Physicians' Primary Care of Southwest Florida

Patient Registration

Last Name_____ First Name_____ Middle Initial_____

Patient DOB**:** _____ Social Security Number_____ Sex: M or F

Address_____City_____ State___ Zip_____

Home Phone Number_____ Work_____ Cell_____

Employer_____ E-Mail Address _____

Who Should We Thank For Referring You_____

Primary Care Physician_____

Marital Status: Single, Married, Divorced, Widowed, or Separated

Employment: Full Time, Part Time, Not Employed, Self Employed, Retired, or Military Duty

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_____

Due to new Healthcare Reform guidelines, Physicians' Primary Care of SW Florida is requesting the following information to get a better sense of the overall diversity of our patient population and have a better understanding of our practice and patient needs. This confidential information will assist us in improving the quality of care you receive in our office.

Please place a check mark to the left of whichever option applies:

1) **Primary Language:** ____English ____German ____Italian ____Spanish ____French ____Other _____

2) **Race:** ____Asian ____American Indian or Alaska Native ____African American ____Native Hawaiian ____Other Pacific Islander ____White ____More than one Race ____Unreported/Refuse to Report

3) **Ethnicity**: ____Hispanic or Latino ____Not Hispanic or Latino ____Unreported/Refuse to Report

4) I acknowledge that I have received a copy of Physicians' Primary Care's Notice of Privacy Practices.

_____ _____ _____

(Signature) (Date) (Witness/Employee)

Updated 8/1/2023

Physicians' Primary Care of Southwest Florida

Patient Self Determination Act Questionnaire

Patient Name: _____ Patient DOB: _____

DON'T LOSE YOUR RIGHT TO DECIDE

You cannot remove all uncertainty about your future healthcare needs, but by having an advance directive you can have the peace of mind that comes from making your wishes known in advance!

Declaration to Decline Life-Prolonging Procedures

[ ] I have made a Living Will

[ ] I do **NOT** designate a Living Will

Health Care Surrogate

[ ] I have designated a Health Care Surrogate

[ ] I do **NOT** designate a Health Care Surrogate

Durable Power of Attorney

[ ] I have appointed a Durable Power of Attorney for Health Care decisions

[ ] I have **NOT** appointed a Durable Power of Attorney for Health Care decisions

_____

Print Name

_____ _____

Signature of Patient or Representative **Date**

Physicians' Primary Care of Southwest Florida

Patient Agreement Conditions

Patient Name: _____ Patient DOB: _____

SELF PAY PATIENTS

I understand and acknowledge that I am responsible for full payment of services rendered to me by all healthcare providers of "Physicians' Primary Care of SW 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 or Responsible Party Signature: _____ Date: _____

FOR PATIENT WITH INSURANCE COVERAGE

I understand and acknowledge that "Physicians' Primary Care of SW Florida" will file claim(s) for insurance payment(s) with only those insurance companies with which "Physicians' Primary Care of SW Florida" participates as a provider. I agree to pay for any copayment or deductibles which are considered a "Patient Responsibility", under the conditions of my policy, at the time the service is provided. Should my insurance carrier later determine that additional costs are not covered under the conditions of my policy, and I am designated as the responsible party for such services, any remaining balance will be billed to me and I will pay the remaining balance within thirty (30) days from the date of billing. I agree to assume and necessary fees involved in the collection of this account should it become delinquent. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits for any services rendered to be paid directly to the provider or the party that accepts assignment.

Patient or Responsible Party Signature: _____ Date: _____

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 the 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 carries 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: _____

NOTICE OF PRIVACY PRACTICES

I have been offered and/or received by Physicians' Primary Care a Notice of Privacy Practices.

Patient or Responsible Party Signature: _____ Date: _____

Physicians' Primary Care of Southwest Florida

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Patient DOB: _____

Please CHECK one of the following:

_____ I give my permission to Physicians' Primary Care (PPC) to disclose my protected health information and patient medical record information to the following individuals who are my family members, legal representatives, guardians, health care surrogates, or have Power of Attorney on behalf of myself.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

OR

_____ I request that all my Protected Health Information and/or Medical Record Information be disclosed to **ME ONLY.**

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: _____ Date: _____

Physicians Primary Care of Southwest Florida

Patient History-Family Practice/Internal Medicine

Patient Name: _____ Patient DOB: _____

Medical Problems - Please list or check **current** medical problems:

____Diabetes ____Emphysema ____**Hyper**thyroid ____**Hypo**thyroid ____Atrial Fibrillation ____Hypertension

____High Cholesterol ____GERD ____Arthritis

Other:

_____

_____

Please list **past** medical problems:

_____

_____

_____

Hospitalizations/Surgeries - List all Hospitalizations/ Surgeries (including dates if known)

_____Cholecystectomy (Gallbladder) _____Appendectomy (Appendix) _____Rotator Cuff Repair (Right or Left)

_____Hernia Repair _____Pacemaker Insertion _____Coronary Artery Bypass Graft (CABG) _____C-Section

_____Knee Replacement (Right or Left) _____Tonsillectomy _____Back Surgery

_____Hysterectomy (Total or Partial) _____Neck Surgery _____Hip Replacement (Right or Left)

Other:

_____

_____

Allergies - List Allergies and Reactions

_____

_____

Family History

	Age	Alive or Deceased	All Health Problems/ Cause of Death
Father:			
Mother:			
Brother's:			
Sister's:			
Son's:			
Daughter's:			
Maternal Grandparents:			
Paternal Grandparents:			

Physicians Primary Care of Southwest Florida

Patient History-Family Practice/Internal Medicine

Patient Name: _____ **Patient DOB:** _____

Social History	**Women Only**
Lived in SW FL how long? Originally From?	Age when periods began?
Are you a permanent or seasonal resident?	Number of pregnancies?
Most recent primary occupation?	Number of live births?
Marital status: S M D W Separated	Number of miscarriages?
Language spoken at home?	Have you had hysterectomy? Yes or No
Last grade completed?	Do you have your ovaries? Yes or No
Do you have a religious preference?	Do you have your cervix? Yes or No
What are your hobbies or Interests?	Date of last pap smear?
Are you right or left handed? Ambidextrous?	Date of last mammogram?
Do you exercise regularly?	Are you still having periods?
Do you drink caffeinated beverages?	Are your periods regular?
If yes, what is your usual drink and how many per day?	What are you using for contraception?
Do you drink alcohol? If yes, how often and what kind?	Do you perform self breast exams?
Have you used recreational drugs?	Have you reached menopause? Yes or No
Do you smoke? If yes, how many packs per day?	If yes, at what age?
How long have you been smoking?	
If you smoked in the past, when did you quit?	**Preferred Local Pharmacy:**
Do you use a cane, walker, or wheelchair?	
Is it OK to leave test results on your answering machine?	**Preferred Mail Order Pharmacy**:
If yes, do you prefer your cell or home number?	

General Information	**Vaccinations/Immunizations**
Result of last TB (PPD) test:	Date of last Pneumococcal Vaccine:
Date of last TB (PPD) test:	Date of last Influenza (flu) Vaccine:
For Male Patients: Date of last PSA:	Date of last Tetanus Shot:
Date of last Colonoscopy:	Date of last Gardasil (HPV) Injection:
Date of last DEXA/ bone density scan:	Date of last Zostavax (shingles):

Medications- List any medications that you are now taking. (including non-prescription medications)

Medication Name	**Dosage**	**Times Daily**