DIVERSE MEDICAL PROFESSIONALS
1200 S FEDERAL HIGHWAY • SUITE 302 • BOYNTON BEACH, FL 33435
Tel: 561-509-9382 • Fax: 561-509-9362

PATIENT REGISTRATION FORM

Date: _____

Last Name	First Name	Middle Name	Marital Status

Social Security	DOB	Sex (Circle) F M	Race

Address	Unit/Apt #

City	State	Zip Code

Home Phone	Cell Phone	Email

Employer	Occupation	Work Phone (Optional)

***Other Contacts [EMERGENCY CONTACT AND NEXT OF KIN]**

Next of Kin (Last Name, First, Middle)	Relationship to Patient

Phone	Alternate Phone	

Emergency Contact (Last Name, First, Middle)	Relationship to Patient

Phone	Alternate Phone	

INSURANCE INFORMATION

Primary Insurance	Policy Number	Group

Secondary Insurance	Policy Number	Group

(Provide your CURRENT FLORIDA DRIVER'S LICENSE and insurance card to the front desk at check-in)

The information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient Signature: _____ Date: _____

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Please state reason for today's visit: _____

_____

_____

Current or recent prescription medications:

Name of Medication	Dose/ Strength	How Often You Take It (Daily, 3X per day, etc.)	How long have you been taking this medication?

List of Allergies or Drug Reactions (specify drug and reaction such as penicillin or sulfa): _____

_____

_____

Current or recent over-the-counter meds/herbal products, vitamins:

_____

_____

Please list all SURGERIES and HOSPITALIZATIONS including approximate dates.

_____

_____

_____

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Have you been diagnosed with, or have any of the following issues? *(Please check all that apply.)*

RESPIRATORY / LUNG _____ asthma _____ cystic fibrosis _____ emphysema (COPD) _____ tuberculosis _____ pneumonia _____ bronchitis	CIRCULATORY / BLOOD _____ anemia _____ cold hands/feet _____ easy bleeding/bruising _____ wound healing problems _____ high blood pressure _____ high cholesterol	NEUROLOGICAL _____ headache/migraines _____ concussion _____ seizures _____ stroke _____ facial pain _____ muscle disease
HEART _____ chest pain _____ heart failure _____ heart attack _____ other heart disease	KIDNEY AND LIVER _____ kidney failure _____ cirrhosis of the liver _____ jaundice _____ hepatitis A, B or C _____ kidney stones	RHEUMATOLOGY _____ pain in joints _____ swollen/red joints _____ cracking/popping joints _____ arthritis
UROLOGY _____ enlarged prostate _____ benign prostatic hyperplasia _____ frequent urination _____ blood in urine/stool _____ urinary incontinence	EYES / SKIN _____ cataract _____ vision loss _____ glaucoma _____ eczema / psoriasis	GASTROINTESTINAL _____ stomach ulcer _____ acid reflux _____ Crohn's Disease _____ gallstones _____ irritable bowel syndrome
IMMUNE SYSTEM / CANCER _____ HIV _____ lupus _____ allergies	ENDOCRINE _____ diabetes _____ thyroid disease	EARS, NOSE AND THROAT _____ esophageal reflux _____ tonsillitis
MENTAL HEALTH _____ insomnia (can't sleep) _____ bipolar _____ anxiety _____ depression _____ schizophrenia	CANCER: _____ cancer, ***describe/type*** (breast, lung, prostate, etc.)	OTHER CHRONIC / LONG TERM MEDICAL PROBLEMS:

SOCIAL HISTORY

1. Tobacco Usage: _____ Never smoked _____ Quit smoking _____ Presently smoke

2. State what you smoke(d) and how much (For example, 1 cigar per day for 10 years)

_____

3. Do you drink alcoholic beverages? YES or NO *(Circle one)*

If yes, check all that apply: hard liquor _____ beer _____ wine _____

If yes, please estimate how much you drink: _____ Glasses /cans per day / week / month *(Circle)*

6. Have you ever had a drinking problem? YES or NO *(Circle one)*

7. How many cups of coffee, tea, or other caffeine products (like Coke) do you drink daily? _____

8. Do you use, or have you used marijuana, cocaine, IV drugs, or other street drugs? _____

FAMILY HISTORY: Were you adopted? Yes or No If no, complete the following table:

Relative	Living (age?)	Health Problems	Deceased (age?)	Cause(s) of Death
Mother				
Father				
Sister(s)				
Brother(s)				

Please include cancer and what type, diabetes, heart conditions, high blood pressure, strokes, tuberculosis, asthma, mental illness, high cholesterol and other important illnesses.

Imaging Exams: (MRI, CT, X-rays, Bone Scan, Ultrasound etc)

_____

_____

_____

Name of Facility where imaging was performed:

_____

_____

_____

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PAST AND PRESENT DOCTORS AND HOSPITALIZATIONS

Please list all physicians who have cared for you **within the past 5 years**. ***List specialty*** and address, phone and fax (if known).

FAMILY DOCTOR/PRIMARY CARE PHYSICIAN: _____

Address: _____

Phone #: _____ Fax #: _____

SPECIALIST: _____

Address: _____

Phone #: _____ Fax #: _____

SPECIALIST: _____

Address: _____

Phone #: _____ Fax #: _____

HOSPITAL NAME: _____

Address: _____

Phone #: _____ Fax #: _____

HOSPITAL NAME: _____

Address: _____

Phone #: _____ Fax #: _____

Verification: Who completed this form? _____ Patient/Self _____ Relative _____ Friend

PATIENT SIGNATURE: _____ ***DATE:*** _____

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Patient HIPAA Acknowledgment and Consent Form

Patient Name: _____ Date of Birth: _____

_____ **(Patient initials) Notice of Privacy Practices**. I acknowledge that I have read and received a copy of the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the office designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ **(Patient initials) Release of Information**. I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations. This consent specifically includes information concerning psychological/psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases. Healthcare information regarding a prior admission(s) at other affiliated facilities may be made available to subsequent admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to other accomplish goals such as improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating information for quality improvement purposes; and other purposes permitted by law.

Disclosures to Friend/Family. I give permission for my Protected Health Information to be disclosed to:

Name	Relationship	Contact

_____ **(Patient initials) Consent to Email or Text Usage for Healthcare Communications:** If at any time I provide an email or phone number at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text from the Practice. I understand this consent can be revoked in writing. (**Standard text messaging rates may apply.)*

_____ (**Patient Initials**) **Consent for Photographing or Other Recording for Security and/or Health Care Operations:** I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings which are confidential.

Patient Signature_____ **Date** _____