**Year of Last**
Tetanus		Rectal / Stool		Echocardiogram	
Flu		Cholesterol		Stress Test	
Pneumonia		Tuberculosis		CXR	
MMR		Mammogram		Pap Test	
Hepatitis B	_____	Prostate Exam		Bone Density	_____

List any medical problem that other doctors have diagnosed:

	Yes	No		Yes	No		Yes	No
Hypertension			Heart Disease			Hyperlipidemia		
Diabetes			Lung Disease			Cancer		
Coronary Artery Disease			Depression			GERD		
Thyroid Disease			Anxiety			Kidney Disease		
Migraines			Arthritis			Osteoporosis		

Surgeries:

Year	Reason	Hospital

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HEALTH HISTORY QUESTIONNAIRE

Other Hospitalizations:		
Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No**

Pharmacy Name: _____ Phone #: _____ Fax #: _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:		
Name of Drug	Strength	Frequency Taken

Drug Allergies & Reactions: _____

Are you allergic to:

Food	☐ Yes	☐ No	Peanuts	☐ Yes	☐ No
Iodine	☐ Yes	☐ No	Pollen	☐ Yes	☐ No
Adhesive Tape	☐ Yes	☐ No	Animal Dander	☐ Yes	☐ No
Shellfish	☐ Yes	☐ No	Latex	☐ Yes	☐ No

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HEALTH HABITS & PERSONAL SAFETY

All questions in this questionnaire are optional and will be kept strictly confidential.

Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting? ☐ Yes ☐ No			
	If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No			
	# of meals you eat in an average day			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups / cans per day			
Alcohol	Do you drink alcohol? ☐ Yes ☐ No			
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?			
Tobacco	Do you use tobacco? ☐ Yes ☐ No			
	☐ Cigarettes - pks / day	☐ Chew - # / day	☐ Pipe - # / day	☐ Cigars - # /day
	☐ # of years	☐ Or year quit		
Drugs	Do you currently use recreational or street drugs? ☐ Yes ☐ No			
	If yes, please list:			
	Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No			
Sex	Are you sexually active? ☐ Yes ☐ No			
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with the provider about risk of this illness? ☐ Yes ☐ No			
Personal Safety	Do you live alone? ☐ Yes ☐ No			
	Do you have frequent falls? ☐ Yes ☐ No			
	Do you have vision or hearing loss? ☐ Yes ☐ No			
	Physical and/or mental abuse has become a major health issue in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐ Yes ☐ No			

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children	☐ M ☐ F	
				☐ M ☐ F	
				☐ M ☐ F	
Mother				☐ M ☐ F	
				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		Grandmother Maternal		
	☐ M ☐ F		Grandfather Maternal		
	☐ M ☐ F		Grandmother Paternal		
	☐ M ☐ F		Grandfather Paternal		

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HEALTH HABITS & PERSONAL SAFETY

Mental Health	
Is stress a problem for you?	☐ Yes ☐ No
Do you feel depressed?	☐ Yes ☐ No
Do you panic when stressed?	☐ Yes ☐ No
Do you have problems with eating or your appetite?	☐ Yes ☐ No
Do you cry frequently?	☐ Yes ☐ No
Have you ever attempted suicide?	☐ Yes ☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes ☐ No
Do you have trouble sleeping?	☐ Yes ☐ No
Have you ever been to a counselor?	☐ Yes ☐ No
Women Only	
Age at onset of menstruation	
Date of last menstruation	
Period every days	
Heavy periods, irregularity, spotting, pain or discharge?	☐ Yes ☐ No
Number of pregnancies Number of live births	
Are you pregnant or breastfeeding?	☐ Yes ☐ No
Any urinary tract, bladder, or kidney infections within a year?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Any problems with control of urination?	☐ Yes ☐ No
Any hot flashes or sweating at night?	☐ Yes ☐ No
Do you have menstrual tension, pain, bloating, irritability, or symptoms at or around time of period?	☐ Yes ☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes ☐ No
Men Only	
Do you usually get up to urinate during the night?	☐ Yes ☐ No
If yes, # of times	
Do you feel pain or burning with urination?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Do you feel burning discharge from your penis?	☐ Yes ☐ No
Has the force of your urination decreased?	☐ Yes ☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes ☐ No
Do you have any problems emptying your bladder completely?	☐ Yes ☐ No
Any difficulty with erections or ejaculation?	☐ Yes ☐ No
Any testicle pain or swelling?	☐ Yes ☐ No

Other Problems

Check if you have, or had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest / Heart	Recent changes in:
☐ Head / Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	
☐ Lungs	☐ Circulation	

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NOTICE
LABORATORY BILLING INFORMATION

We are providing In House Lab Draw as a convenience to our patients.

Please be advised that lab tests ordered by your physician may NOT be covered by your insurance carrier. Laboratory testing services may require some out-of-pocket expenses for deductibles, co-pays, co-insurance and non-covered services. We cannot guarantee reimbursement from your insurance carrier and we are not responsible for any testing that is not covered by your insurance carrier. You may receive a bill from the lab directly (Quest, LabCorp) for any balance that your insurance carrier did not cover.

Choose One:	**NO:** I have decided not to receive these services. **YES:** I want to receive these services.
Print Name:	**Patient or Guardian Signature:**

Regarding Test Results

Lab results are posted on our patient portal once reveiwed
Upon leaving the office, please make sure you receive your patient portal information

NO SHOW NOTICE

There will be a no show charge of $20 for any appointment that is missed or any appointment that is not cancelled with 24 hour notice.

Print Name:	**Patient or Guardian Signature:**

Referral Process

This applies for all insurances that require referrals:

We have given you all the tools in order to make your necessary appointments.
Due to a high volume of referral requests, please allow 3 to 5 business days for referrals to be processed.
We will no longer issue same day referrals.
If there is a need for urgency, please contact our referral coordinator directly.
If the referral coordinator has not responded to your email or voicemail within 24 hours, please call the office and ask to speak with them directly.

Referral Coordinator Contact Info	**Sample Family Medicine** **Phone: 954-968-4000**

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Notice of Privacy Acknowledgement

Sample Family Medicine, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected 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

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ ID Number: _____

Date of Birth: _____

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons / organizations providing the information:	**Persons / organizations receiving the information:**
Specific description of information (including dates):	**Purpose of requested use or disclosure:**

The patient or the patient's representative must read and initial the following statements:

		Initials
1.	I understand that this authorization will expire on ____ / ____ / ____ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.

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E-mail Consent Form

Patient Name _____ Date _____

Patient E-mail address _____ _____ Patient phone number _____

The LLC and its Staff Members shall be referred to throughout this consent form as "Provider".

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but are not limited to, the following risks:

a. E-mails can be circulated, forwarded, and stored in numerous paper and electronic files.

b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.

c. E-mail senders can easily type in the wrong e-mail address.

d. E-mail is easier to falsify than handwritten or signed documents.

e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.

f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.

g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.

h. E-mail can be used to introduce viruses into the computer system.

i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.

b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.

c. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

e. It is the patient's responsibility to follow-up and/or schedule an appointment.

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E-mail Consent Form

3. PATIENT RESPONSIBILITIES AND AND INSTRUCTIONS:

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.
b. Inform Provider of changes in his/her e-mail address.
c. Confirm that he/she has received and read the e-mail from the Provider.
d. Put the patient's name in the body of the e-mail.
e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing, and questions).
f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
g. Withdraw consent only by e-mail or written communication to Provider.

4. TERMINATION OF THE E-MAIL RELATIONSHIP:

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

PATIENT ACKNOWLEDGEMENT, AGREEMENT AND HOLD HARMLESS

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have / had were answered.

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (print)_____

Patient Signature _____ Date _____

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RECORD RELEASE AUTHORIZATION

To: _____

_____

_____

I hereby authorize and request the release of copies of the following information:

_____ Complete Medical Record _____ X-Rays _____ Laboratory

_____ Procedure Reports Other: _____

(Including current an previous medical records from other practices and practitioners, hospitals, and/or clinics, which are a part of my medical records.)

TO:

Sample Family Medicine
Sample Family Medicine, LLC
5596 W. Sample Rd
Margate, FL 33073

Phone (954) 968-4000 · Fax (954) 968-4099

Patient Name: _____ Date of Birth: _____

Phone #: _____

Signature: _____ Date: _____

Signature of Witness: _____ Date: _____

_____ Single Disclosure. _____ Continuing Disclosure for 120 days. Expiration date: _____

I hereby release the facility from any liability which may arise as a result of the use of the information contained in the records released.

Note: There is a fee of $1.00 per page for the first 20 pages and 35 cents per page thereafter.