Maitland Primary Care

301 S. Maitland Avenue, Suite B
Maitland, FL 32751
407/678-3255

PATIENT REGISTRATION

PATIENT'S NAME LAST	FIRST	M.I.	SEX	MARITAL STATUS	DATE OF BIRTH

MAILING ADDRESS			SOCIAL SECURITY NUMBER
CITY	STATE	ZIP	EMPLOYER/OCCUPATION
TELEPHONE - HOME	BUSINESS	EXT	DRIVER'S LICENSE NUMBER

NAME OF PERSON OR PARTY RESPONSIBLE FOR PAYMENT OF MEDICAL BILLS

GUARANTOR'S NAME		SOCIAL SECURITY NUMBER	HOME PHONE BUSINESS
MAILING ADDRESS		DRIVER'S LICENSE NUMBER	PATIENT IS (CIRCLE ONE): SELF SPOUSE SON DAUGHTER
CITY	STATE ZIP	DATE OF BIRTH	EMPLOYER

INSURANCE COMPANY	GROUP #	POLICY #

EMERGENCY NOTIFICATION INFORMATION

PERSON TO BE NOTIFIED IN AN EMERGENCY			HOME TELEPHONE
ADDRESS			BUSINESS TELEPHONE EXT
CITY	STATE	ZIP	RELATIONSHIP TO PATIENT

CONSENT FOR TREATMENT

I hereby give consent to Maitland Primary Care to provide whatever treatment the assigned providers may deem necessary to the patient named above.

I understand I am responsible for payment to Maitland Primary Care outpatient charges and that payment is due at the time of service. In the event of hospital admission, I hereby assign insurance benefits, otherwise payable to me, to be paid directly to Maitland Primary Care for Professional Physician's fees and authorize release of information for insurance purposes. I understand I am responsible for charges not covered by the insurance policy.

I hereby request payment of authorized Medicare benefits and/or any other insurance benefits to be made either to me or on my behalf to Maitland Primary Care for any services furnished me by Maitland Primary Care. I authorize any holder of medical information about me to release to Maitland Primary Care and its agents any information needed to determine these benefits payable for related services.

By signing below, I agree to be present for all scheduled appointments at Maitland Primary Care. Failure to give 24-hour notice for cancelled appointments will result in a $25.00 charge.

Signature of patient: _____ Date: _____

E-mail address: _____

Relationship to policy holder: _____

Witness: _____

Maitland Primary Care
Personal Profile Questionnaire

Patient name: _____ Age: _____ Date: _____

1. How did you find out about our practice? _____

2. Family information:

	Name	Age
Mother:		
Father:		
Spouse:		
Siblings:		

Kids:

Name	Age

3. Allergies: _____

4. Current medications: _____

_____

5. Date of last tetanus shot: _____

6. Habits:

Cigarettes	packs/day
Cigars/pipe	per day
Drugs	
Coffee	cups/day
Alcohol	drinks/week
Exercise	times/week
Seat belts	% of time

7. Surgeries:

Date	Reason

8. Recent hospitalizations:

Date	Reason

9. Circle the problem that runs in your family, and give the relation of your family member:

	Relation		Relation
Diabetes		Headaches	
Tuberculosis		Mental illness	
Heart disease		Seizures	
High blood pressure		Joint pain	
Stroke		Thyroid problems	
Kidney disease		Bleeding problems	
Liver disease		Gout	
Cancer		Back problems	
Arthritis		Muscle problems	
Anemia		Varicose veins	
Heat/cold intolerance		Tremors/shakes	
Leg ulcers		Memory problems	
Thrombophlebitis		Depression	
Fainting		Easy bruising	

10. Personal health history -- Circle any problems you have:

Unusual weight loss	Sinus infections	Palpitations	Kidney stones
Weakness/fatigue	Nosebleeds	Blood transfusions	Venereal diseases
Unexplained rashes	Bleeding gums	Chest pain	Hernias
Hair/nail changes	Frequent sore throat	Rheumatic fever	Frequent urination
Severe headaches	Hoarseness	Swallowing problems	Hay fever
Head injury	Lumps in neck	Heartburn	Lumps in testicles
Contacts/glasses	Goiter	Bowel problems	Discharge from penis
Cataracts	Breast lumps	Blood in stool	Painful periods
Glaucoma	Chronic cough	Black stools	Abnormal bleeding
Other eye problems	Bloody sputum	Diverticulosis	Last period:
Hearing problems	Wheezing/asthma	Hemorrhoids	Last Pap smear:
Ringing in ears	Tuberculosis	Liver problems	Number of pregnancies:
Dizziness	Other breathing problems	Gall bladder problems	Number of children:
Frequent earaches	Heart trouble/murmurs	Hepatitis	Birth control method:
Frequent colds	High blood pressure	Constipation/diarrhea	Abortions:

Please explain:

ADVANCED DIRECTIVES

In the event you become unable to tell your physician and family how you want to be treated, federal and state laws provide ways for you to make your wishes known. The federal Patient Self Determination Act states that each competent adult patient has the right to prepare a written "advanced directive" regarding healthcare decisions. The advance directive is typically expressed in one or more of the three basic types or forms: a Living Will declaration, a Durable Power of Attorney for healthcare, or a Designation of a Healthcare Surrogate, or representative to make healthcare decisions for you, the patient, when the patient becomes incapable of making those decisions.

The Living Will enables you to indicate in writing treatment preferences if you should become incapacitated and terminally ill. In a Living Will, you may indicate your wishes regarding healthcare treatments and life-prolonging procedures and the circumstances under which you wish these procedures to be withdrawn or withheld, and you may also designate a surrogate to carry out your wishes.

Through a Durable Power of Attorney, you can name a person to communicate your wishes regarding medical, legal, and financial matters should you become incapacitated. This may include authorizing medical treatment and administration of drugs.

Designation of a Healthcare Surrogate allows you to name a person who will make healthcare treatment decisions on your behalf should you become incapacitated. Healthcare surrogates must be named by you before you become incapacitated, but surrogates do not assume their responsibility until after you become incapacitated to make decisions regarding medical treatment.

Advance directives can help protect your right to make medical choices that can affect your life. The stress on your family during a difficult time can be considerably reduced because your family will be relieved of the responsibility of trying to decide what your wishes would be. Your family and physician will have clear guidelines concerning your wishes for your care.

I, _____, understand the above and do hereby affirm that:

{ } I have not prepared a:
- { } Living Will Declaration
- { } Durable Power of Attorney for Healthcare
- { } Designation of a Healthcare Surrogate at this time.

{ } I have prepare a:
- { } Living Will Declaration
- { } Durable Power of Attorney for Healthcare
- { } Designation of a Healthcare Surrogate and I have provided a copy to _____ _____. I understand the information I have provided may be modified or changed at any time, and I must provide another copy after any changes in the future.

{ } I have prepared a:
- { } Living Will Declaration
- { } Durable Power of Attorney for Healthcare
- { } Designation of a Healthcare Surrogate but I have not provided a copy to my physician at this time. I understand it is my responsibility to provide my physician with a copy of my advanced directives.

_____

Witness Patient Date

Maitland Primary Care
301 S. Maitland Avenue, Suite B
Maitland, FL 32751
407 678-3255
Fax# 407-599-5966

Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting us in writing.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name

(Print) _____

(Signature) _____

Date: _____

Witness: _____

Maitland Primary Care

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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by **Maitland Primary Care** (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardian, health care surrogates, or have power of attorney on behalf of the Patient: **(Patient must fill out) Name/Relationship:**_____

_____

_____

• Patient agrees that the Practice may disclose the following types of information contained in the Patient's medical records (please **initial, do not check,** the appropriate categories listed below):

	Restrictions		Restrictions
_____ HIV/AIDS Information	_____	_____ Mental Health Information	_____
_____ Substance Abuse Information	_____	_____ If Patient is under the age of eighteen (18), Pregnancy information	_____
_____ Sexually Transmitted Disease Information	_____		

•Patient agrees and consents to the Practice releasing information to Patient in the following alternative manners (please **initial, do not check** the appropriate spaces below):

_____ Via e-mail to the Patient's designated e-mail address which is: _____.

_____ Via Regular Mail with any envelopes being marked personal and confidential and addressed to Patient.

_____ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient's name, social security number and date of birth.)

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent. If you revoke this consent, Maitland Primary Care will only continue to treat you on an emergency basis, and in that case for 30 days.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I MAY RECEIVE A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date:_____ Time:_____ AM / PM

_____ _____

Signature of Patient/Authorized Representative* Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient. Please attach proof of guardianship with a court document.

_____

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