

**Registration Forms
(Please Print)**

Patient Name:		Patient DOB(mm/dd/yyyy): / /	
		Age:	
Patient SSN:	Race:	Language:	
Ethnicity: <input type="checkbox"/> Not Provided <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic		Marital Status (Circle One): Single Mar Div Wid Sep Dom.Part	
Primary Patient Street Address : (address, city, st, zip)			
Secondary Patient Street Address: (address, city, st, zip)			
Patient Phone Number(s): Home:		Cell:	Work:
Patient Email Address:			
Patient Employer:		<input type="checkbox"/> Please check here if visit is employment related.	
Reason for your visit:		Chose clinic because/Referred to clinic by (please check one box): ↓ ↓ ↓	
<input type="checkbox"/> Family <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> ZocDoc <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Other _____			
Pharmacy Name, Address, Phone Number(This may assist with calling in or electronically submitting medications): ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓			
IN CASE OF EMERGENCY			
Name of Friend or Relative: ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓		Relationship to patient: ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓	Best number to contact: ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓
Are we authorized to discuss any medical or financial issues with this person? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are they authorized to make medical decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Responsible Party Information (for minors)			
Parent Name:		Parent SSN:	Parent DOB (mm/dd/yyyy):
INSURANCE INFORMATION			
(Please give your insurance card(s) to the receptionist.)			
Is this patient covered by insurance?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Insurance Carrier:	
Subscriber's name:		Subscriber's S.S#:	Subscriber's Birth date:
Privacy Policy Acknowledgement			
<p>With my consent, Sarasota Family Medical Clinic may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations, as well as to comply with a subpoena or worker's compensation matter. I further authorize Sarasota Family Medical Clinic to access my medication history through our electronic prescription service.</p> <p>I have the right to review Sarasota Family Medical Clinic's Notice of Privacy Practices, prior to signing this consent. I may revoke my consent in writing except to the extent that the practice has already made disclosures upon my prior consent.</p> <p>In addition, I authorize Sarasota Family Medical Clinic to leave a message regarding appointment reminders with whoever answers my cell phone, home phone or on my answering machine.</p> <p>PLEASE PROVIDE YOUR INSURANCE CARD AND DRIVERS LICENSE SO WE CAN MAKE A COPY FOR YOUR FILE.</p> <p>ASSIGNMENT and RELEASE: I certify that I, and/or my dependent(s) have insurance coverage with the above insurance company(ies) and assign directly to Sarasota Family Medical Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature of all insurance submissions.</p> <p>The above named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize Sarasota Family Medical Clinic to download my medication history and Rx benefits into my account from a Rx clearinghouse.</p>			
Patient/Parent/Guardian Signature:			Date:
Parent/Guardian Name(printed):			Relationship:

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advanced Directives
<input type="checkbox"/> None <input type="checkbox"/> Do Not Resuscitate <input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> Living Will <input type="checkbox"/> HC Proxy Date Reviewed:

Medications – List all medications you take, prescription and non-prescription, and the dosage																						
<input type="checkbox"/> I do not take any medications																						
<table border="1"> <thead> <tr> <th>Medication Name</th> <th>Dosage</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Medication Name	Dosage																				
Medication Name	Dosage																					

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)
<input type="checkbox"/> No Known Allergies

Medical History – Check if you have ever experienced the following conditions, and year of onset.			
Condition	Year	Condition	Year
<input type="checkbox"/> None		<input type="checkbox"/> Gallbladder Disease	
<input type="checkbox"/> Allergies		<input type="checkbox"/> GERD (Reflux)	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Hepatitis C	
<input type="checkbox"/> Angina		<input type="checkbox"/> Hyperlipidemia	
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Irritable Bowel Disease	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Atrial Fibrillation		<input type="checkbox"/> Migraine Headaches	
<input type="checkbox"/> Benign Prostatic Hypertrophy		<input type="checkbox"/> Myocardial Infarction	
<input type="checkbox"/> Blood Clots		<input type="checkbox"/> Osteoarthritis	
<input type="checkbox"/> Cancer – Type		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Cerebrovascular Accident		<input type="checkbox"/> Peptic Ulcer Disease	
<input type="checkbox"/> Coronary Artery Disease		<input type="checkbox"/> Renal Disease	
<input type="checkbox"/> COPD (Emphysema)		<input type="checkbox"/> Seizure Disorder	
<input type="checkbox"/> Crohn’s Disease		<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Depression		<input type="checkbox"/> Other	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Other	

Surgical History – Check if you have received the following procedures, and year performed.			
Surgical Procedure	Year	Surgical Procedures	Year
<input type="checkbox"/> None		Male Only	
<input type="checkbox"/> Angioplasty		<input type="checkbox"/> Prostate Biopsy	
<input type="checkbox"/> Angioplasty w/Stent		<input type="checkbox"/> TURP	
<input type="checkbox"/> Appendectomy		(Trans-urethral resection of Prostate)	
<input type="checkbox"/> Arthroscopy Knee		<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Back Surgery		<input type="checkbox"/> Other	
<input type="checkbox"/> CABG (heart bypass)		<input type="checkbox"/> Other	
<input type="checkbox"/> Carpal Tunnel Release			
<input type="checkbox"/> Cataract Extraction		Female Only	
<input type="checkbox"/> Cholecystectomy		<input type="checkbox"/> Augmentation Mammoplasty	
<input type="checkbox"/> Colectomy		<input type="checkbox"/> Bilateral Tubal Ligation	
<input type="checkbox"/> Colostomy		<input type="checkbox"/> Breast Biopsy	
<input type="checkbox"/> Gastric Bypass		<input type="checkbox"/> Cesarean Section	
<input type="checkbox"/> Hernia Repair		<input type="checkbox"/> D and C	
<input type="checkbox"/> Hip Replacement		<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Knee Replacement		<input type="checkbox"/> Mastectomy	
<input type="checkbox"/> LASIK		<input type="checkbox"/> Myomectomy	
<input type="checkbox"/> Liver Biopsy		<input type="checkbox"/> Reduction Mammoplasty	
<input type="checkbox"/> Pacemaker		<input type="checkbox"/> TAH/BSO	
<input type="checkbox"/> Small Bowel Resection		<input type="checkbox"/> Vaginal Hysterectomy	
<input type="checkbox"/> Thyroidectomy		<input type="checkbox"/> Other	
<input type="checkbox"/> Tonsillectomy		<input type="checkbox"/> Other	

Health Maintenance – Check if you have received the following, and date of most recent exam.			
Exam	Date	Exam	Date
<input type="checkbox"/> None		<input type="checkbox"/> GYN Exam	
<input type="checkbox"/> Breast Exam		<input type="checkbox"/> Influenza Vaccine	
<input type="checkbox"/> Cardiac Stress Test		<input type="checkbox"/> Lipid Panel	
<input type="checkbox"/> Colonoscopy		<input type="checkbox"/> Mammogram	
<input type="checkbox"/> DEXA Scan		<input type="checkbox"/> PAP Test	
<input type="checkbox"/> Echocardiogram		<input type="checkbox"/> Physical Exam	
<input type="checkbox"/> EKG		<input type="checkbox"/> Pneumococcal Vaccine	
<input type="checkbox"/> Eye Exam		<input type="checkbox"/> Pulmonary Function Test	
<input type="checkbox"/> FOBT (stool card for hidden blood)		<input type="checkbox"/> Sigmoidoscopy	
<input type="checkbox"/> Foot Exam		<input type="checkbox"/> Tetanus Vaccine	

Family History – Check if any family member(s) has had any of the following conditions.							
<input type="checkbox"/> Adopted							
Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CAD (Heart Attack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer - Type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CVA (Stroke)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family History – continued							
Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperlipidemia (High Cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (High Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PVD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social History for Adult Patient							
Occupation				Employer			
Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many?		Female(s)		Male(s)	
Tobacco Use	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Less	<input type="checkbox"/> Former/Year quit:		<input type="checkbox"/> Chewing <input type="checkbox"/> Pipe	<input type="checkbox"/> Cigar <input type="checkbox"/> Cigarette		
<input type="checkbox"/> No				<input type="checkbox"/> Smokeless	Brand:		
Alcohol Use	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Less	<input type="checkbox"/> Former/Year quit:		<input type="checkbox"/> Beer <input type="checkbox"/> Wine	<input type="checkbox"/> Liquor <input type="checkbox"/> Other:		
<input type="checkbox"/> No							
Exercise Activity	<input type="checkbox"/> Moderate <input type="checkbox"/> Vigorous <input type="checkbox"/> Sedentary	Days/Week:		Sleep Pattern:			
				<input type="checkbox"/> Changes	<input type="checkbox"/> No Changes		
Caffeine Use	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Less	<input type="checkbox"/> Former/Year quit:		<input type="checkbox"/> Chocolate <input type="checkbox"/> Coffee	<input type="checkbox"/> Soda <input type="checkbox"/> Tea		
<input type="checkbox"/> No				<input type="checkbox"/> Tablets	<input type="checkbox"/> Other:		
For Pediatric Patient							
Patient Reside with:	Primary	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Both Parents	<input type="checkbox"/> Other:		
	Secondary	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Other:			
Mother's Occupation				Father's Occupation			
Parents Relationship				Childcare			
<input type="checkbox"/> Married <input type="checkbox"/> Single		<input type="checkbox"/> Divorced <input type="checkbox"/> Separated		<input type="checkbox"/> Mother <input type="checkbox"/> Grandparent		<input type="checkbox"/> Father <input type="checkbox"/> Nanny	
<input type="checkbox"/> Widowed				<input type="checkbox"/> Sibling <input type="checkbox"/> Daycare			
Tobacco Exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No				Patient is current smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Smokers at home: <input type="checkbox"/> Yes <input type="checkbox"/> No							

Patient Consent for Receipt and Transmittal of Protected Health Information

DO WE HAVE PERMISSION TO:

1. Mail notices to your home address:
2. Leave the following information on your HOME answering machine/voice mail:
 - a. Appointment information
 - b. Billing information
 - c. Medical information
3. Leave the following information on your WORK answering machine/voice mail:
 - a. Appointment information
 - b. Billing information
 - c. Medical information
4. I give permission to share appointment and billing information with the person listed below:
 - a. Name: _____
5. I give permission to share medical information with the person listed below:
 - a. Name: _____

(Please Circle One)

YES	NO
	NO
YES	NO
YES	NO
YES	NO
YES	NO
YES	NO

Patient Name: _____

Date of Birth: ____/____/____

Patient Signature: _____

Date: ____/____/____

Guardian Signature: (If under 18 years old) _____

Date: ____/____/____

Guardian Name (Printed): _____