TODAY'S DATE

Elite Health Care
A Premier Medicare Practice

PATIENT REGISTRATION FORM

Social Security No.:	First Name:	Middle:	Last:
Sex: ☐ M ☐ F	Birth date:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated	
Race: ☐ Asian ☐ Black/African American ☐ White ☐ American Ind./Alaska Nat. ☐ Native Hawaiian ☐ Pacific Islander ☐ Haitian Black ☐ Haitian White ☐ More Than One Race		Ethnicity: ☐ Hispanic or Latino ☐ Non – Hispanic	Preferred Language:
		Employed: ☐ Yes ☐ No	Employer:
Street Address:		Home Phone:	
City: State: ZIP Code:		Cell Phone:	
Email:	Work Phone:	Preferred Method of Contact:	
Referral Source: ☐ Referring Provider ☐ Ins. Company ☐ Flyer/Mailing ☐ Walk-In ☐ Hospital ☐ School ☐ Yellow Pages ☐ Newspaper ☐ Health Fair ☐ Family/Friend ☐ Other/Unknown ☐ Outreach Event			

EMERGENCY CONTACT

☐ Parent ☐ Spouse ☐ Child ☐ Other			Sex: ☐ M ☐ F
First Name:	Middle:	Last:	
Preferred Language:	Home Phone:	Cell Phone:	Work Phone:

PREFERRED PHARMACY

Pharmacy Name:	Phone:	Fax:	
Street Address or Cross Street:	City:	State:	Zip Code:

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	GENERAL CONSENT FOR TREATMENT AND BILLING
1.	I, the undersigned, give permission for myself or minor child, as indicated above, to undergo all necessary tests, examinations, treatments, or other procedures required by the medical or dental staff for Family Health Centers of Southwest Florida, Inc. (FHCSWF) to diagnose and/or treat illness(es).
2.	I realize that the practice of medicine, surgery, and dentistry is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatments or examinations by FHCSWF.
3.	I consent to the release of my medical and dental information by FHCSWF and/or authorized institutions or agencies accepting the patient for medical, dental, or institutional care. I consent to the release of medical and dental information to patient's insurer. I give permission to release data (medical, dental, and personal) to such government agencies as is required of FHCSWF.
4.	I hereby authorize payment to FHCSWF of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS otherwise payable to me, but not to exceed the health center and/or physician's or dentist's regular charges for this period of treatment.

	FHCSWF PATIENT USE OF CONTROLLED SUBSTANCES
1.	I acknowledge that I have received a copy of the FHCSWF Patient Information on the Use of Controlled Substances, which is a mutual agreement between me and FHCSWF.

	FHCSWF PATIENT BILL OF RIGHTS AND RESPONSIBILITIES
1.	I acknowledge that I have received a copy of the FHCSWF Patient Bill of Rights and Responsibilities, which is a mutual agreement between me and FHCSWF.

HIPAA – NOTICE OF FHCSWF PRIVACY PRACTICE

1. I acknowledge that I have received a copy of the Notice of Privacy Practices that explains the commitment of FHCSWF to protecting my personal health information in compliance with the law.
I do hereby authorize the unrestricted release of my personal health information to the following individuals:

	NAME:	RELATIONSHIP (e.g. – Mother, Sister, Spouse, etc.)
1.	1.	
	2.	
	3.	

ADVANCE DIRECTIVES – RIGHT TO DECIDE – END OF LIFE DECISIONS

You cannot remove all uncertainty about your future healthcare needs but, by having Advanced Directive, you can have the peace of mind that comes from making your wishes known in advance.

1. Do you have a Living Will?
☐ I have a Living Will – Please make a copy and FHCSWF will place in your Medical Record.
☐ I do NOT have a Living Will.

2. Do you have a Health Care Surrogate?
☐ I have a designated Health Care Surrogate who is_____and can be reached at_____.
☐ I do NOT have a designated Health Care Surrogate.

3. Do you have a Durable Power of Attorney?
☐ I have an appointed Durable Power of Attorney who is_____and authorized to make Health Care decisions for me.
☐ I have NOT appointed a Durable Power of Attorney for my Health Care decisions.

Signature of Patient/Responsible Party/Guarantor:_____ Date:_____

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PATIENT HISTORY FORM

Why have you come to see the doctor? _____

How long have you had this problem? _____

Are you taking any medications? Yes _____ No _____ If YES please list below:

MEDICATION	DOSAGE	FREQUENCY

Have you ever been in the hospital or had surgery? Yes _____ No _____ If YES please list below:

WHERE	WHEN	WHY	DOCTOR

Have you ever had any procedures/screenings? Yes _____ No _____ If YES please list below:

PROCEDURE/SCREENING	WHEN	WHERE	DOCTOR
OPERATION			
COLONOSCOPY			
MAMMOGRAM			
BONE DENSITY			
PAP SMEAR			
IF DIABETIC, DILATED EYE EXAM			

Have you ever seen a specialist? Yes _____ No _____ If YES please list below:

NAME	SPECIALTY	WHY

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Do you have any allergies to any medications, drugs, foods or other things? Yes _____ No _____
If yes, please list below what you are allergic to and type of reaction:

_____

_____

SOCIAL HISTORY

	YES	NO	If YES, how much in one day
Do you drink alcohol?			
Do you smoke tobacco?			
Do you drink coffee?			
Do you use drugs?			

WEIGHT GAIN/LOSS

	YES	NO	If yes, how much
Have you gained weight recently?			
Have you lost weight recently?			

FAMILY HISTORY

Have you or any members of your family had, or currently have, any of the following diseases?

	YES		NO		If YES, who	
Cancer						
Tuberculosis						
Diabetes						
High Blood Pressures						
Heart Attack						
Stroke						
Epilepsy (Seizures)						

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PATIENT HISTORY FORM

Have you had any of the following diseases?

	YES	NO
Asthma		
Bronchitis		
Cancer		
Diabetes		
Eye Infections		
Heart Disease		
Hepatitis		
Hernia		
High Cholesterol		
Hives or Rashes		
Hypertension		
Influenza (Flu)		
Kidney Disease		
Liver Disease		
Malaria		
Pneumonia		
Rheumatic Fever		
Tuberculosis		
Venereal Disease		
Vaccines/Immunizations for	**YES**	**NO**
Influenza – Flu		
Pneumovax – Pneumonia		
Pertussis – Whooping Cough		
Tetanus		
Date of Last Tetanus		
Prevnar		
Date of Last Prevnar		
Zostavax		
Date of Last Zostavax		

Do you have any of the following problems?

	YES	NO
Frequent Colds		
Pain in Chest		
Vomiting		
Nausea		
Swollen Neck Glands		
Loss of Voice		
Cough		
Difficulty Swallowing		
Earaches		
Shortness of Breath		
Toothaches		
Loss of Hearing		
Nose Bleeds		
Bleeding Gums		
Sore Throat		
Pain on Urination		
Empty Bladder Often		
Dribbling		
Nervous Spells		
Joint Pain		
Paralysis		
Mental Illness		
Depression		
Anxiety		
Confusion		

Other medical information: