YOUNG at HEART
FAMILY MEDICINE, LLC

TopLine MD Alliance

# PATIENT REGISTRATION FORM

## Patient Information

Name:_____ Date of Birth:_____
*First, Middle and Last name as it appears on insurance card*

Sex: ❍ Male ❍ Female Social Security Number:_____

Marital Status: ❍ Single ❍ Married ❍ Widow ❍ Divorced ❍ Other:_____

Race/Ethnicity: ❍ Asian ❍ Black ❍ Hispanic ❍ Pacific Islander ❍ White ❍ Other:_____

Check one: ❍ Employed ❍ Retired ❍ Full-Time Student ❍ Other:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Primary Care Physician:_____ Phone:_____

## How did you hear about us?

❍ Our Website ❍ Insurance website or list ❍ Referred by Doctor_____

❍ Newspaper ❍ Mailing (letter or postcard) Doctor Phone #_____

❍ Radio ❍ Another patient (family or friend) ❍ Other_____

## Insurance Information

*Please provide your insurance card to the receptionist*

❍ Commercial ❍ Medicaid ❍ Medicare ❍ Worker's Compensation ❍ Other:_____

Insurance Company: _____

Insured/Card Holder's Name:_____ Birthdate:_____

Relationship:_____ Phone #:_____

Policy #:_____ Group #:_____

## Secondary Insurance Information

*Please provide your insurance card to the receptionist*

❍ Commercial ❍ Medicaid ❍ Medicare ❍ Worker's Compensation ❍ Other:_____

Insurance Company: _____

Insured/Card Holder's Name:_____ Birthdate:_____

Relationship:_____ Phone #:_____

Policy #:_____ Group #:_____

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# PATIENT REGISTRATION FORM *cont.*

## Emergency Contact

Name:_____ Sex: ❍ Male ❍ Female
*First, Middle and Last Name*

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Social Security Number:_____

## Pharmacy

Pharmacy Name:_____ Phone #:_____

Pharmacy Address:_____

## Spouse/Guarantor/Responsible Party

Name:_____ Date of Birth:_____
*First, Middle and Last Name*

Sex: ❍ Male ❍ Female Relationship:_____

Daytime Phone:_____ Social Security Number:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Employer Name: _____

Employer Address:_____

City:_____ State:_____ Zip Code:_____

**Your appointment time has been set aside for you alone; no other patients are scheduled at the same time. If you can't keep it, kindly cancel in advance. There will be a $ 50.00 charge for missed appointments. Initials_____**

I hereby authorize payment, directly to Young at Heart Family Medicine, LLC of benefits due to me from my insurance company, otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for charges, lab work and vaccines not covered by my insurance contract as performed in the office, and for any co-payments and/or deductible amounts as specified in my insurance contract. I acknowledge that Private Health Information material (HIPAA) is posted, and available upon request.

_____ _____ _____
Patient Name 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:

Young at Heart Family Medicine, LLC
9750 NW 33rd St, Suite 105
Coral Springs, FL 33065
Phone: (754) 336-7119 Fax: (754) 336-6390

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.**

# NOTICE OF PRIVACY PRACTICES

https://www.toplinemd.com/practice-terms-policies/

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") provides me with certain rights regarding the privacy of my protected health information. I acknowledge that I have been provided access to the Practice's Notice of Privacy Practices through a QR code and/or website link and have been given the opportunity to review it. I understand that the Practice may revise its Notice of Privacy Practices from time to time and that I may access the most current version by using the QR code and/or website link.

Patient Signature: _____

Patient or Legal Guardian Name (print): _____

Date: _____

**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: _____

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## Lab Fee Policy

There will be an additional fee of $25.00 when using our in-house laboratory services. This fee is separate from your office visit charges.

If you choose not to have your laboratory work drawn in-house, please notify a member of our staff. You will be provided with a laboratory order to have your labs drawn at a participating external provider (such as Quest Diagnostics or LabCorp).

Please indicate your selection below:

☐ YES – I choose to have my laboratory work drawn in-house and understand the $25.00 lab fee applies.

☐ NO – I do not wish to have my laboratory work drawn in-house and request an external lab order.

By signing below, I acknowledge that I have read and understand the Lab Fee Policy and my selection above.

Patient Name: _____

Signature: _____

Date: _____

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# Patient History Form

Name _____ Date of birth _____ Date of appointment _____

**Sex at birth**

◯ Male ◯ Female

**Gender Identity (Optional)**

◯ Male ◯ Female ◯ Non-binary

## Patient Information

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

**Previous or referring doctor**

_____

Primary or other

**Date of last physical exam**

_____

(MM/DD/YYYY)

## Personal Health History

**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**

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

| Surgery Year | Surgery Reason | Surgery Hospital |
|---|---|---|
| | | |
| | | |
| | | |

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# Patient History Form

Name | Date of birth | Date of appointment

**Sex at birth**

◯ Male ◯ Female

**Gender Identity (Optional)**

◯ Male ◯ Female ◯ Non-binary

**Other Hospitalizations**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

**Have your ever had a blood transfusion?** ◯ Yes ◯ No

**Pharmacy Information**

Name | Phone # | Fax #

**List your prescribed drugs and over-the-counter drugs, such as vitamins an inhalers**

| Name of Drug | Strength | Frequency Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Drug Allergies & Reactions**

**Are you allergic to**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Food | ◯ Yes | ◯ No | Shellfish | ◯ Yes | ◯ No | Animal Dander | ◯ Yes | ◯ No |
| Iodine | ◯ Yes | ◯ No | Peanuts | ◯ Yes | ◯ No | Latex | ◯ Yes | ◯ No |
| Adhesive Tape | ◯ Yes | ◯ No | Pollen | ◯ Yes | ◯ No | | | |

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# Patient History Form

Name _____ Date of birth _____ Date of appointment _____

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◯ Male ◯ Female

**Gender Identity (Optional)**

◯ Male ◯ Female ◯ Non-binary

## About you

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 4x/week for 30 mins.)

◯ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 mins.)

**Diet**

◯ Yes ◯ No Are you dieting? # of meals you eat in an average day _____

◯ Yes ◯ No If yes, are you on a physician prescribed medical diet

**Caffeine**

◯ None ◯ Coffee ◯ Tea ◯ Cola # of cups/cans per day _____

**Alcohol**

◯ Yes ◯ No Do you drink alcohol? If yes, what kind? _____

◯ Yes ◯ No Are you concerned about the amount you drink? # of drinks per week _____

**Tobacco**

◯ Yes ◯ No Do you use tobacco? # of years _____ or year quit _____

◯ Cigarettes - pks/day ◯ Chew - #/day ◯ Pipe - #/day ◯ Cigars - #/day

**Drugs**

◯ Yes ◯ No Do you currently use recreational or street drugs?

If yes, please list: _____

◯ Yes ◯ No Have you ever given yourself street drugs with a needle?

**Sex**

◯ Yes ◯ No 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.

**Personal Safety**

◯ Yes ◯ No 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 the 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?

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# Patient History Form

Name _____ Date of birth _____ Date of appointment _____

**Sex at birth**

◯ Male ◯ Female

**Gender Identity (Optional)**

◯ Male ◯ Female ◯ Non-binary

## Family Health History

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

**Father** Age _____

Significant Health Problems

_____

_____

_____

_____

**Mother** Age _____

Significant Health Problems

_____

_____

_____

_____

**Siblings**

Age _____ ◯ M ◯ F

Significant Health Problems

_____

_____

Age _____ ◯ M ◯ F

Significant Health Problems

_____

_____

Age _____ ◯ M ◯ F

Significant Health Problems

_____

_____

Age _____ ◯ M ◯ F

Significant Health Problems

_____

_____

**Children**

Age _____ ◯ M ◯ F

Significant Health Problems

_____

_____

Age _____ ◯ M ◯ F

Significant Health Problems

_____

_____

Age _____ ◯ M ◯ F

Significant Health Problems

_____

_____

Age _____ ◯ M ◯ F

Significant Health Problems

_____

_____

**Grandparents (Maternal)**

Grandmother Age _____

Significant Health Problems

_____

_____

_____

Grandfather Age _____

Significant Health Problems

_____

_____

_____

**Grandparents (Paternal)**

Grandmother Age _____

Significant Health Problems

_____

_____

_____

Grandfather Age _____

Significant Health Problems

_____

_____

_____

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# Patient History Form

Name _____ Date of birth _____ Date of appointment _____

**Sex at birth**

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**Gender Identity (Optional)**

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## 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 |

## Other Problems

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

◯ Skin _____

◯ Head / Neck _____

◯ Ears _____

◯ Nose _____

◯ Throat _____

◯ Lungs _____

◯ Chest / Heart _____

◯ Back _____

◯ Intestinal _____

◯ Bladder _____

◯ Bowel _____

◯ Circulation _____

Recent changes in:

◯ Weight _____

◯ Ability to sleep _____

◯ Energy Level _____

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# Patient History Form

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**Sex at birth**

◯ Male ◯ Female

**Gender Identity (Optional)**

◯ Male ◯ Female ◯ Non-binary

## For Women

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

| Age at onset of menstruation | Date of last menstruation | # of days between period | # of pregnancies | # of live births |
|---|---|---|---|---|
| | | | | |

Heavy periods, irregularity, spotting, pain or discharge? ◯ Yes ◯ No

Are you pregnant or breastfeeding? ◯ Yes ◯ No

Any urinary tract, bladder, or kidney infections within the 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

## For Men

Do you usually get up to urinate during the night? If yes, # of times _____ ◯ Yes ◯ No

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 a 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

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# FINANCIAL POLICY

Thank you for choosing Young at Heart Family Medicine, LLC as your health care provider. We are committed to building a successful physician-patient relationship. The following is a statement of our Financial Policy. Our office will be happy to answer any questions or concerns you may have.

## PAYMENT IS DUE AT THE TIME OF SERVICE
## ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT
*WE ACCEPT: CASH, CHECK, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS*

**PROOF OF INSURANCE:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We are in network with most major insurance carriers. However, it is the patient's responsibility to verify that we are a participating provider of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all co-payments, co-insurances and deductibles must be paid at time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

**HMO/REFERRALS:** It is the patient's responsibility to obtain a referral form from your primary care physician if your insurance carrier requires it for your visits. If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.

**MINOR PATIENTS:** The parent or guardian accompanying the minor is responsible for payment of services rendered.

**MISSED APPOINTMENTS:** Unless cancelled 24 hours in advance, there is a $50.00 fee for missed appointments. Please help us serve you better by keeping scheduled appointments.

**NONCOVERED SERVICES:** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

**RETURNED CHECKS:** Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) along with a $30.00 NSF fee from the office.

**COLLECTION POLICY:** Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

**FORMS:** There is a flat fee of $75.00 for each set of forms the office completes on your behalf.

I HAVE READ AND FULLY UNDERSTAND the Financial Policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth.

**Patient Name:**_____ **Date:**_____

**Patient/Responsible Party Signature:**_____