

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.



PATIENT REGISTRATION FORM

Patient's legal name:										
	Last	First	M.I.	(Maiden)						
Preferred or another	known-by name:									
Home address:	Street	City		Chaha 7in						
	Street	City	/	State Zip						
Social Security numbe	er://	Date of birth:/	/	Sex: F 🔲 M 🔲						
Home phone: ()	Cell pho	one: ()	Work phone:	()						
Email:										
How would vou prefei	r to receive appointment	reminders? ⊞ phone	email te	ext						
, _, _,			一							
Emergency contact:										
	Last	First	Relationship	Phone						
ACKNOWLI	ACKNOWLEDGMENT OF RECEIPT OF ADVANCE DIRECTIVE INFORMATION									
	(Livin	g Will or Power of Attorne	ey)							
An advanced health care	directive, also known as livi	ng will nersonal directive	e advance directive	or advance decision is a						
	a person specifies what action	- · · ·		The state of the s						
decisions for themselves	because of illness or incapac	city. In the U.S., it has a le	-	-						
t is legally persuasive v	without being a legal docum	nent.								
Please initial after each	statement:									
				_						
I have comple	eted an ADVANCE DIRECTIV	E for health care:	☐ Yes	■ No						
If yes, pl	lease indicate which:		Living Will							
				of Attorney						
l am requesti	ng information regarding A	DVANCE DIRECTIVES:	☐ Yes	□ No						
	5 -5 - 5									



INSURANCE INFORMATION

Primary Medical Insurance	Seconda	ary Medical Insura	ince	
Insurance Carrier:				
Carrier's Phone Number:				
Policy #:				
Group #:				
ubscriber:				
Subscriber's Soc. Sec. #:				
Relationship to Patient:				
If you are currently uninsured, please complete the following Person responsible for payment:	<u>.</u>			
Name:Last	First	M.I.	Relati	ionship
Address:				
Street	City		State	Zip
Certification Statement: I certify that the information above is	true and accurat	e to the best of my	knowledge.	
Name of Patient (Print)				
Name of Responsible Party (Print)	Signature	of Responsible Party		
Responsible Party Driver's License #	Siø	nature Date		



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.

provide 24-hour advance notice. This allows us waiting to see a physician. We understand, however attempt to work with you. If you can't contact u make your scheduled appointment time. If you make	to change or cancel an appointment, we ask that you please is to offer your appointment to another patient who may be ver, that emergencies can and do happen, and will make every is 24 hours in advance, please call as soon as you know you cannot iss your appointment without notice or provide less than 24-hour w. We may charge you \$25 for a no-show appointment. Patients rom the practice.
any form of pain medications and/or narcotics. If medications, please be advised we may refer you	e not pain management providers and therefore do not guarantee you have a chronic condition that requires long-term use of such to a pain management or mental health clinic for treatment of the ecodone, Morphine, Oxycodone, Methadone, Darvocet, Percocet,
co-payment at the time of the visit could result in	nce and co-payment for every visit. Failure to make n cancellation of the scheduled appointment. Patients are ce. (ABN form provided to Medicare HMO plans).
	alid proper ID, proper insurance information or missing le. Any patient who misrepresents themselves by using outdated d from the practice.
	rithout insurance, please confirm self-pay fees prior to your aboratory fees. Cosmetic pre-operative clearance is the patient's URANCE.
Patient signature:	Date:



MEDICAL PATIENT/HEALTH HISTORY (ADULT)

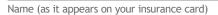
Past	t Medical History								
Plea	se check all that apply								
	Alcoholism		Chest pain		Heartburn		Migraine headaches		
	Allergies		Circulation problems		Hepatitis C		Obesity		
	Anemia		Crohn's disease		High blood pressure		Osteoarthritis		
	Anxiety		CVA (stroke)		High cholesterol		Osteoporosis		
	Arthritis		Depression		Irritable bowel disease		Thyroid Disorder		
	Asthma		Diabetes		kidney disease		Seizure Disorder		
	Atrial fibrillation		Enlarged prostate		Liver disease		Ulcers		
	Blood clots		Gallbladder disease		Lung Disease/ Emphysema		Valve disease		
	Cancer		Heart failure		Mental illness				
1 2 3	Please list all prior surgeries. Include dates and any complications. 1								
<u>lmn</u>	nunizations: please lis	t the	last date of the below imm	uniza	tions. Approximate dates are fi	ne.			
Date	e of last flu shot:		111		_ None	□ l'	m not sure		
	e of last pneumonia sho		11		_ None	□ l'	m not sure		
Date	e of last tetanus shot:		111		_ None	□ I'	m not sure		
Date	e of last shingles shot:		111		☐ None	□ l'	m not sure		
Date	e of last MMR shot:		11		☐ None	□ l'	m not sure		



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
	Ì	
* If you need more room to list your medications,	olease write do	wn 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 numbe	r:
		a
Do you have allergies to medications?	Yes [』 No
If yes, please list drug(s) and reactions(s):		



Date of Birth



Health Maintenance									
Date of last physical/preventative medical exam:									
Are you receiving alternative care?	□ No								
If yes, kind: Acupuncture	Chiropractic	Other:							
Do you see a dentist on a regular basis?	es 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:	//						



Name (as it appears on your insurance card)

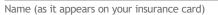
Date of Birth

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 w	vould like o	ur medical practice to know?	☐ Yes	No	



Date of Birth



Uses tobacco:
Amount per day: (packs, ounces, cigars, pipes) Number of years: Tobacco cessation ever discussed:
Tobacco cessation ever discussed:
Secondary smoke exposure: LYes LNo
Alcohol Use History
Drinks alcohol:
Type:
Caffeine Use History
Drinks Caffeine: Coffee Pop Tea Energy Drinks
How many daily:
Illegal Drug Use History
Uses illegal drugs:
If currently or formerly, please indicate drugs used:
Have you ever sought treatment for drug use:
Sexual History:
Do you have any concerns about possible exposure to sexual
transmitted diseases that you would like to discuss or be tested for?
Are you currently sexually active?
Have you ever been treated for a sexually transmitted disease?
How do you identify yourself? Heterosexual Homosexual Bisexual Homosexual
Exercise History:
Exercise Frequency:
Occasionally
Type of exercise you prefer:



AUTHORIZATION TO DISCUSS PERSONAL HEALTH INFORMATION WITH FAMILY AND FRIENDS

Date:	Name	Relationship to Patient	p	Phone	Proce	cific Visit, cedure or gnosis	Restrictions: Visit, Procedu Diagnosis		Date Revoked	
*										
							<u> </u>			
					-					
					+		-			
					-					
					+-					
		-			+		-			
	es 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									
Reviewe	ed and/or Revised.									
Date	Signature	Date	Signature	e		Date S	ignature			



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