

 ***New Patient Registration***

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_\_\_\_\_\_

Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age \_\_\_\_\_\_\_\_\_\_\_ Sex: Female / Male Martial Status: Single Married Divorced Widowed

Permanent Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Address (If different from above) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone number ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consent to call / leave message: Yes or No

Cell Phone number ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consent to call / leave message: Yes or No

Work Phone number ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consent to call / leave message: Yes or No

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred method of communication: Home Phone Cell Phone Work Phone Email

Patient’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST \_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_

If patient is a minor: Fathers Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mothers Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Number ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST \_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_

Is your visit due to: Auto Accident or Worker’ Comp If yes date of accident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-----------------------------------------------------------------------------------------------------------------------------------------------------------Whom may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If referred by a physician: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREFERRED PHARMACY:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY PHARMACY:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Guarantor:**

Are you personally responsible for the payment of your fees? Yes No

If not, who is?

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_

**PRIMARY INSURANCE COMPANY:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY/ACCIDENT INSURANCE COMPANY:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CENSUS DATA**

**Please Check below if you do not feel comfortable providing the following information.**

* I decline to give any of the information below.

**ETHNICITY:** Hispanic Non-Hispanic

**RACE:** Please circle one

Alaskan Native Indian Unknown

Asian Multi-Racial Not Report

Black/African American Native American Indian White

Hawaiian Other Race

Hispanic Pacific Islander

**PREFERRED LANGUAGE:** Please circle one

Albanian Filipino Malayan Sudanese

Arabic Finnish Mandarian Swahili

Armenian French Norwegian Swedish

Azerbaijani German Other Tagalog

Bosnian Greek Pakistan Taiwanese

Bulgarian Hebrew Polish Thai

Cambodian Hmong Portuguese Turkish

Chinese Hungarian Romanian Ukranian

Creole Indonesian Russian Vietnamese

Czech Italian Samoan Yiddish

Danish Japanese Serbo - Croatian

Dutch Korean Sign Language

English Laotian Slovak

Estonian Lebanese Spanish

Farsi Lithuanian Sudanese

**HISTORY & PHYSICAL**

What brings you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­­­­­­­­­­­­­­­­­Do you have any medicine allergies? Yes No Unknown

If yes, please list name of medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any food allergies? Yes No Unknown

If yes, please list food allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of Medications taken regularly (include vitamins, hormones, birth control, aspirin, sleeping tabs, etc)

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication | Dose | Frequency/Times | Reason for Medication |
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**Past Surgical History:**

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| --- | --- | --- |
| Month/Year of Surgery | Surgeon/Hospital | Type of Surgery |
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**Family History:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Living  | Deceased | Age | Cause of Death | Medical Problems |
| Mother |  |  |  |  |  |
| Father |  |  |  |  |  |
| Sibling |  |  |  |  |  |
| Spouse |  |  |  |  |  |

**PAST MEDICAL HISTORY - Please check ‘Yes’ if applicable:**

AIDS/HIV \_\_Y High Cholesterol \_\_Y Gout \_\_Y

Anemia \_\_Y Hypertension \_\_Y Heart Attack \_\_Y

Anxiety/Depression \_\_Y Kidney Disease ­\_\_Y Heart Problems \_\_Y

Arthritis \_\_Y Liver Disease \_\_Y Hepatitis \_\_Y

Asthma \_\_Y Meniere Disease \_\_Y Hernia \_\_Y

Bleeding Disorder \_\_Y Migraines \_\_Y Seizures/Epilepsy \_\_Y ­­ ­­

Blood Clot \_\_Y Stroke \_\_Y Thyroid problems \_\_Y

Blood Transfusion \_\_Y Tuberculosis \_\_Y Ulcers \_\_Y

Cancer \_\_Y Pulmonary Embolism \_\_Y Pacemaker \_\_Y

Chronic Ear Infection \_\_Y Rheumatoid Arthritis \_\_Y Nasal Polyps \_\_Y

COPD \_\_Y Peripheral Vascular Disease \_\_Y Diabetes \_\_Y

Difficulty Swallowing \_\_Y Osteoporosis \_\_Y Orthotics \_\_Y

Explain any above checked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY - Please circle one:**

Smoking status? Never smoked Former smoker Current every day smoker Current some days smoker

Tobacco years of use: \_\_\_\_\_\_ Smoked since the age of: \_\_\_\_\_\_\_\_\_\_ Chewing tobacco? Yes No

Currently employed? Yes No Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Live Alone/with others: Alone Others Single or Multi-level home/work: Single level Multi-level Home

Are you able to care for yourself? Yes No

Alcohol intake? None Occasional Moderate Heavy Daily Intake:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine intake? None Occasional Moderate Heavy Daily Intake:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Illicit drugs? Yes No

Diet? Regular Vegetarian Vegan Gluten Free Carbohydrate Cardiac Diabetic Specific\_\_\_\_\_\_\_\_\_

Exercise level? None Occasional Moderate Heavy Sporting Activities:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General Stress level? Low Medium High

Hand dominance? Left Right Both

Work/Auto Related Injury: Work Auto None If injured. Is litigation ongoing: Yes No

Is a Blood transfusion acceptable in an Emergency? Yes No Do you have an Advanced Directive? Yes No

**REVIEW OF SYSTEMS - Please check each item ‘Yes’ as they relate to your health:**

**CONSTITUTIONAL: ENDOCRINE: HEMATOLOGY/LYMPH:**

Weight Loss \_\_Yes Loss of Hair \_\_Yes Bruising \_\_Yes

Fatigue \_\_Yes Heat/Cold Intolerance \_\_Yes Gums Bleed Easily \_\_Yes

Fever \_\_Yes **RESPIRATORY: MUSCULOSKELETAL:**

**EYES:** Cough Easy \_\_Yes Joint Pain Swelling \_\_Yes

Glasses/Contacts \_\_Yes Wheezing \_\_Yes Stiffness \_\_Yes

Eye Pain \_\_Yes Chills \_\_Yes Muscle Pain \_\_Yes

Double Vision \_\_Yes **GASTROINTESTINAL:** Back Pain \_\_Yes

Cataracts \_\_Yes Heartburn/Reflux \_\_Yes SKIN:

**EAR, NOSE, THROAT:** Nausea/Vomiting \_\_Yes Rash/Sores \_\_Yes

Difficulty Hearing \_\_Yes Constipation \_\_Yes Lesions \_\_Yes

Ringing in Ears \_\_Yes Change in BM \_\_Yes Itching/Burning \_\_Yes

Vertigo \_\_Yes **GENITOURINARY:** **NEUROLOGICAL:**

Sinus Trouble \_\_Yes Burning/Frequency \_\_Yes Loss of Strength \_\_Yes

Nasal Stiffness \_\_Yes Night time \_\_Yes Numbness \_\_Yes

Frequent Sore Throat \_\_Yes Blood in Urine \_\_Yes Headaches \_\_Yes

**CARDIOVASCULAR:** Erectile Dysfunction \_\_Yes Tremors \_\_Yes

Murmur \_\_Yes Abnormal Discharge \_\_Yes Memory Loss \_\_Yes

Chest Pain \_\_Yes Bladder Leakage \_\_Yes **FEMALES ONLY:**

Palpitations \_\_Yes **ALLERGIC/IMMUNOLOGIC:** Age Onset Period \_\_\_\_\_\_\_\_

Dizziness \_\_Yes Hives/Eczema \_\_Yes Periods Regular? YES or NO

Fainting Spells \_\_Yes Hay Fever \_\_Yes Number Pregnancies \_\_\_\_\_\_

Shortness of Breath \_\_Yes **PSYCHIATRIC:**  How many Children: \_\_\_\_\_\_\_

Difficulty Lying Flat \_\_Yes Anxiety/Depression \_\_Yes

Swelling Ankles \_\_Yes Mood Swings \_\_Yes

 Difficult Sleeping \_\_Yes

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Matthew Harris MD, MBA**

108 Intracoastal Pointe Dr.

Jupiter, FL 33477

(O) 561-529-4494

(F) 561-529-4494

**Consent Form to Release/Receive Medical Records**

Please check one:

□ Please release my medical records to:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ I authorize Joint Preservation and Limb Reconstruction Center to request my medical records from:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the selected above to either release or receive my medical records including office notes, x-rays, operative reports, and any information regarding medical consultations and treatment I have received.

Patient’s First and Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient OR Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with HIPAA privacy regulations