

**PHYSICIANS' PRIMARY CARE
Patient Registration**

Social Security Number: _____ **Birth Date:** _____ **Account Number:** _____

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

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

Country: _____ **Sex :** M or F **Phone number:** _____ **Work:** _____ **Cell:** _____

Employer: _____ **E-Mail Address:** _____ **Referring Doctor:** _____

Primary Care Physician: _____ **Marital Status:** Single, Married, Divorced, Widowed or Separated

Employment: Full Time, Part Time, Not employed, Self Employed, Retired, Military Duty **Student:** Full, Part time

Insurance Information:

Name of Insurance (s): _____ Effective Date: _____

Subscriber Information:

Name of policy holder: _____ Relationship to the patient: Self, Spouse, Child, Other

Date of Birth: _____ Social Security Number: _____ Employer : _____

Address (if different than patients): _____ Home Number: _____

Work/Cell Number: _____

Emergency Contact Information:

Name: _____ Phone Number: _____ Relationship: _____

How did you hear about our office? _____

LIFETIME SIGNATURE AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claim, and authorize the use of this signature on all of my insurance claims. I understand that I am responsible for my bill. I authorize payment of medical benefits to Physicians Primary Care of SW Florida.

Patient or Responsible Party Signature: _____

Date: _____

LIFETIME AUTHORIZATION/ MEDICARE CERTIFICATION

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I REQUEST THAT THIS AUTHORIZATION ALSO APPLY TO ALL OTHER INSURANCE.

Signed: _____

Medicare Number: _____

Date: _____

PHYSICIANS' PRIMARY CARE OF SOUTHWEST FLORIDA

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Patient acknowledges and agrees that Physicians' Primary Care (PPC) may disclose Patients protected health information and patient medical record information to the following individuals who are the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient.

In addition, the Patient agrees that PPC may disclose the following type of information, contained in the Patients medical records (please initial the appropriate categories that you choose to disclose listed below):

- HIV/AIDS Information
- Mental Health Information
- Substance Abuse Information
- Sexually Transmitted Disease Information
- If Patient is under the age of eighteen (18), Pregnancy Information

May we leave test results on any of the following: (Please initial the device(s) of your choice:

- Home Answering Machine
- Cellular Phone Voicemail
- Work Voicemail or Answering Machine

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to PPC in writing.

Signature of Patient or Authorized Representative: _____ Date: _____

Printed Name of Patient or Authorized Representative: _____ Relationship: _____

Patients Social Security Number: _____

**PHYSICIANS' PRIMARY CARE OF SOUTHWEST FLORIDA
PAYMENT AGREEMENT CONDITIONS:**

SELF PAY PATIENTS:

I understand and acknowledge that I am responsible for full payment of services rendered to me by all healthcare providers "Physicians' Primary Care of Southwest Florida" and understand and acknowledge that any amount(s) which are designated "patient responsibility" are payable at the time the service is provided. Should any separate payment arrangement(s) be established my self pay responsibility that are not kept current, I agree to assume any necessary fees involved in the collection of any remaining balance should it become delinquent.

Patient/Responsible Party Signature: _____ Relationship: _____

PATIENTS WITH INSURANCE COVERAGE:

I understand and acknowledge that "Physicians' Primary Care of Southwest Florida" will file a claim(s) for insurance payment(s) with only those insurance companies with which "Physicians' Primary Care of Southwest Florida" participates with. I agree to pay for any copay or deductibles which are considered a "patient responsibility", under the conditions of my policy, at the time the service is provided. If your copay is not paid the day of your appointment there will be a \$15.00 uncollected copay fee charged to your account.

Patient/Responsible Party Signature: _____ Relationship: _____

Account# _____

Name: _____ DOB: _____ Sex: M or F Physician: _____

Reason for Visit Today: _____ Referred By: _____

Allergies: List Allergies and Reactions

Immunizations: Check those that you have had & year received.

Flu ___ Tetanus ___ Rubella ___ Varivax ___
Zostavax ___ Gardasil ___ Pneumonia ___

FAMILY HISTORY: AGE

ALIVE/DECEASED

HEALTH PROBLEMS/CAUSE OF DEATH

Father	_____	_____	_____
Mother	_____	_____	_____
Sister's	_____	_____	_____
Brother's	_____	_____	_____
Children	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____

SOCIAL HISTORY:

Do you use tobacco? _____ Do you wear seatbelts? _____ Marital Status: S M D W or Seperated
 Do you drink alcohol? _____ Do you do Self Breast Exams? _____ Occupation: _____
 Do you drink caffeinated Beverages? _____ (Coffee, Tea, Soda) Amount _____
 Do you exercise regularly? _____
 Have you used any Recreational drugs? _____
 Do you have an answering Machine? _____ May we leave a msg? _____

MEDICAL PROBLEMS: List current medical problems.

HOSPITALIZATIONS/SURGERIES:

MEDICATIONS: Including birth control pills, vitamins, including the dose and frequency, you take with or without a prescription.

WOMEN: Age of 1st Period _____ 1st Day of last period _____ **MEN:** Last colonoscopy _____
 Duration: _____ Flow: Regular, Moderate, Heavy Last Pap smear: _____
 Last Colonoscopy: _____ Last Mammogram: _____
 Last Bone Density Study: _____

PREGNANCY HISTORY:

Number of pregnancies _____ Number of living children _____
Number of miscarriages _____ Number of terminations _____
Number of C/Sections _____ Date of last pregnancy _____
Weight of largest baby _____
How long was your longest labor _____

Check any complications of pregnancy:

Infections _____ Gestational Diabetes _____ Prolonged Labor _____
Bleeding _____ 2 weeks Over Due _____ Retained Placenta _____
Toxemia (high blood pressure) _____ Other _____

PLEASE LIST ITEMS YOU WOULD LIKE TO DISCUSS WITH YOUR PHYSICIAN:
