Largo Family Care

PATIENT REGISTRATION FORM

Today's Date: ___________________________

Name:____ Sex: ❑M ❑F

Local Address:____

City: __________________________________ State:____________ Zip:________________________

Home Phone:________________Work Phone:__________________ Cell Phone:__________________

Email: ____

Date of Birth: ___________________________ Age:________ SS#: ____________________________

Ethnicity:_________________________________ Preferred Language:_________________________________

Race: ❑American Indian or Alaska Native ❑Black or African American ❑Asian
❑Native Hawaiian or Other Pacific Islander ❑Unreported/Refused to Report ❑White

Emergency Contact: _______________________Phone: ______________Relationship:_____________

Marital Status: □ Single □ Married □Divorced/Separated □ Widowed

Employed: ❑Full Time ❑Part-time ❑Unemployed ❑Disabled ❑Retired ❑Military

Employer: ______________________________ Job Title: ____________________________________

Local Pharmacy Name: ____________________Address: ____________________________________

Preferred Lab Facility:_________________________

Insurance Card(s): Please present to receptionist to photocopy for file.

Primary Insurance: _______________________Secondary Insurance: __________________________

Whom may we thank for referring you to us?

❑ Friend/Family ❑ The Beacon local paper ❑ Postcard ❑ Valpak ❑ Consult A Nurse ❑Health Fair
❑ Hospital_____________ ❑ Physician referral __________ ❑ Insurance___________
Internet: ❑ Google Plus ❑ Facebook ❑ Vitals ❑ Healthgrades ❑ Yelp ❑ Family Care at Walsingham.com

I hereby authorize Largo Family Care to release all or part of my medical records to Medicare and/or any other companies, if requested, without any liability to Largo Family Care. I hereby authorize Medicare and/or my insurance companies to pay directly to Largo Family Care any payments, assignments or benefits due me.

____Date: ____________________
Patient Signature

Reason for Today's Visit?____

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

Cardiovascular:
□Arrhythmia □Murmur □ Angina/heart stents □Clots in legs/arms □High cholesterol □High blood pressure
□Heart attack □Congestive Heart Failure
Pulmonary:
□Asthma □Pneumonia □Lung Clots □COPD/Emphysema □Sleep Apnea
Gastrointestinal:
□Cirrhosis □ Hepatitis □Irritable Bowels □Crohn's disease □Heartburn (reflux)
□Gastric Ulcers □Diverticulitis □Rectal bleeding □Colonoscopy
Renal/GU:
□Prostate Enlargement □Kidney stones □Incontinence/loss of bladder control □Urinary Tract Infections
Musculoskeletal:
□Chronic Pain (where?)__________ □Fibromyalgia □Gout □Arthritis □Osteoporosis
Endocrine:
□Diabetes (□Type I or □Type II) □Thyroid problems (□High or □Low)
Neurological:
□Stroke □Dementia □Migraines □Multiple Sclerosis □Parkinson □Neuropathy □Seizures □TIA/ministroke
Allergy/Immunology/Dermatology:
□Allergies □eczema □frequent ear infections □psoriasis □frequent sinus infection
Other:
□Any Cancer (what kind?)______________________________
□Cataract □Glaucoma □Anemia or blood problems □Psychiatric care

CURRENT MEDICATIONS

Name, strength, frequency

1. ______________________________ 7. ______________________________
2. ______________________________ 8. ______________________________
3. ______________________________ 9. ______________________________
4. ______________________________ 10. ______________________________
5. ______________________________ 11. ______________________________
6. ______________________________ 12. ______________________________

ALLERGIES **Do you have allergies to drugs, food, latex, dye?** **YES** **NO**

Allergy - list medication, food, latex, dye, etc.	Reaction - rash, shortness of breath, hives, itching, etc

SURGICAL HISTORY

Surgery	Facility

FAMILY HISTORY

Living	Age	Health Status
Father		
Mother		
Sisters		
Brothers		
Deceased	**Age at Death**	**Cause of Death**
Father		
Mother		
Sisters		
Brothers		

Social History

Number of Children? ______________________ Ages ____

Do you smoke? Yes ____ No ____ How much ______ How Long ______ Year Quit ____________

Do you drink alcohol? Yes ____ No _____ how much per week? _________________________________

Do you exercise? Yes ____ No _____What do you do? ___________________Frequency__________

Please check all that applies:

Eyesight: □ Good □ Fair □ Poor □ Glaucoma

Ears, Nose, Throat: □ Poor Hearing □ Sore Throat □ Sinus Problems

Gastrointestinal: □ Swallowing Problems □ Indigestion □ Bloody stools □ Diarrhea

Genitourinary: □ Difficulty Urinating □ Blood in Urine □ Prostate Problems □ Kidney problems

Musculoskeletal: □ Muscle Pain □ Joint pain □ Arthritis

Integumentary: □ Skin Rash □ Skin Disorders

Neurological/Psychiatry: □ Fainting □ Depression □ Anxiety □ Drug Dependence

Endocrine: □ Thyroid Disease □ Diabetes

Hematologic/Lymphatic: □ Taking Blood Thinners □ Taking Aspirin □ Coumadin

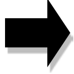
Allergic/Immunologic: □ Sinusitis □ Hayfever □ Allergies

Patient Signature: ______________________________________ **Date:** _______________________

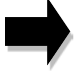
Largo Family Care- Patient HIPAA Acknowledgment and Consent Form

Patient Name: ____

Date of Birth: ____



______(Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received 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 Privacy Officer 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.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated 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. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

- 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 accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members
I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

______ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is______________________________.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is______________________________.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.
NOTE: This revocation only applies to communications from this Practice.
Patient Name: ____

Patient/Patient Representative Signature: ____

Date: ______________________________ Time: ____________________

Consent for Photographing or Other Recording for Security and/or Health Care Operations
____ (Patient Initials) 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. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.
____ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:
Name: ____ Date: ____________________
Name: ____ Date: ____________________
____ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature __________________________________ Date ___________________________

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ __________________________

Signature of Patient or Personal Representative **Date**

____ __________________________

Printed Name of Patient or Personal Representative **Relationship to Patient**