REGISTRATION FORM

Patient Information:

Name of Patient: _____ Maiden Name: _____
Social Security #: _____ Date of Birth: _____ Sex: M F
Marital Status: _____ Race: _____ Ethnic Group: _____ Language: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home phone: _____ Cell Phone: _____
Work phone: _____ E-Mail address: _____
Preferred Contact Method: _____ Preferred Reminder Method: _____
Drivers License #: _____ Date Expired: _____ State: _____
Employer: _____

Guarantor Information:

Guarantor Name: _____ Relationship to Patient: _____
Social Security #: _____ Date of Birth: _____ Sex: M F
Address: _____
City: _____ State: _____ Zip Code: _____
Home phone: _____ Cell Phone: _____
Work phone: _____ E-Mail address: _____
Employer: _____

Insurance Information #1:

Primary Insurance: _____
Policy #: _____ Group #: _____
Address: _____
Telephone #: _____ Contact Person: _____
Name of Insured: _____ Relationship to patient: _____
Insured Date of Birth: _____ Social Security #: _____

Insurance Information #2:

Primary Insurance: _____
Policy #: _____ Group #: _____
Address: _____
Telephone #: _____ Contact Person: _____
Name of Insured: _____ Relationship to patient: _____
Insured Date of Birth: _____ Social Security #: _____

Emergency Contact Information:

Name: _____ Telephone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Relationship to patient: _____

I herby grant permission to Lakeland Medical Associates to employ such medical, lab, and x-ray procedures as considered necessary in my diagnosis and treatment. I authorize the holder of medical or other information to release, to my insurance carrier, government agency, or its intermediary, any information needed for this or any related insurance claim. I further permit a copy of this authorization to be sued in place of the original. I authorize payment of medical benefits to the physician for services rendered. I understand that I am financially responsible for the charges regardless of insurance coverage and/or payment.

Signature of Patient: _____ Date: _____

Signature of Responsible Party: _____ Date: _____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Furthermore, by my specific initials, I authorize my physician and his/her staff, to contact me by the designated means noted below.

_____ Home Phone

_____ Home Answering Machine/Voice Mail

_____ Office/Work Place, Voice Mail

_____ Cell Phone/Voice Mail

_____Fax: # ( )_____Location:_____

Additionally, by my initials I authorize my physician and his/her staff, to communicate information regarding appointments, medical results and billing issues to:

_____ Spouse_____

_____ Others_____

This Authorization shall remain in force until revoked in writing, Attention of Privacy Officer

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

ASSIGNMENT OF BENEFITS

To accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is very difficult for us to keep track of all of the individual requirements of the plans. Each plan has different restrictions regarding how often services may be rendered and, more importantly, where you should obtain these services.

Even within a single insurance company, the plans differ, depending on what type of contract your employer has negotiated.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible.

Unfortunately, if you do not inform us of special requirements required by your plan and we order services that you need, such as lab work, hospitalization, and supplies that are not covered by your plan, we may bill you directly for those charges. Payment for these services may be your responsibility.

With your cooperation and our help, you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on your medical needs.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

_____ _____

Patient's Signature Date

LAKELAND MEDICAL ASSOCIATES

Consent For Treatment

I hereby grant permission to Lakeland Medical Associates physicians to provide medical services, as they deem necessary.

Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment by our physicians.

1. Our office will file insurance claims for you, however your share of the cost of our services is due at the time of service.
2. We accept cash, checks, VISA, Discover or MasterCard.
3. We do not file third party insurance claims such as auto insurance or accident insurance. It is your responsibility to pay for services rendered. You can collect from the insurance company with your paid receipt from us.
4. The adult bringing a minor (under age 18) for treatment is the responsible party for payment of our service.
5. Co pays: Your co-pays and deductibles are due at the time of service. In order to be eligible participants, we must sign contracts agreeing to collect co-payments at the time service is rendered; therefore, we must collect your co-pay prior to seeing the doctor. We are unable to bill for co-payments, so please do not ask us to do this. Our office is simply following the orders of your managed care contract or insurance company. If we do not collect this co-payment, your insurance company has the right to terminate our provider privileges.
6. Medicaid Pending: If you are Medicaid Pending, you will be required to pay, just as if you were private pay, until you receive your Medicaid card.
7. Insurance cards: If you do not bring in your insurance or Medicaid card and we are unable to verify your insurance, you will be required to pay your visit in full.
8. If you are unable to take care of payment today, please ask to speak with the financial counselor so that we can authorize arrangements with your treating doctor.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the above terms.

_____ _____

Signature of Patient Date

_____ _____

Signature of Legal Guardian Relationship

MEDICAL HISTORY

Date: _____
Name: _____
Occupation: _____
Education Level: _____
Pharmacy: _____

Are you allergic to any medications? YES NO
List all drug allergies: _____
_____
List all current medications: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you use over-the-counter Medications? Yes No
Please List: _____
_____
_____

PERSONAL HISTORY:

Have you ever had: (*Place X in the appropriate box)*

	YES	NO	Type / Comment
Stroke			
Eye Disease			
Headaches			
Heart Disease			
Heart Murmur			
High Blood Pressure			
Tuberculosis			
Asthma/COPD			
Colon Disease			
Intestinal Disease			
Hepatitis			
Rectal Bleeding			
Kidney Disease			
Breast Lumps			
Cancer			
Skin Cancer			
Arthritis			
Diabetes			
High Cholesterol			
High Triglycerides			
Thyroid Disease			
Depression			
Anxiety			
Alcohol Problems			

List previous surgical procedures:

Date	**Procedure**
_____	_____
_____	_____
_____	_____
_____	_____

List other medical problems and hospitalizations:

Date	**Procedure**
_____	_____
_____	_____
_____	_____
_____	_____

Most Recent Tetanus Shot: _____
Most Recent Pneumonia Vaccine: _____
Most Recent TB Skin Test: _____
Have you ever had a colonoscopy? YES NO
When? _____

Women:
Last Menstrual Period: _____
Do you use birth control? YES NO
If yes, which method? _____
Most recent pap smear: _____
Most recent mammogram: _____
Have you ever been pregnant? YES NO #: _____
Are menses? ____ Normal ____Abnormal

Men:
Most recent PSA: Date: _____
Most recent prostate exam: Date: _____

Are you on a special diet? YES NO

Do you exercise? YES NO

FAMILY HISTORY:

Has a blood relative had: (*Place X is appropriate Box)*

	YES	NO	Type	Relative
Cancer				
Diabetes				
Heart Attack				
Stroke				
Hypertension				
Alcoholism				
High Cholesterol				

Circle Correct Answers Below:
Do you us tobacco? YES NO
Cigarettes: YES NO **Smokeless:** YES NO
Currently or Past? _____ Quit Date: _____

Do you us illegal drugs? YES NO

Do you drink? (i.e. beer, wine or liquor) YES NO
When was the last time you had (Women 4 or more / Men 5 or more) drinks in one day?
_____ Never
_____ More than 12 months ago
_____ 3 – 12 months
_____ Within the last 3 months