Welcome to Florida Care Medical Center

Your health is our priority.

We wish to take a moment and welcome you to our practice.

Thank you for entrusting us with your care. We look forward to serving you and strive to treat every patient with dignity and respect. To provide continuity of care, our patients can select a personal clinician who works with our entire healthcare team to provide you with comprehensive, high-quality care. To reach this goal our skilled professionals take a personalized approach to care by sitting down with you and discussing your healthcare needs, goals and treatment options. We treat a full spectrum of both acute illnesses and chronic conditions.

To expedite the new patient registration process, we ask that you read and/or complete the following forms:

- Patient Registration Form
- Medical Health History
- Office Policy Notice to Patients
- Acknowledgement of Receipt of Notice of Privacy Practices

For your first appointment, please bring completed copies of the above forms, as well as:

- **Insurance card(s)**
- **Photo ID**
- **A list of current medications and dosage**
- **Co-payment (if required by your insurance)**

For new patients, we respectfully ask that you arrive 15 minutes prior to your scheduled appointment time with your completed paperwork. If you are unable to complete this paperwork ahead of time, please arrive 30 minutes ahead of your appointment.

If you have a non-life-threatening emergency after office hours, please call our office and we will direct you to the appropriate physician. If you are having an emergency, please call 911.

Again, thank you for choosing **Florida Care Medical Center**. We look forward to seeing you and will do our best to make your visit as pleasant, efficient and complete as possible.

FLORIDACARE MEDICAL CENTER

Name (as it appears on your insurance card) Date of Birth

PATIENT REGISTRATION FORM

Patient's legal name: _____ _____
Last First M.I. (Maiden)

Preferred or another known-by name: _____

Home address: _____
Street City State Zip

Social Security number: ____ / ___ / _____ **Date of birth:** ___ / ___ / _____ **Sex:** F ☐ M ☐

Home phone: ( ) _____ **Cell phone:** ( ) _____ **Work phone:** ( ) _____

Email: _____

How would you prefer to receive appointment reminders? ☐ phone ☐ email ☐ text

Emergency contact: _____
Last First Relationship Phone

ACKNOWLEDGMENT OF RECEIPT OF ADVANCE DIRECTIVE INFORMATION

(Living Will or Power of Attorney)

An advanced health care directive, also known as living, will, personal directive, advance directive or advance decision, is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity. In the U.S., it has a legal status in itself, whereas in some countries it is legally persuasive without being a legal document.

Please initial after each statement:

I have completed an ADVANCE DIRECTIVE for health care: ☐ Yes ☐ No

If yes, please indicate which: ☐ Living Will ☐ Durable Power of Attorney

I am requesting information regarding ADVANCE DIRECTIVES: ☐ Yes ☐ No

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INSURANCE INFORMATION

Primary Medical Insurance	Secondary Medical Insurance
Insurance Carrier:	
Carrier's Phone Number:	
Policy #:	
Group #:	
Subscriber:	
Subscriber's Soc. Sec. #:	
Relationship to Patient:	

If you are currently uninsured, please complete the following:

Person responsible for payment:

Name: _____ _____
Last First M.I. Relationship

Address: _____
Street City State Zip

Certification Statement: I certify that the information above is true and accurate to the best of my knowledge.

_____
Name of Patient (Print)

_____ _____
Name of Responsible Party (Print) Signature of Responsible Party

_____ _____
Responsible Party Driver's License # Signature Date

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OFFICE POLICY NOTICE TO PATIENTS

We strive to provide you with the best personalized care available. To make this possible, we adhere to a set of very important guidelines. Please read them carefully, initial all the lines and indicate your agreement by signing at the bottom.

_____ **Cancellation and No-Show Policy:** If you wish to change or cancel an appointment, we ask that you please provide 24-hour advance notice. This allows us to offer your appointment to another patient who may be waiting to see a physician. We understand, however, that emergencies can and do happen, and will make every attempt to work with you. If you can't contact us 24 hours in advance, please call as soon as you know you cannot make your scheduled appointment time. If you miss your appointment without notice or provide less than 24-hour advance notice, it will be considered a no-show. We may charge you $25 for a no-show appointment. **Patients who repeatedly no-show may be dismissed from the practice.**

_____ **Pain Medications:** Our primary care physicians are not pain management providers and therefore do not guarantee any form of pain medications and/or narcotics. If you have a chronic condition that requires long-term use of such medications, please be advised we may refer you to a pain management or mental health clinic for treatment of the chronic condition. **Example of narcotics: Hydrocodone, Morphine, Oxycodone, Methadone, Darvocet, Percocet, Oxycontin.**

_____ **Insurance/Co-Pays:** Please bring updated insurance and co-payment for every visit. Failure to make co-payment at the time of the visit could result in cancellation of the scheduled appointment. Patients are responsible for charges not covered by insurance. (ABN form provided to Medicare HMO plans).

_____ **Missing proper identification:** Patients without valid proper ID, proper insurance information or missing insurance information, may be asked to reschedule. Any patient who misrepresents themselves by using outdated or someone else's identification may be dismissed from the practice.

_____ **Self-pay:** If you are a true self-pay patient without insurance, please confirm self-pay fees prior to your appointment. Office visit, procedures, and laboratory fees. Cosmetic pre-operative clearance is the patient's responsibility. **THIS IS NOT COVERED BY ANY INSURANCE.**

Patient signature:_____ Date: _____

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MEDICAL PATIENT/HEALTH HISTORY (ADULT)

Past Medical History

Please check all that apply.

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Blood clots
- ☐ Cancer
- ☐ Chest pain
- ☐ Circulation problems
- ☐ Crohn's disease
- ☐ CVA (stroke)
- ☐ Depression
- ☐ Diabetes
- ☐ Enlarged prostate
- ☐ Gallbladder disease
- ☐ Heart failure
- ☐ Heartburn
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel disease
- ☐ kidney disease
- ☐ Liver disease
- ☐ Lung Disease/ Emphysema
- ☐ Mental illness
- ☐ Migraine headaches
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Thyroid Disorder
- ☐ Seizure Disorder
- ☐ Ulcers
- ☐ Valve disease

Past Surgical History

Please list all prior surgeries. Include dates and any complications.

1. _____
2. _____
3. _____
4. _____
5. _____

Immunizations: please list the last date of the below immunizations. Approximate dates are fine.

Date of last flu shot:	____/____/____	☐ None	☐ I'm not sure
Date of last pneumonia shot*:	____/____/____	☐ None	☐ I'm not sure
* Type: _____			
Date of last tetanus shot:	____/____/____	☐ None	☐ I'm not sure
Date of last shingles shot:	____/____/____	☐ None	☐ I'm not sure
Date of last MMR shot:	____/____/____	☐ None	☐ I'm not sure

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Medications

List any prescription, herbal or over-the-counter medications that you are currently taking.

Medication name*	Strength	Dosage/Directions
Example: Aspirin	325mg	1 tab daily

* *If you need more room to list your medications, please write down your other medications on a separate piece of paper and bring it with you to your appointment.*

Please list your preferred pharmacy name and phone number:

_____

Do you have allergies to medications? ☐ Yes ☐ No

If yes, please list drug(s) and reactions(s): _____

_____

_____

_____

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Health Maintenance

Date of last physical/preventative medical exam:_____

Are you receiving alternative care? ☐ Yes ☐ No

If yes, kind: Acupuncture Chiropractic Other: _____

Do you see a dentist on a regular basis? Yes No Date of last dental exam: ____/___/____

Adults only: Date of last cholesterol test? ___/___/____

Women ages 21+ last pap smear: ___/___/____

Adults ages 50+
date of last colonoscopy: ___/___/____

Women ages 40+ last mammogram: ___/___/____

Adults ages 65+
last osteoporosis screening (Dexa Scan): ___/___/____

Men ages 40+ last prostate exam: ___/___/____

FLORIDACARE MEDICAL CENTER

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Family History

Please indicate if your mother, father or sibling has any of the following diseases now or if it was their cause of death (COD). Please also indicate if aunt/uncle/grandparents in the "other" box. Check all that apply. If you are not sure, please place a question mark (?) in those boxes.

	MOTHER		FATHER		SISTER(S)		BROTHER(S)		OTHER		
	Yes	COD	Yes	COD	Yes	COD	Yes	COD	Yes	COD	Relationship
Diabetes											
Heart disease											
High blood pressure											
High cholesterol											
CVA (stroke)											
Kidney disease											
Alcoholism											
Alzheimer's disease											
Asthma											
Blood clots											
Cancer											
Circulation problems											
Depression/anxiety											
Development delays											
Eczema											
Irritable bowel disease											
Mental illness											
Migraines											
Obesity											
Seizure disorder											
Substance abuse											
Other family history											

Social History

Check all that apply.

Do you have good family support? ☐ Yes ☐ No

Do you feel safe at home? ☐ Yes ☐ No

Any religious or cultural needs that you would like our medical practice to know? ☐ Yes ☐ No

If yes, please describe: _____

_____

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Tobacco Use History

Uses tobacco: ☐ Currently ☐ Formerly ☐ Never

Tobacco type: ☐ Cigarettes ☐ Chewing ☐ Cigar ☐ Pipe ☐ Snuff ☐ Other_____

Amount per day: _____ (packs, ounces, cigars, pipes) Number of years: _____

Tobacco cessation ever discussed: ☐ Yes ☐ No

Secondary smoke exposure: ☐ Yes ☐ No

Alcohol Use History

Drinks alcohol: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely ☐ Never

Type: _____

Caffeine Use History

Drinks Caffeine: ☐ Coffee ☐ Pop ☐ Tea ☐ Energy Drinks

How many daily: _____

Illegal Drug Use History

Uses illegal drugs: ☐ Currently ☐ Formerly ☐ Never

If currently or formerly, please indicate drugs used: _____

Have you ever sought treatment for drug use: ☐ Yes ☐ No

Sexual History:

Do you have any concerns about possible exposure to sexual transmitted diseases that you would like to discuss or be tested for? ☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No Do you engage in risky sexual behavior? ☐ Yes ☐ No

Have you ever been treated for a sexually transmitted disease? ☐ Yes ☐ No

How do you identify yourself? ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Prefer not

Exercise History:

Exercise Frequency:

☐ Occasionally ☐ 2-3 times a week ☐ 3-4 times a week ☐ 5+ times a week

Type of exercise you prefer: _____

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AUTHORIZATION TO DISCUSS PERSONAL HEALTH INFORMATION WITH FAMILY AND FRIENDS

Date:	Name	Relationship to Patient	Phone	Specific Visit, Procedure or Diagnosis	Restrictions: Visit, Procedure Diagnosis	Date Revoked
*						

* Indicates emergency contact

You have my permission to discuss my personal health information with the individuals designated above. This authorization will be effective on the date below and will remain in effect until revised or revoked. This authorization can be revoked at any time, either verbally or in writing.

Patient Signature Patient Representative Signature Date

Reviewed and/or Revised.

Date	Signature

Date	Signature

Date	Signature

FLORIDACARE MEDICAL CENTER

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OUR PATIENT CARE PARTNERSHIP

Understanding Expectations, Rights and Responsibilities

As a patient, you have the right to:

- Receive information about your rights.
- Effective communication in a manner you understand, including interpretive and translation services.
- Have your personal dignity respected.
- Considerate and respectful care, including the right to be free from all forms of harassment, neglect, exploitation, and verbal, mental, physical and sexual abuse.
- Receive care, regardless of your age, race, ethnicity, religion, culture, language, sex, national origin, sexual orientation, physical or mental disability, gender identity or expression, socioeconomic status, or source of payment.
- Be involved in decisions that affect your care, treatment, or services.
- Receive necessary information from your physicians to give or withhold informed consent prior to the start of any procedure or treatment when possible.
- Legally appoint someone else to make decisions for you if you become unable to do so, and have that person approve or refuse care, treatment, and services.
- Give or withhold informed consent prior to and during recording or filming for purposes other than identification, diagnosis or treatment.
- Receive information about the persons responsible for your care, treatment, or services.
- Refuse care, treatment, or services after being informed of the consequences of such refusal.
- Formulate advance directives and have them followed.
- Have your complaints addressed and receive resolution within a timely, reasonable and consistent manner.
- Confidentiality, personal privacy and security.
- Access, request amendment to, and obtain information on disclosures of your health information as allowed by law.
- Care rendered in a clean and safe environment.
- Be free from restraint or seclusion of any form not necessary for health or safety, used as a means of coercion, discipline, convenience, or retaliation by staff.
- Accommodations for the physically challenged.
- Pain management.
- Access protective and advocacy services.
- Consent to or decline to participate in research studies and clinical trials.
- Have your cultural, psychosocial, spiritual and personal values, beliefs and preferences respected.
- Have access to pastoral and other spiritual services.
- Be informed, along with your family as permitted by you, about the outcomes of care, treatment and services that have been provided, including unanticipated outcomes.

As a patient, you have the responsibility to:

- Provide information about past illness, hospitalizations, medications, and other matters related to your health, including changes in your symptoms or condition.
- Inform your care providers when information has not been understood.
- Follow the recommendations and advice of your care providers and understand that you are responsible for the consequences if you refuse to do so.
- Provide complete and accurate information about insurance and your ability to meet the financial obligations of your care.
- Be considerate and respect the rights and property of other patients, visitors, and hospital staff.

Complaints or Grievances:

- You have the right to discuss your concerns, complaints or grievances with your care providers.

  You may contact our Patient Care Advocate by phone at or by email at: 407-842-8283. curryford@myfloridacaremedicalcenter.com