Joseph C. & Ann S.
DAY PRIMARY CARE

APT DATE:_____
APT TIME:_____
PROVIDER:_____

Patient Registration Form

Please bring the following items to your first appointment: picture ID, insurance card, all medication bottles (including over-the counter medications) and any Advance Directives.

Date: _____

Name _____**Birth Date** _____ **Sex: MALE** ☐ **FEMALE** ☐
Address _____**City** _____**State** _____**Zip** _____
Alternate Address _____**City** _____**State**____ **Zip** ____
Home Phone _____ **Cell Phone** _____ **Social Security No.** ____-___-____
Email Address _____
Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Other**
Living Situation: ☐ **Alone** ☐ **Spouse** ☐ **Children** ☐ **Caregiver** ☐ **Other**
Race: _____ **Ethnicity:** _____
Current Occupation: _____

Person to contact in case of emergency:
Name _____**Phone** _____**Relationship**_____

Insurance Information **(YOU MUST bring picture ID and insurance card to appointment)**

Primary Insurance: Name_____
Member ID # _____ Group # _____
Insured Birth date _____Relationship to you: **SELF** ☐ **SPOUSE** ☐ **OTHER** ☐
Secondary Insurance: Name_____
Member ID # _____ Group # _____
Insured Birth date _____Relationship to you: **SELF** ☐ **SPOUSE** ☐ **OTHER** ☐
Name of Previous Primary Care Dr _____
Phone (____) _____Fax (____) _____
How did you hear about us?
_____
List any other physician/specialist currently treating you:
_____

Advance Directives do you have any of the following? (if YES, please bring in copy to your appointment)

1. Livings will Yes ☐ No ☐
2. Health care surrogate: Yes ☐ No ☐
3. Power of attorney: Yes ☐ No ☐
4. Advanced directive: Yes ☐ No ☐
5. Do not resuscitate: Yes ☐ No ☐

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Medication/Supplement List

Please list all medications and over-the-counter medications you are currently taking.

Please BRING your medication bottles to EVERY appointment.

Name of Medication	Strength	How many times a day
Example: Aspirin	***81mg***	***One a day***

PHARMACY:

LOCAL**: _____ PHONE**#: _____

MAIL ORDER: _____ PHONE #: _____

- **I authorize and give consent to the Day Primary staff to check my prescription history from external sources. (please check and initial) _____**

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Medical History: (Please circle)

Abnormal Mammogram	*Depression*	*Hepatitis*	*Postmenopausal bleeding*	*Blood Clots*
Abnormal Pap Smears	*Diabetes*	*High blood pressure*	*Seizures*	*Vision Problems*
Addiction Problems	*Elevated PSA*	*High Cholesterol*	*Shingles*	*Weight issues*
Arthritis	*Head Injury*	*Memory trouble/loss*	*Stomach Ulcers*	*Cancer*
Bleeding Problems	*Heart Problems*	*Mental Illness*	*Trouble walking*	*Kidney Problems*
Stroke	*Heart Attack*	*Migraines*	*Skin Problems*	
Sexually Transmitted Disease				

OTHER: _____

Allergies: _____

Surgery & Procedure History (Include the year):

_____

_____

_____

Describe any hospitalizations or recent illnesses:

_____

_____

Family History: Who in your family has/had any disease or illness? (Example: Diabetes, High blood pressure, Cancer, Heart Disease, Thyroid Disease, and Mental Illness)

Family Member	Medical Problem	Living or Deceased	Age at death
Mother		Living ☐ Deceased ☐	
Father		Living ☐ Deceased ☐	
Siblings		Living ☐ Deceased ☐	
Other:			

Social History:

1. How is your Diet? Poor ☐ Average ☐ Good ☐ Excellent ☐
2. Do you currently smoke? Yes ☐ No ☐ If yes, start date _____ How much per day_____
   If former smoker, when did you quit? _____How many years did you smoke? _____
   How much did you smoke? _____Is there any tobacco exposure at home? Yes ☐ No ☐
3. Do you drink? Yes☐ No ☐ Beer_____Wine_____Liquor_____
   How often? _____ How much? _____
4. Do you exercise? Yes ☐ No ☐
   If yes, what exercise do you do? _____
   How often? _____For how long? _____

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Preventative Screening: (Please date the last time you had one of the following)

Influenza Shot_____
Pneumovax Shot _____
Prevnar 13 _____
Shingles Shot _____
Tetanus Shot _____

DEXA _____
Colonoscopy _____
Mammogram _____
Pap smear _____

Dermatology exam _____
Eye Exam _____
Dental Exam _____

Women

Age of first period _____ Date of last normal period _____
Birth control method _____ Are you sexually active currently? _____
No. of pregnancies _____ No. of live births _____

Men

Last PSA _____ Rectal Exam _____ No. of children: _____
Are you sexually active currently? _____

What do you want to discuss with your healthcare provider during today's visit?

_____
_____
_____
_____
_____

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Insurance Benefits and Information Release

SIGNATURE REQUIRED ON THIS FORM

1. I understand that the physician services of the Day Primary Care are to be billed by the Council on Aging Martin County, Inc. Medical information regarding my visit to the Day Primary Care will be available to the Day Primary Care staff.
2. I hereby authorize the physician to release all information necessary concerning my diagnosis treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any service rendered that are not paid for directly by me.
3. I understand that the Day Primary Care has a no-show policy. As a courtesy to our office as well as to our patients who are waiting to schedule with the physician, please give us at least 24-hour notice. If you do not cancel or reschedule your appointment with at least 24-hour notice, we may assess a $25.00 “no-show” service charge to your account.
4. I understand that the Day Primary Care does not prescribe the use of long-term controlled medications and if necessary, I will discuss the options with my provider during my initial visit.

_____
Patient’s Name (PRINT)

_____
Patient’s Name (SIGNATURE)

_____
DATE

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our duties. The law requires us to protect the privacy of your health information, give you this notice, follow it, and tell you if a breach affects your information.

How we use and share your information. *Treatment:* with specialists, hospitals, pharmacies, and home health agencies involved in your care. *Payment:* to bill Medicare, Medicaid, and other health plans. *Operations:* to run our practice, manage your care, review quality, and train staff. We may also send appointment reminders and health-related information, and share with business associates who agree in writing to protect it.

Other uses the law allows or requires. Public health and safety; reporting suspected abuse, neglect, or exploitation; health oversight and audits; court orders and subpoenas; law enforcement; coroners and funeral directors; organ donation; research; workers' compensation; military and national security; and as otherwise required by law. We follow stricter laws that protect HIV, mental health, and substance use disorder records.

Your choices. Unless you tell us not to, we may share information with family or caregivers involved in your care, and with disaster relief organizations. *Fundraising:* As a nonprofit, the Council on Aging of Martin County may use your name and contact information. You may opt out of fundraising communications at any time. Just let our staff know. Opting out will not affect your care in any way.

Uses that need your written permission. Marketing, sale of your information, most sharing of psychotherapy notes, and any use not described here. You may revoke your permission in writing at any time.

Your rights. You may get a copy of your record (usually within 30 days; a reasonable fee may apply); ask us to correct it; ask us to contact you in a certain way or at a certain address; ask us to limit what we share (if you pay in full out of pocket, we will not share that service with your health plan); get a list of certain disclosures from the past six years; get a paper copy of this notice; and name a representative, such as a health care surrogate or power of attorney, to act for you.

Changes and complaints. We may change this notice, and changes will apply to all information we hold; the current notice is posted in our office and on our website. If you believe your privacy rights were violated, contact our Privacy Officer or the U.S. Department of Health and Human Services Office for Civil Rights (1-877-696-6775, hhs.gov/ocr/complaints). **We will not retaliate against you for filing a complaint.**

Privacy Officer: Adam Levenson · 772-223-7800

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SIGNATURE REQUIRED ON THIS FORM

I acknowledge that I have received a copy of the Council on Aging of Martin County — Day Primary Care Notice of Privacy Practices.

Patient name (print): _____

Date of birth: _____

Signature of patient or legal representative: _____

Date: _____

If signed by a legal representative, relationship / authority (health care surrogate, POA, guardian):

_____

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Permission for Verbal Communication

The Health Insurance Portability and Accountability Act (**HIPAA**)

THIS IS A REQUIRED FORM – PLEASE FILL OUT AND SIGN

_____ _____ _____

Print name of Patient **Date of Birth** **Last 4 digits of Social Security Number**

I wish to be contacted in the following manner:

Primary choice telephone number: _____Home Work Cell
Secondary choice telephone number: _____Home Work Cell

Please indicate if you authorize us to leave a message or fax information:
☐ YES ☐ NO This includes results, name of physician, date and time of appointment and any instructions.

I permit Day Primary Care, their physicians, nurses, and other personnel to discuss my health information including billing and payment information, test results or lab results in person or by telephone, with the following family members or friends involved in my medical care.

In an attempt to preserve the confidential nature of the doctor-patient relationship, please select the various locations/persons with whom or where we may leave messages regarding appointments or other administrative matters. I authorize Day Primary Care to send my records to any referring physician and or specialist to coordinate care and treatment in the future.

This may include information related to psychiatric care, drug and alcohol use, HIV testing and/or AIDS.
Limit discussions to the following medical condition(s) or services(s): _____

Name	Phone		Relationship
1._____	_____	Home Work Cell	_____
2._____	_____	Home Work Cell	_____
3._____	_____	Home Work Cell	_____

_____None, I do not wish my information discussed with anyone other than myself.

Release of information under this document is limited to verbal discussions as indicated above and/or limited paper records or business office documents as necessary for my immediate assistance.

This authorization is valid unless revoked. If at any time I do not want verbal discussions to be permitted between my health care providers or facility and any of the individuals name above (provided that the information has not yet been released) I must notify my Health Care Provider or contact the Day Primary Care.

_____ _____

Patient or Authorized Signature **Date**

Relationship to Patient (Explain and/or attach Legal Documentation) _____

Note: Medical records exceeding 25 pages cannot be received via fax. Mail to Day Medical Center. **CDs/USBs cannot be accepted.** Thank you.

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Authorization for Release of Medical Records

1. **I Authorize:**

_____
Name of sending person/organization
person/organization

_____
Street Address

_____
City State Zip Code

_____
(772)221-1794
Phone Fax

2. **To Release to:**

Day Primary Care
Name of receiving

900 SE SALERNO ROAD
Street Address
STUART, FL 34997
City State Zip Code
(772) 223-7864 (772)781-2963
Phone Fax

3. **INFORMATION TO BE RELEASED:** (Check all applicable)
☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-Ray Reports
☐ Electrocardiogram (ECG) ☐ Allergy Records ☐ Other _____

SPECIAL AUTHORIZATION: Check applicable box (es) and sign immediately below.
By signing below, I am authorizing the office to release any and all information regarding:
☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: _____ Date: _____

4. Records from the time period: ___/___/___ through ____/____/____

5. Purpose of Disclosure: (Check applicable purpose)
☐ Continue Medical Care ☐ Payment of Insurance Claim ☐ Legal
☐ Personal ☐ Other: _____

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee will be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Date of Birth: _____ Home Phone: _____