North Florida Family Medicine

New Patient Registration

Last Name: _____ **First Name:** _____ **Preferred Name:** _____

Middle Name: _____ **Suffix:** _____

Gender: _____ **Date of Birth:** _____/_____/_____ **Social Security Number:** _____-_____-_____

Home Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone Numbers: Home_____ Mobile_____ Work_____

Do you agree to receive automated text alerts on your mobile phone? ☐ Yes ☐ No
Do you agree to receive automated phone calls on your mobile phone? ☐ Yes ☐ No

Email Address: _____

Contact Preference: ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Mail ☐ Portal

Preferred Language: _____

Race:

☐ White ☐ Asian ☐ Other: _____
☐ Black or African American ☐ American Indian ☐ Decline to specify

Ethnicity:

☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other: _____ ☐ Decline to specify

Marital Status:

☐ Married ☐ Divorced ☐ Widowed
☐ Single ☐ Separated ☐ Partner

Legal Guardian (if patient is a minor)

Name: _____ Relationship to Patient: _____

Emergency Contact

Name: _____ Relationship to Patient: _____ Phone Number: _____

Employer: _____**Occupation:** _____

Guarantor (please complete if someone other than the patient is responsible for payment)

Last Name: _____ First Name: _____ DOB: _____

Patient's Relationship to Guarantor: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Pharmacy Name: _____ Location: _____ Phone Number: _____

Insurance Information

Primary Policy

Payer (Insurance Company): _____Policy Number: _____ Group Number:_____

Policy Holder Name: _____ **Patient's Relationship to Policy Holder:** _____

Policy Holder Date of Birth: _____/_____/_____**Policy Holder Gender:** _____

Secondary Policy

Payer (Insurance Company): _____Policy Number: _____ Group Number:_____

Policy Holder Name: _____ **Patient's Relationship to Policy Holder:** _____

Policy Holder Date of Birth: _____/_____/_____**Policy Holder Gender:** _____

North Florida Family Medicine

Allergies

Please list all known drug allergies, as well as the type of reaction and level of severity.

☐ No known drug allergies

Allergy	Reaction (if known)	Severity (if known)

Medications

Please list all medications you are currently taking. You may attach a separate paper if needed.

☐ No medications

Medication Name	Dose	Route (oral, subcutaneous, etc.)	Frequency (daily, twice a day, nightly as needed, etc.)

Vaccinations

Please list all vaccinations you have had.

Vaccine Name	Date

Family History

Please list any family history of illness or disease.

Illness or Disease	Family Member(s)

North Florida Family Medicine

Social History

Smoking Status:

- ☐ Never Smoker
- ☐ Former Smoker
- ☐ Current Every Day Smoker
- ☐ Current Some Day Smoker

If applicable:

Cigarettes – packs per day: _____

Chewing tobacco – packs per day: _____

At what age did you start smoking? _____

Total number of years smoking: _____

Secondhand smoke exposure? ☐ Yes ☐ No

Alcohol Consumption:

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Do you use any illegal drugs? ☐ Yes ☐ No If yes, please list: _____

Caffeine Intake:

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Highest Level of Education:

- ☐ _____ Grade
- ☐ 2-Year College
- ☐ 4-Year College
- ☐ Post-Graduate

Living Situation: ☐ Lives alone ☐ Lives with others

Other details:

☐ Not Sexually Active ☐ Sexually Active with One Partner ☐ Sexually Active with Multiple Partners

Sexual orientation: _____

Number of Children: _____

How often do you exercise?

- ☐ Never
- ☐ A few times a week
- ☐ Once a day
- ☐ Multiple times a day

Do you routinely wear a seatbelt? ☐ Yes ☐ No

Do you have an Advance Directive? ☐ Yes ☐ No

Which statement best reflects your wishes on advanced care recommendations?

- ☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.
- ☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- ☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.

North Florida Family Medicine

Surgical History

Please list any surgeries you have had and write in the date.

- ☐ NONE
- ☐ Appendectomy (date: _____)
- ☐ Bariatric Surgery (date: _____)
- ☐ Breast Augmentation (date: _____)
- ☐ Breast Lumpectomy (date: _____)
- ☐ Breast Mastectomy (date: _____)
- ☐ C-section (date: _____)
- ☐ Colectomy (date: _____)
- ☐ Colostomy (date: _____)
- ☐ Gallbladder Cholecystectomy (date: _____)
- ☐ Heart Valve Replacement (date: _____)
- ☐ Heart Bypass Surgery (CABG) (date: _____)
- ☐ Heart Transplant (date: _____)
- ☐ Heart Angioplasty (stents) (date: _____)
- ☐ Joint Replacement (Hip) (date: _____)
- ☐ Joint Replacement (Knee) (date: _____)
- ☐ Joint Replacement (Shoulder) (date: _____)
- ☐ Kidney Stone Removal (date: _____)
- ☐ Kidney Transplant (date: _____)
- ☐ Kidney Nephrectomy (date: _____)
- ☐ Liver Transplant (date: _____)
- ☐ Liver Shunt (date: _____)
- ☐ Ovaries Oophorectomy (date: _____)
- ☐ Ovaries Tubal Ligation (date: _____)
- ☐ Prostate Biopsy (date: _____)
- ☐ Prostate TURP (date: _____)
- ☐ Prostatectomy (date: _____)
- ☐ Skin Cancer Excision (date: _____)
- ☐ Tonsillectomy (date: _____)
- ☐ Uterus Hysterectomy (date: _____)
- ☐ Other _____

  _____

Gynecologic History (if applicable)

Last Pap smear: ____/____/____

Have you had an abnormal Pap smear? ☐ Yes ☐ No

Current birth control method: _____

Last Mammogram: ____/____/_____

Obstetric History (if applicable)

Total number of pregnancies: _____

Number of full term pregnancies: _____

Number of premature pregnancies: _____

Number of induced abortions: _____

Number of miscarriages: _____

Number of ectopic pregnancies: _____

Number of multiple births (twins, triplets): _____

Number of living children: _____

North Florida Family Medicine

Past Medical History

Please tell us about your medical history. Check all that apply:

- ☐ NONE
- ☐ ADHD
- ☐ AIDS/HIV
- ☐ Abuse/Dosmetic Violence
- ☐ Acne
- ☐ Allergies
- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism Spectrum Disorder
- ☐ Birth Defects or Inherited Disease
- ☐ Bladder Problem
- ☐ Blood Disorder
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Breast Problem
- ☐ COPD
- ☐ Cancer
- ☐ Chickenpox
- ☐ Colon Cancer
- ☐ Congenital Anomalies
- ☐ Congestive Heart Failure
- ☐ Constipation
- ☐ Coronary Artery Disease
- ☐ Dementia
- ☐ Depression
- ☐ Developmental or Behavioral Disorder
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Ear or Hearing Problems
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Endometriosis
- ☐ Fibromyalgia
- ☐ GI Problems
- ☐ Gout
- ☐ Head Injury/Concussion
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hospitalizations
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ MRSA Exposure
- ☐ Melanoma
- ☐ Mental Illness
- ☐ Muscle, Joint, or Bone Problems
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Other _____
  _____
  _____
  _____
- ☐ Ovarian Cancer
- ☐ Polyps
- ☐ Pre-eclampsia
- ☐ Pulmonary Embolism
- ☐ Reflux/GERD
- ☐ Rosacea
- ☐ Seizures/Epilepsy
- ☐ Skin Cancer (Not Melanoma)
- ☐ Skin Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thrombophilias
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Varicosities
- ☐ Vision or Eye Problems
- ☐ Vitamin B12 Deficiency
- ☐ Vitamin D Deficiency

Please let us know if there is anything else you would like to disclose.

_____

_____

What issues would you like addressed at your first appointment?

_____

_____

North Florida Family Medicine

Authorization to Disclose Protected Health Information (PHI)

Please complete this form if you would like for us to be able to share protected health information (such as test results, etc.) with another person.

Patient Name: _____Date of Birth: _____/_____/_____

By signing this form, I authorize the release of protected health information as follows:

From

North Florida Family Medicine
1717 SW Newland Way
Lake City, FL 32025
Phone: 386-754-4111
Fax: 386-754-4118

To

Last Name: _____First Name: _____

Home Phone: _____Mobile Phone: _____

Relationship to Patient: _____

Would you like this authorization to expire on a certain date? ☐ Yes ☐ No If yes, which date? _____/_____/_____

This authorization allows North Florida Family Medicine to use and disclose (release) certain PHI, which includes medical records, as I have directed.

I understand that:

- The PHI may include information about mental health, substance and/or alcohol abuse, HIV/AIDS, and STDs.
- This authorization may be used to share the same type of PHI indicated above which may be created in the future, until the expiration date.
- This authorization will remain in effect until the date specified above or, if no date is specified, until I revoke it in writing.
- I have the right to revoke this authorization at any time, if I do so in writing to North Florida Dermatology and that the revocation will not apply to action already taken as a result of this authorization.
- I may refuse to sign this authorization and doing so will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.
- PHI released per this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.

Patient Signature: _____Date: _____

or

Legal Representative Signature: _____ Date: _____

Relationship to Patient: _____

North Florida Family Medicine

Consent and Authorization Form

I. **Authorization for Medical Care:** I consent to any Care that may be considered necessary and/or advisable in the judgment of my Healthcare Provider. I understand that my Healthcare Provider is an employee of North Florida Family Medicine. I consent to having photographs taken of me in the course of and related to my Care and to the use of such photographs and my medical data for treatment and educational purposes. I understand that my physician may access my medical information from a variety of sources, including information about my medication use that comes from electronic prescribing software and databases. **Telemedicine**. I understand and agree that my Healthcare Provider may utilize telemedicine (the electronic communication of medical information) including, but not limited to, videoconferencing, electronic transmission of imaging, and remote monitoring of vital signs as part of my Care. Except in emergency circumstances, my Healthcare Provider will explain the risks and benefits of telemedicine prior to the telemedicine encounter. I understand that I have the right to seek Care elsewhere in lieu of a telemedicine encounter.

II. **Risk Management and Dispute Resolution:** I agree that my patient information (including, but not limited to, my medical records, billing information, and information I disclose to a health care provider in the course of my Care) may at any time be used by and disclosed to employees, officers, agents, and legal representatives of North Florida Family Medicine for purposes of risk management, and formal and informal dispute resolution processes (including, but not limited to, litigation and mediation) involving one or both of these entities.

III. **Release of Medical Information:** I authorize North Florida Family Medicine to release information from my medical records (including information relating to psychiatric and/or psychological care, alcohol and/or substance abuse, and HIV tests) and any other information that may be required to secure payment for charges incurred by me or on my behalf to: (1) any North Florida Family Medicine affiliated provider; (2) my referring physician; (3) the guarantor on my accounts; (4) any Third Party Payor (including, but not limited to, Medicare, Medicaid, Tri-care, governmental programs, health, accident, automobile, or other insurance, worker's compensation, HMO (commercial, Medicaid, Medicare), self-insured employers and any other sponsors who may contribute payment for Care) that contributes payment for my Care. In addition, I authorize the release of any information to county, state, or federal public health agencies, as required by law.

IV. **Assignment of Benefits and Responsibility for Payment:** I assign to North Florida Family Medicine payment from any Third Party Payor with whom I have coverage or from whom benefits are or may become payable to me, for Care I receive (past, present, or future). I agree to be personally responsible for payment of any Care that is not covered by a Third Party Payor, including, but not limited to, non-covered or out-of-network services, deductibles, co-insurance, and/or co-payments.

V. **Guarantor Agreement:** By signing this form, I agree that all charges connected with Care not covered by any Third Party Payor are due and payable by me at the time the Care is rendered or at the discontinuation of Care. If the insurance information I have provided is not active at the time of Care, I will be responsible for any balance due at the time the Care is rendered. The charges I agree to pay are those listed in North Florida Family Medicine’s current fee schedule (which is available for inspection upon request) as modified by any applicable contract North Florida Family Medicine may have with a Third Party Payor. I understand that billing statements will be sent to the patient to whom the Care has been rendered and the guarantor is responsible for payment. I acknowledge that, unless the North Florida Family Medicine and my Third Party Payor have agreed that I will not be billed, if North Florida Family Medicine has agreed to bill my Third Party Payor, it has agreed to do so as a courtesy and that North Florida Family Medicine has the right to demand payment in full from me at any time prior to full payment from any Third Party Payor. If an overdue account is referred to collections, I agree to pay the attorney's fees, court costs, and/or collection agency fees associated with the collection process. I consent to North Florida Family Medicine or any third party contacting me by telephone, including my cellular phone, for purpose of collecting any amounts owed by me. I specifically waive any exemption of wages from garnishment, which might be available by law, and agree that my wages can be garnished in the event a judgment is entered against me for collection of charges I have agreed to pay.

VI. **Agreement to Pay for Professional Component of Pathology Services**: When a specimen of my skin, tissue, blood, urine, stool, or similar material is tested, the testing will be performed under the supervision of a pathologist at a separate facility. I understand I will receive a bill from the pathologist for these services for each test. By signing this document, I agree to be responsible for the pathologist's bill to the extent that payment is not provided by my Third Party Payor.

VII. **Agreement to Mediate:** In accepting Care at North Florida Family Medicine, I agree that before I file any lawsuit against North Florida Family Medicine or any of its providers, employees, or agents, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third party person who has been certified to be a mediator tries to help settle claims. I further agree that any mediation must take place in the state and county where my treatment was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

I acknowledge that I have been provided a copy of the Consent and Authorization Form and I have read and understand its contents. I understand that I may ask questions regarding the Consent and Authorization Form and I may request a copy of this document at any time.

Patient Signature: _____ Date: _____

or

Legal Representative Signature: _____ Date: _____

Relationship to Patient: _____

North Florida Family Medicine

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact North Florida Family Medicine at 386-754-4111.

Our legal duty to protect health information about you

We understand your health information is personal and we are committed to protecting it. We create a record of the care and services you receive at North Florida Family Medicine to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by North Florida Family Medicine, whether made by the provider or staff members. This notice describes how we may use and disclose your health information, and provides examples where necessary. This notice also describes your rights regarding your health information.

We are required by law to maintain the privacy of health information, to provide individuals with notice of our legal duties and privacy practices with respect to health information, and to abide by the terms of the notice currently in effect.

Changes to this notice

We reserve the right to change our privacy practices and this notice at any time. We reserve the right to make the revised notice effective for health information we already have about you as well as any information we receive in the future. A copy of the current notice will be available upon request at our office.

Consistent with state and federal law, we may use and disclose your health information without your written permission in the following circumstances:

We may use and disclose your health information to provide medical treatment to you and to coordinate or manage your healthcare and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may use and disclose your health information when you need lab work or an x-ray. Also, we may use and disclose your health information when referring you to another healthcare provider or to recommend treatment alternatives to you.

We may use and disclose your health information to bill and receive payment for services rendered. For example, a bill may be sent to you or your insurance company. The items on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used so that your health plan will pay the medical bill. We may also tell your health plan about a treatment you are expected to receive in order to obtain prior approval or to determine if your health plan will pay for that treatment.

We may use and disclose your health information for healthcare operations. We will use your health information for regular operations of the clinic to provide patients with quality care. For example, members of the medical staff may use information in your health record to assess the care you receive and the outcomes of your treatment.

We may also use and disclose your health information:

- When necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- To authorized officials when required by federal, state, or local law.
- In response to a subpoena, court, or other administrative order.
- As required by law, for public health activities. For example, preventing or controlling disease, reporting births and deaths, and reporting abuse and neglect.
- For authorized Worker’s Compensation activities.
- To health oversight agencies. For example: agencies that enforce compliance with licensure or accreditation requirements.

- To coroners, medical examiners, or funeral directors to carry out their duties.
- As required by military command authorities, if you are a member of the armed forces.
- To our business associates to carry out treatment, payment, or health care operations on our behalf. For example, we may disclose health information about you to a company who bills insurance companies for our services.
- For research or to collect information in databases to be used later for research.
- To a correctional institution having lawful custody of you as necessary for your health and the safety of others.

You may refuse to permit certain uses and disclosures of your health information

Unless you object, we may use or disclose your health information in the following circumstances:

- Individuals involved in your care or payment for your care. We may use or disclose information to a family member, legal representative, or other persons involved with or responsible for your care or the payment of your care.

Uses and disclosures of health information that require your written permission

Other uses and disclosures of health information not covered by this notice or applicable law will be made only with your written permission. If you provide permission to use or disclose health information, you may revoke that permission at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your revocation. We are unable to take back any disclosures already made with your permission.

We will not use or disclose your protected health information for marketing purposes, nor will we sell your protected health information without your written permission.

Your rights regarding your health information

You have the following rights regarding health information we maintain about you:

- Right to See and Obtain Copies of your Health Information

  You have the right to see and obtain copies of health information used to make decisions about your care. Usually this includes medical and billing records.

  To view and copy your health information, you must give written authorization. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to see and obtain copies of your health information in certain very limited circumstances. You have the right to appeal the denial.

- Right to Amend

  If you think that your health and billing information is incorrect or incomplete, you may ask us to correct it. We may deny your request if:

  1. The information was not created by us;
  2. We believe the information is correct and complete; or
  3. You do not have the right to review parts of the medical record under certain circumstances.

  We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial.

  If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, as needed, including persons you name who have received information about you and who need the amendment. Your request must be in writing and include an explanation of your reason(s) for the amendment.

- Right to an Accounting of Disclosures

  You have the right to request an Accounting of Disclosures. This Accounting of Disclosures report does not include disclosures made for your treatment, payment, or health care operations. It also does not include disclosures made to or requested by you, or that you authorized.

  You must submit your request for a report in writing to North Florida Family Medicine. Your request must state a time period, which is limited to the previous six years from the date of the request. The first request for an accounting of disclosures will be provided free of charge. We may charge you for additional report requests made within a 12 month period.

- Right to Request Restrictions

  You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or healthcare operations. If we agree with your request, we will comply unless the information is needed to provide emergency treatment, is required by law, or is otherwise required to be disclosed as listed in this notice.

  You must make your request for restrictions in writing to North Florida Family Medicine. Your request must include what information you want to limit and how you want the limits to apply.

  You have the right to restrict disclosures of health information made to a health plan when the items or services were paid in full prior to being rendered. Certain limitations apply.

- Right to Choose How We Communicate With You

  You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Please advise us of your preferred method of communication at the time of patient registration. We will not ask you the reason for your request and will accommodate reasonable requests.

- Right to a Paper Copy of This Notice

  You have the right to receive a copy of this notice from North Florida Family Medicine.

- Right to Breach Notification

  You have the right to and will receive notification in the event of a breach of your unsecured protected health information, unless such notification is exempt by law.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us. You will not be penalized or denied services for filing a complaint. To file a privacy complaint with North Florida Family Medicine, please contact us at 1717 SW Newland Way, Lake City, FL 32025 or call 386-754-4111. To file a complaint with the Secretary of the Department of Health and Human Services, visit the Office for Civil Rights website at www.hhs.gov/ocr.

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and I have read and understand its contents. I understand that I may ask questions regarding the Notice of Privacy Practices and I may request a copy of this document at any time.

Patient Signature: _____ Date: _____

or

Legal Representative Signature: _____ Date: _____

Relationship to Patient: _____