Longwood Medical Group

DBA: Family Practice of Central Florida

REGISTRATION FORM

Today's Date: _____/_____/_____

Last Name: _____ First Name: _____ Sex: ☐ Male ☐ Female

Preferred Name: _____ Social Security # (optional:) _____

Date of Birth: _____/_____/_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: (_____) _____ - _____ Mobile Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____ Preferred Contact Method: ☐ Home ☐ Mobile ☐ Work

Email Address: _____ Occupation: _____

Employer: _____ Employer Phone Number: (____) _____ - _____

How did you hear about us? _____

INSURANCE INFORMATION

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Name of Primary Insurance: _____ Name of Secondary: _____

Person Responsible for Bill: _____ Date of Birth: _____/_____/_____

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify: _____)

IN CASE OF EMERGENCY

Name of local friend/relative: _____

Relationship to Patient: _____

Phone: (_____) _____ - _____ Alternate Phone: (_____) _____ - _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I understand that a charge of $25.00 will be added to my account if I do not show up for a scheduled appointment or fail to give a minimum 24 hour cancellation notice. I understand that if I miss consecutively 3 scheduled appointments that I can be dismissed from the practice. I also authorize Longwood Medical Group or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: ____/____/_____

HEALTH QUESTIONNAIRE

Please indicate each of your medical problems by marking the appropriate box.

☐ High Blood Pressure	☐ Anemia	☐ Hepatitis
☐ Diabetes	☐ High Cholesterol	☐ Venereal Disease (Describe: _____)
☐ Heart Disease	☐ Glaucoma	☐ Anxiety
☐ Cancer (Describe: _____)	☐ Chest Pain/Tightness	☐ Depression
☐ Asthma	☐ Shortness of Breath	☐ Arthritis
☐ Emphysema / Lung Disease	☐ Lightheadedness	☐ Gout
☐ Kidney Problems	☐ Headache	☐ Skin Diseases
☐ Thyroid Disease	☐ Hemorrhoids	☐ Blood Disorders

Please list any other health problems below:

_____

_____

_____

MEDICATIONS

Please list all medications that you are now taking, strength (in milligrams) and how often. Include non-prescription medications and vitamins. If you are not taking any, please write N/A.

Drug Name	Dose	Drug Name	Dose

Please list any additional medications or the back of this page.

ALLERGIES

Please list all your allergies. If you do not have any known allergies, please write N/A.

Allergy:	Reaction:

SOCIAL HISTORY:

☐ Smoking	Duration: _____	Amount: _____	Year Quit: _____
☐ Alcohol	Duration: _____	Amount: _____	Year Quit: _____
☐ Caffeine	Duration: _____	Amount: _____	Year Quit: _____
☐ Drugs	Duration: _____	Amount: _____	Year Quit: _____

FAMILY HISTORY:

If any blood relative has suffered from the following conditions, please check the box and list which relative.

☐ Heart Disease	Relative: _____ Circle: Maternal/Paternal
☐ Diabetes	Relative: _____ Circle: Maternal/Paternal
☐ Thyroid	Relative: _____ Circle: Maternal/Paternal
☐ Stroke	Relative: _____ Circle: Maternal/Paternal
☐ High Blood Pressure	Relative: _____ Circle: Maternal/Paternal
☐ Substance Abuse	Relative: _____ Circle: Maternal/Paternal
☐ Asthma	Relative: _____ Circle: Maternal/Paternal
☐ Emphysema/Lung Disease	Relative: _____ Circle: Maternal/Paternal
☐ Cancer (Describe: _____)	Relative: _____ Circle: Maternal/Paternal
☐ Glaucoma	Relative: _____ Circle: Maternal/Paternal
☐ Mental Health	Relative: _____ Circle: Maternal/Paternal
Other: _____	Relative: _____ Circle: Maternal/Paternal

SURGERIES:

Please list any surgeries (including the year). If you have not had any, please write N/A.

SURGERY:	YEAR:
_____	_____
_____	_____
_____	_____

Please list any additional surgeries on the back of this page.

CARE TEAM:

Are you under the care of another doctor for any medical problem? ☐ YES ☐ NO

Specialty of Physician: _____ How long have you seen this physician: _____

Name of Physician: _____ Phone Number: _____

Location: _____

IMMUNIZATIONS:

Immunization Name:	Year:
☐ Tetanus (DT)	_____
☐ Prevnar (Pnemonia)	_____
☐ Zostavax (Shingles)	_____
☐ Flu Shot	_____

PROCEDURES:

NAME OF PROCEDURE:	YEAR	COMMENTS:
☐ EKG	_____	_____
☐ Colonoscopy	_____	_____
☐ Bone density study	_____	_____
☐ Cardiac Workup	_____	_____
☐ Stool Occult Blood	_____	_____
☐ Other: _____	_____	_____

WOMEN ONLY:

Menstrual Periods

Age Onset: _____ Periods Regular/Irregular: _____ Are you still having periods? _____

Date of Last Period: _____ Pregnancies: _____ Births: _____ Miscarriages: _____

Last Pap Smear: _____ Results: _____

Last Mammogram: _____ Results: _____

PHARMACY

Name of Pharmacy: _____

Phone Number: (_____) _____ - _____ Fax Number: (_____) _____ - _____

Address: _____ City: _____

State: _____ ZIP Code: _____

The above information is true to the best of my knowledge.

Patient Name: _____ Date of Birth: _____

Patient/Guardian Signature: _____ Today's Date: _____

Office Use Only

_____

_____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: ____/____/_____
Social Security Number (optional): _____ - _____ - _____

INFORMATION REQUEST FROM:

Name of Facility / Doctor: _____

Address: _____ City: _____
State: _____ ZIP: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

REQUESTOR OF INFORMATION:

Longwood Medical Group
Phone: (407) 333-3360
Fax: (407) 333-2920

STAT

INFORMATION TO BE DISCLOSED (please specify):

DESCRIPTION	DATE(S)	DESCRIPTION	DATE(S)
☐ Admission Form ☐ Physician Dictated Reports ☐ Physician Orders ☐ Physician Progress Notes ☐ ER Documentation ☐ X-Ray Reports ☐ Laboratory Reports ☐ EKG(s)		☐ Operative Documentation ☐ Invasive Procedure ☐ EKG(s) ☐ Medical Sheets ☐ Nursing Documentation ☐ Other: ☐ Entire Medical Record	

PURPOSE OF DISCLOSURE: ☐ Continuing care with another physician/hospital ☐ Personal Copy ☐ Other (specify):

AUTHORIZATION: I understand that:

- This authorization will remain in effect for 365 days
- I may revoke this authorization at any time in writing but if I do, it will not affect any actions taken prior to receiving the revocation
- I may refuse to sign this authorization and that it is strictly voluntary
- If the requestor or receiver is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations and may be re-disclosed
- If I do not sign this form, my health care and the payment for my health care will not be affected
- I understand that I may see and obtain a copy of the information described on this form for a reasonable copy fee, if I ask for it.
- I will receive a copy of this form after I sign it.

I acknowledge the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

Patient/Guardian/Representative Printed Name: _____

Patient/Guardian/Representative Signature: _____ Date: ___/___/_____

Witness Signature: _____ Date: ___/___/_____

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Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule

Federal civil rights laws and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, together protect your fundamental rights of nondiscrimination and health information privacy. Civil Rights help to protect you from unfair treatment or discrimination, because of your race, color, national origin, disability, age, sex (gender), or religion. Federal laws also provide conscience protections for health care providers.

The Privacy Rule protects the privacy of your health information; it says who can look at and receive your health information, and also gives you specific rights over that information. In addition, the Patient Safety Act and Rule establish a voluntary reporting system to enhance the data available to assess and resolve patient safety and health care quality issues and provides confidentiality protections for patient safety concerns.

The following individuals listed below are approved to release medical information to:

Name:	Relationship to the Patient:
Person 1: _____	_____
Person 2: _____	_____
Person 3: _____	_____
Person 4: _____	_____
Person 5: _____	_____

Patient Name: _____ Date: ____/____/_____

Patient/Guardian Signature: _____ Date: ____/____/_____

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FINANCIAL POLICIES

- ☐ Copays are due and collectable at check-in for patient visits.
- ☐ Any outstanding account balances must be paid prior to patient being seen, or payment plan arrangements must be made.
- ☐ Self-pay patients must pay for services at check-in.
- ☐ If an appointment is not cancelled at least 24 hours in advance, patient will be charged a twenty-five dollar ($25) fee; this will not be covered by your insurance company.

For any financial questions or concerns, please contact our billing department at (407) 767-8200.

CANCELLATION/NO SHOW POLICY:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a twenty five dollar ($25) fee; this will not be covered by your insurance company.

PRESCRIPTION REFILLS:

Please allow 4-5 business days to fully process medication refill requests. To submit a request, please contact your pharmacy and have them send in a "Medication Refill Request" to our office and it will be handled accordingly.

In some cases, the providers will request to see you for an appointment before filling the prescription(s) for various reasons. In this situation, you will be contacted by a staff member to set up an appointment to meet with the provider.

MEDICAL FORMS:

Certain medical forms require a fee that will not be covered by your insurance company. For questions regarding the specific fee, please speak to the receptionist.

By signing below, I acknowledge the above information and understand office policies.

Patient Printed Name: _____

Patient Signature: _____ Date: _____