CENTRAL MEDICAL GROUP, P.A.

Patient Registration Form

PATIENT INFORMATION:

First Name: ____________________ Last Name: ____________________ Middle Initial: _____

Date of Birth: ____________ Social Security Number: ____________________

Sex: Female ☐ Male ☐ Other ☐ ____________

Marital Status: Single ☐ Separated ☐ Married ☐ Widowed ☐ Divorced ☐

Address: ____

City: ____________________ State: __________ Zip: __________

Home Phone: ____________________ Mobile Phone: ____________________

E-mail: ______________________________

EMERGENCY CONTACT:

First Name: ____________________ Last Name: ____________________ Relationship: ____________

Address: ______________________________ City: ____________ State: ______ Zip: ______

Phone Number: ____________________

ETHNICITY/LANGUAGE/RACE:

Ethnicity: Not Hispanic or Latino ☐ Hispanic or Latino ☐

Race: American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race: ____________________ ☐

Primary Language: English ☐ Creole ☐ Spanish ☐ Other ☐ ____________

Primary Care Physician: ______________________________ Phone: ____________________

Referring Doctor: ______________________________

Pharmacy: ______________________________ Phone: ____________________

I hereby authorize direct payment of medical benefits to Dr. ____________ for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Patient Name (Please Print): ____

Signature: ______________________________ Date: ____________________

PERSONAL MEDICAL HISTORY- Do you now(current) or have had (past) any of the following conditions
□**NONE**

- □Heart disease / Murmur / Angina
- □High cholesterol
- □High blood pressure
- □Low blood pressure
- □Heartburn (reflux)
- □Anemia or blood problems
- □Swollen ankles
- □COPD
- □Cancer:___________________
- □ Shortness of breath
- □ Asthma
- □ cough
- □ Sinus problems
- □ Seasonal allergies
- □ Tonsillitis
- □ Ear problems
- □ Emphysema
- □Eye disorder / Glaucoma
- □Seizures
- □Stroke
- □Headaches / Migraines
- □Neurological problems
- □Depression / Anxiety
- □Psychiatric care
- □Diabetes
- □Kidney / Bladder
- □ Hepatitis
- □Arthritis
- □ Osteoporosis
- □Ulcers/colitis
- □Thyroid problems

□Other____

SURGICAL HISTORY – Please check off any procedure or Surgery you have had in the Past □**NONE**

	Year of Surgery		Year of Surgery
□ Cataract		□Back Surgery(Lumbar)	
□Sinus Surgery		□EGD (Stomach Endoscopy)	
□Neck Surgery		□Colonoscopy	
□ Coronary Bypass		□ Hip surgery Left or Right	
□Coronary Stent		□Knee Surgery Left or Right	
□ Heart Surgery (other than coronary bypass)		□Vasectomy	
□Breast Surgery Left or Right		□Ovary Removal	
□ Appendectomy		□ Hysterectomy (Total)	
□Gallbladder Removal		□ Hysterectomy (Partial)	

Other:

FAMILY HISTORY- Indicate which relative has had the following diseases (parents siblings most important)
□**NONE**

	High Blood Pressure	Heart Disease	Diabetes	Cancer	Asthma	Hayfever	Arthritis	Kidney Disease	Glaucoma	Stroke	Migraine	Mental Illness	Alcoholism	Bleeds Easily	Anemia	Psoriasis	Eczema	allergies	High Cholesterol
Father																			
Mother																			
Brother(s)																			
Sister(s)																			
Mother's Relative																			
Father's Relative																			

SOCIAL HISTORY

Tobacco USE

Smoke cigarettes: □ Never □ Yes □ No

Quit Date:__________ **How many packs did you smoke?**________

Approximately how many packs a day did you smoke?_________

Alcohol Use

Do you drink Alcohol? □ Never □ Yes □ No

# of drinks/Week:____________

□ Beer □Wine □Liquor

Medication Name	Strength	How Often	Medication Name	Strength	How Often

PREVENTIVE SERVICES EDUCATION SHEET

The promotion of healthy lifestyles and the early identification of potential health risks will benefit you and are important to us. In accordance with the current United States Preventive Services Task Force (USPSTF) guidelines, we have put together the following information for your guidance. Please read this preventive education sheet and feel free to discuss any of the topics with your physician. Only you can take appropriate actions to maintain your health and well being.

I. LIFESTYLE CHANGES

Diet and Exercise

A healthy diet and regular exercise are the most effective ways to maintain good health, longevity and increase you quality of life. Choose a diet low in saturated fat, cholesterol, sugar and salt; eat plenty of vegetables, fruits, grains which provide vitamins, mineral and fibers, lean meats, pastas, etc. Twenty minutes of exercise, three times a week (i.e., walking, swimming, etc.) will keep your heart and bones healthy.

Substance Abuse

Use of tobacco is known to cause heart disease, strokes and lung cancer. Excessive alcohol intake is associated with many illnesses, including cancer, liver disease and impaired judgment (as in driving). Illicit drug use has many risks such as AIDS, hepatitis, heart problems, and mental and social disorders.

Sexual Behavior

Certain sexual practices (i.e., promiscuity, unprotected sex) can expose you to potentially fatal diseases such as AIDS, STDs, (sexually transmitted diseases) and other common infections.

Excessive Sun Exposure

Causes skin cancer. Always wear sunscreen when exposed to the sun. The higher the SPF (sun protection factor) you use, the higher the protection level against the ultraviolet rays.

Injury Prevention

Take advantage of the many safety products that are important in preventing serious injury. These include seat belts, bicycle helmets and other protective gear, safe work habits (lifting bending, etc.) smoke detectors, firearm safety, poison prevention, water safety practices for adults and children, CPR training for house hold members, etc.

Dental Health

Brush and floss regularly. See you dentist for routine visits every six months.

II. ADVANCE DIRECTIVES

A document, that is also called a Living Will, which advises your family and physicians of your desires should you become incapacitated and unable to make decisions regarding your health care.

Have you prepared a living will? Yes ______ No ______

Please sign below and acknowledge that you have read and understand this information.

____
Print Full Name

______________________________ ______________
Signature Date

Patient Consent Form

(Please read and Sign)

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of their patient
- Use of prescribed medication
- Taking and utilization of cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Central Medical Group/ Medical Pulmonary Associates, P.A. includes consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Central Medical Group/ Medical Pulmonary Associates, P.A. may use my information for the purposes of treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Central Medical Group/ Medical Pulmonary Associates, P.A. of benefits otherwise payable to me. I hereby authorize the release of my medical records to third party insurers of authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers or for work related injury, to my employer or designee understand that I am financially responsible for charges not covered by this authorization. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations includes but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

I hereby object to the disclosure of my Private Health Information to the following individuals:

1.________________________ 2.________________________

3.________________________ 4.________________________

I acknowledge that I have reviewed the Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

________________________ ________________________

Patient (or Responsible Party) Signature Date

________________________ ________________________

Print Name Date of Birth

Central Medical Group, P.A.

6610 N .UNIVERSITY DRIVE - SUITE 120 - TAMARAC, FLORIDA 33321 - (954) 720-6166 - FAX 954-720-3638
7707 N. UNIVERSITY DRIVE - SUITE 106 - TAMARAC, FLORIDA 33321 - (954) 722-4206 - FAX (954) 722-4226
2929 N. UNIVERSITY DRIVE – SUITE 108 – CORAL SPRINGS, FLORIDA 33065 – (954) 340-1992 – FAX (954) 340-1430

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CARDIOLOGY & INTERNAL MEDICINE

LAURA ZITON, D.O.,A.C.O.F.P
American Osteopathic Board of Family Medicine

MARANDA STREIT, D.N.P, B-C
Doctor of Nursing Practice-Board Certified

BROKEN APPOINTMENTS

We see our patients by appointments only. An appointment in this office is a contract of time reserved for your treatment with our complete office staff at your disposal.

When a patient does not keep a scheduled appointment, the doctor has lost time and then must wait for the next schedule patient. However, if notice was given we could have accommodated another patient.

A 24 hour notice is required if you are unable to keep your appointment. We do charge for broken appointments.

The fee is $25.00

Thank you for your cooperation

Patient Signature:________________________________