

LECOM ENGLEWOOD FAMILY PRACTICE

NEW PATIENT REGISTRATION

Viewed: Y / N Initials _____

LAST NAME _____ FIRST _____ MIDDLE _____

LOCAL ADDRESS _____

BILLING ADDRESS _____

OTHER ADDRESS _____

Circle the months you are in FL - ** Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec ** or FULL YEAR

DOB _____ Home Telephone# _____ Mobile# _____

Legal Sex ____ Male ____ Female Social Security# ____ - ____ - ____

Patient EMAIL _____ Portal Access? Yes or Decline

Language- ENGLISH or OTHER _____ RACE _____

Ethnicity ____ non-Hispanic ____ Hispanic/Latino ____ Declined _____

Marital Status _____

Emergency Contact Name _____

Relationship _____ Home# _____ Mobile# _____

Preferred Pharmacy Name _____ Phone# _____

Pharmacy Address _____

Employed _____ Retired _____ Minor _____

If Employed list Employer, address, telephone# and Occupation

LAST NAME _____ FIRST _____

Responsible Insurance Party (if other than patient)

Full Name _____

Full Address _____

Relationship to the patient _____ Telephone# _____ DOB _____

Primary Insurance _____ ID# _____

Secondary Insurance _____ ID# _____

"I understand that it is my responsibility to make sure LECOM is in network with my insurance plan/policy and will call to confirm such".

I understand and agree that, regardless of my insurance status, all deductible and co-payment charges are due at time of service. This office files my primary and secondary insurance as a courtesy to me. I am financially responsible for my bill. I assign all insurance benefits to LECOM Englewood Family Practice and further authorize the release of any medical or other information necessary to process claims. I have read all the information on this form and have completed the above information as true and correct to the best of my knowledge.

SIGNATURE _____ DATE _____

Please return this form to the desk with your driver's license and insurance card(s) for copying. Thank you!

How did you hear about us?

___ Advertising

___ Primary Care Physician

___ Specialist

___ Word of Mouth

___ Patient in the Practice

___ Hospital

___ Insurance Company

___ Other _____ Specify: _____

LECOM ENGLEWOOD FAMILY PRACTICE

HIPAA and Consent to Share Personal Medical Records

LAST NAME _____ FIRST _____ MIDDLE _____

I understand that this office may need to use and disclose information about my health and or medical problems during the course of providing care for the purposes of arranging, conducting or referring my treatment; for obtaining payment for services; and for operating the practice. I consent to the use of my information for the purposes of treatment, payment and health care operations (TPO), by signing this form.

With this consent, this office may call my home or other alternative location and leave a message on voice or in person in reference to any items that assist the practice in carrying our TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, this office may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patients statements.

I also understand that my consent is NOT needed if the law requires this practice to report certain aspects of my protected health information to a government agency in cases of suspected abuse, communicable disease and if they suspect that I may be a potential bodily harm to myself or others.

I understand that I have the right to review this practices' privacy notice, to request restrictions on the use of my information and to revoke my consent at a later date.

I also recognize and understand that if I withhold consent for the use of my health-related information necessary for the purpose of treatment, payment, or practice operation, that this office or its agents may refuse to undertake my care.

SIGNATURE _____ DATE _____

PRINTED NAME _____ Relationship to patient _____

Listed below are the family members, and or friends I authorize this office to share and or discuss my medical health information with.

1. Full Name _____

Full Address _____

Relationship to the patient _____ Telephone# _____ DOB _____

2. Full Name _____

Full Address _____

Relationship to the patient _____ Telephone# _____ DOB _____

LAST NAME _____ FIRST _____ MIDDLE _____

3. Full Name _____

Full Address _____

Relationship to the patient _____ Telephone# _____ DOB _____

FINANCIAL POLICY

"I understand that it is my responsibility to make sure LECOM is in network with my insurance plan/policy and will call to confirm such".

I understand and agree that, regardless of my insurance status, all deductible and co-payment charges are due at time of service. This office files my primary and secondary insurance as a courtesy to me. I am financially responsible for my bill. I assign all insurance benefits to LECOM Englewood Family Practice and further authorize the release of any medical or other information necessary to process claims. I have read all the information on this form and have completed the above information as true and correct to the best of my knowledge.

SIGNATURE _____ DATE _____

Please return this form to the desk. Thank you!

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name _____, _____
LAST FIRST Middle

Date of Birth _____ SSN: _____ - _____ - _____

Name of Physician/Facility: _____

FAX: _____ - _____ - _____ Phone: _____ - _____ - _____

ADDRESS: _____

I hereby release my records to:

LECOM Englewood Family Practice

2828 S McCall Road, Suite 21

Englewood, FL 34224

p-941-290-5111 f-941-473-3583

PLEASE FAX RECORDS WE CANNOT ACCEPT FILES ON DISK

*Please include all information for the designated patient, including, but not limited to, OFFICE NOTES, LAB Reports, IMAGING Reports, Consultations, PT/OT Note, ALL Test Results, History & Physical, Psychiatric information.

The Purpose or need for disclosure is:

_____ Treatment _____ Transferring Care
_____ Payment for Claim _____ Life/Health Insurance
_____ Other: _____

I hereby authorize said physician/facility to release such information as requested. The physician/facility is also hereby released from any legal liability which might arise from the release of the requested information.

** Patient/Guardian Signature: _____ Date: _____

Relationship to, if not, the Patient: _____

Request Expiration date: _____

** Signature other than patient's: In the case of a minor patient, this authorization must be signed by a parent or legal guardian. In the case of a patient who is physically unable to sign this authorization, he/she should place an "X" on the signature line and have his/her assent witnessed. In the case of a deceased patient, this authorization must be signed by the next of kin or executor/administrator of the estate.

LECOM Englewood Family Practice

\$25 LATE CANCELLATION and or NO SHOW POLICY

When our office books your appointment, we are setting aside a dedicated time slot just for you. We only ask that if you must reschedule your appointment, that you please provide us with at least 24 hours' notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

As a patient you understand by signing this agreement policy, a \$25 fee will be charged directly to you, not your insurance company, for any appointment you fail to show and or cancel within 24 hours notice.

Thank you for your understanding and consideration.

Patient Name _____

Patient or Guardian Signature _____

Date _____ Patient DOB _____

HEALTH HISTORY FORM - LECOM ENGLEWOOD FAMILY PRACTICE (Page 1 of 3)

Patient Name _____ DOB _____ Chart# _____

Preferred Pharmacy _____ address _____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

ALLERGIES (list anything you are allergic to...medication, food, insects, materials, and how each affects you.

1. _____
2. _____
3. _____

MEDICATIONS (list all the medications you are taking. Include prescribed drugs and over the counter drugs such as vitamins and inhalers.

DRUG NAME	STRENGTH (MG)	FREQUENCY TAKEN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

IMMUNIZATION HISTORY AND MOST RECENT DATES

Chicken Pox _____	Date _____	Meningococcus _____	Date _____
Flu Shot _____	Date _____	Tdap _____	Date _____
MMR Measles, Mumps, Rubella _____	Date _____	Tetanus _____	Date _____
Gardasil/HPV _____	Date _____	Pneumonia _____	Date _____
Hepatitis A _____	Date _____	Hepatitis B _____	Date _____

Permission to obtain Florida Immunization record? Yes No

HEALTH HISTORY FORM - LECOM FAMILY MEDICAL PRACTICE

(Page 2 of 3)

Patient Name _____

FAMILY HEALTH HISTORY

<u>RELATION</u>	<u>ALIVE?</u>	<u>AGE</u>	<u>HEALTH PROBLEMS</u>
FATHER	Y/N	___	_____
MOTHER	Y/N	___	_____
SISTER(S)	Y/N	___	_____
BROTHER(S)	Y/N	___	_____

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

- | | | |
|--|--|---|
| ☐ Anxiety Disorder | ☐ Diverticulitis | ☐ Kidney Disease |
| ☐ Arthritis | ☐ Fibromyalgia | ☐ Kidney Stones |
| ☐ Asthma | ☐ Gout | ☐ Leg/Foot Ulcers |
| ☐ Bleeding disorder | ☐ Has Pacemaker | ☐ Liver Disease |
| ☐ Blood clots or DVT | ☐ Heart attack | ☐ Osteoporosis |
| ☐ Cancer | ☐ Heart Murmur | ☐ Polio |
| ☐ Coronary artery disease | ☐ Hiatal Hernia or Reflux | ☐ Pulmonary Embolism |
| ☐ Claustrophobic | ☐ HIV or AIDS | ☐ Reflux or Ulcers |
| ☐ Diabetes-Insulin | ☐ High Cholesterol | ☐ Stroke |
| ☐ Diabetes-non insulin | ☐ High Blood Pressure | ☐ Tuberculosis |
| ☐ Dialysis | ☐ Overactive Thyroid | ☐ Other |

PAST SURGICAL HISTORY

	<u>SURGERY</u>	<u>REASON</u>	<u>YEAR</u>	<u>HOSPITAL</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

HEALTH HISTORY FORM - LECOM FAMILY MEDICAL PRACTICE (Page 3 of 3)

Patient Name _____

SOCIAL HISTORY

Do you have smoke and carbon monoxide detectors in your home? Yes No

Are you passively exposed to smoke? Yes No

Do you use sunscreen routinely? Yes No

Do you or have you ever smoked tobacco? Yes No

Do you or have you ever used any other forms of tobacco or nicotine? Yes No

What was the date of your most recent tobacco screening? _____

What is your level of alcohol consumption? _____ drinks per week

What is your level of caffeine Consumption? None Occasional Moderate Heavy

What is your relationship status? married single divorced widow

What is your exercise level? _____

Are you blind or do you have difficulty seeing? Yes No

Are you deaf or do you have serious difficulty hearing? Yes No

Do you have difficulty walking or climbing stairs? Yes No

Do you have difficulty dressing or bathing? Yes No

Do you have difficulty doing errands alone? Yes No

Are you able to walk? Yes No

Do you have transportation difficulties? Yes No