DATE _____

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

PATIENT INFORMATION

SOCIAL SECURITY # _____

FIRST NAME _____ MIDDLE _____

LAST NAME _____

SEX _____ DATE OF BIRTH _____ /_____/_____

MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ LEGALLY SEPARATED ❑ DIVORCED ❑ WIDOWED

RACE ❑ CAUCASIAN ❑ BLACK ❑ NATIVE AMERICAN ❑ ASIAN ❑ HISPANIC ❑ _____

LANGUAGE ❑ ENGLISH ❑ SPANISH ❑ OTHER _____

(CHECK ONE) ❑ EMPLOYED ❑ RETIRED ❑ FULL TIME STUDENT ❑ SELF EMPLOYED ❑ UNEMPLOYED ❑ DISABLED ❑ PART TIME STUDENT

EMPLOYER _____

HOME ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____

WORK PHONE (_____) _____

CELL PHONE (_____) _____

PRIMARY CARE PHYSICIAN _____

HOW DID YOU HEAR OF US?
❑ PHYSICIAN ❑ WALK-IN ❑ FRIEND ❑ REFERRAL SERVICE
❑ YELLOW PAGES ❑ INSURANCE ❑ NEWSPAPER

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY _____

POLICY/SUBSCRIBER'S NAME _____ DATE OF BIRTH _____ RELATIONSHIP _____

GROUP # _____ EFFECTIVE DATE _____ MEMBER ID # _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____

POLICY/SUBSCRIBER'S NAME _____ DATE OF BIRTH _____ RELATIONSHIP _____

GROUP # _____ EFFECTIVE DATE _____ MEMBER ID # _____

PARENT/LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT _____

ADDRESS IF DIFFERENT THAN PATIENT

_____

_____

HOME PHONE (_____) _____

WORK/CELL PHONE (_____) _____

PARENT/LEGAL GUARDIAN NAME _____

ADDRESS IF DIFFERENT THAN PATIENT

_____

_____

HOME PHONE (_____) _____

WORK/CELL PHONE (_____) _____

PREFERRED PHARMACY

PHARMACY NAME _____ ADDRESS _____ PHONE _____

ALTERNATE ADDRESS

STREET _____ CITY _____ STATE _____ ZIP CODE _____

PHONE (_____) _____

Intercoastal **Medical Group** INCORPORATED

Patient Name:_____

Date of Birth:_____ Appt Date:_____

Primary Care Physician: _____ **Reason For Visit:** _____

Review Of Systems

General
- ❒ Weight Change
- ❒ Chills
- ❒ Fever/Night Sweats
- ❒ Fatigue

Eyes/Ears/Nose/Throat
- ❒ Headache
- ❒ Facial Pain
- ❒ Eye or Vision Problem
- ❒ Ear Pain
- ❒ Hearing Loss
- ❒ Nosebleeds (Epistaxis)
- ❒ Neck Problems

Cardiovascular
- ❒ Chest Pain or Discomfort
- ❒ Palpitations

Respiratory
- ❒ Shortness of Breath
- ❒ Cough
- ❒ Wheezing

Gastrointestinal
- ❒ Loss of Appetite
- ❒ Heartburn
- ❒ Nausea or Vomiting
- ❒ Abdominal Pain
- ❒ Dark or Bloody Stool

Musculoskeletal
- ❒ Joint Pain/Stiffness
- ❒ Muscle Aches

Urinary
- ❒ Difficulty Urinating
- ❒ Blood in Urine
- ❒ Dermatology
- ❒ Rash
- ❒ Skin Lesions

Endocrine
- ❒ Excessive Thirst
- ❒ Blood Sugar Problems

Neurological
- ❒ Dizziness
- ❒ Fainting
- ❒ Motor Disturbances
- ❒ Sleep Disturbances

Gynecological
- ❒ Breast Pain/Discharge
- ❒ Menstrual Problems
- ❒ Last Period: _____

Other
- ❒ Anxiety
- ❒ Depression
- ❒ Bleeding Problems

Other: _____

Medications *(use extra page if needed)*

Medication Name	Strength	Frequency	Medication	Strength	Frequency

Allergies and Reaction: _____

_____

Please list other Doctors/Specialists/Health Care Providers you see: _____

_____

Preventive Health Measures

Date		Date	
Mammogram	_____	Colonoscopy	_____
Pap Smear	_____	Fecal Occult Blood	_____
Bone Density	_____	Prostate Test (PSA)	_____
Eye Exam	_____	Prostate Exam	_____

Vaccine History

Date		Date	
Chicken Pox	_____	Meningitis	_____
Flu	_____	Pneumonia	_____
Hepatitis A	_____	Shingles	_____
Hepatitis B	_____	Tetanus	_____

Medical History

- ❒ Abnormal Pap
- ❒ Allergies (Seasonal)
- ❒ Anemia
- ❒ Anxiety
- ❒ Aneurysm
- ❒ Arthritis
- ❒ Asthma
- ❒ Atrial Fibrillation
- ❒ Back Pain
- ❒ Barrett's Esophagus
- ❒ BPH
- ❒ Cancer: _____
- ❒ Congestive Heart Failure
- ❒ COPD
- ❒ Coronary Artery Disease
- ❒ Crohn's Colitis
- ❒ Depression
- ❒ Diabetes
- ❒ Diverticulitis
- ❒ Erectile Disorder
- ❒ Gastroparesis
- ❒ Glaucoma
- ❒ GERD
- ❒ Gout
- ❒ Heart Attack (MI)
- ❒ Hemorrhoids
- ❒ Hernia
- ❒ High Cholesterol
- ❒ High Blood Pressure
- ❒ Hyperthyroidism
- ❒ Hypothyroidism
- ❒ IBS
- ❒ Insomnia
- ❒ Kidney Disease
- ❒ Kidney Stones
- ❒ Migraines
- ❒ Osteopenia
- ❒ Osteoporosis
- ❒ Peripheral Artery Disease
- ❒ Shingles
- ❒ Seizures
- ❒ Sleep Apnea
- ❒ Spinal Problems
- ❒ Stroke (TIA)
- ❒ Thyroid Nodule
- ❒ Ulcerative Colitis
- ❒ Vitamin B12 Deficiency
- ❒ Vitamin D Deficiency
- ❒ Pregnancy: # _____
- ❒ # Of Full Term:_____

Other: _____

Intercoastal **Medical Group** INCORPORATED

Patient Name:_____

Date of Birth:_____ Appt Date:_____

Surgical History

ENT	Date	Gastrointestinal	Date	Cosmetic	Date
Sinus Surgery		Appendix		Abdominoplasty (stomach)	
Tonsillectomy		Colon Resection		Breast Augmentation	
Orthopedic		Endoscopy - Upper		Breast Reduction	
Back Surgery		Gallbladder		Rhinoplasty (nose)	
Hip Replacement		Hernia Repair		Rhytidectomy (face lift)	
Side: _____		Type: _____		**Cardiovascular/Thoracic**	
Knee Replacement		**GYN/Female**		Bypass	
Side: _____		C-Section		Carotid Surgery	
Neck Surgery		D & C		Heart Catheterization	
Rotator Cuff Repair		Hysterectomy		Pacemaker	
Genitourinary		Tubal Ligation		PTCA	
Bladder Surgery		Breast Surgery		Lung Surgery	
Kidney Surgery		Type: _____		Bronchoscopy	
Prostate Surgery		**Ophthalmologic**			
Vasectomy		Cataract Surgery			
		Lasik			

Other: _____

Family History

	Alive	Age at Death	Health Issues / Cause Of Death
Father	❒	_____	_____
Mother	❒	_____	_____
Brother(s): # ___	❒	_____	_____
Sister(s): # ___	❒	_____	_____
Children: # ___	❒	_____	_____

Other Family Medical History: _____

Social History

Relationship Status
❒ Single
❒ Domestic Partnership
❒ Married
❒ Separated
❒ Divorced
❒ Widowed

Religion:_____

Employment Status
❒ Currently on disability
❒ Unemployed
❒ Part time
❒ Full time
❒ Retired
❒ Volunteer work

Occupation (current/previous)

_____

Highest Education/Degree

_____

❒ Currently in school

Exercise
❒ Exercises regularly
❒ Exercising occasionally
❒ Not exercising

Living Conditions
❒ Homebound
❒ Private residence
❒ Alone
❒ With spouse
❒ With parents
❒ With relatives *(other than parents)*
❒ In assisted living facility
❒ In nursing home
❒ Caregiver of another person

Personal And Home Safety
❒ Housing with smoke detectors
❒ Shower/Tub grab bars
❒ Use sun protection
❒ Wear Seatbelts

Sleep Pattern
Average hours of sleep: _____
❒ Problems related to sleep

Caffeine Use
❒ None
❒ Coffee: ____cups/day
❒ Tea: ____cups/day
❒ Cola:____ cups/day
❒ Over the counter caffeine pills

Tobacco Use
❒ Never ❒ Current ❒ Former, Quit: _____
How much? _____ packs/day Started: _____
Use any other tobacco products?
❒Yes, Type: _____ ❒No ❒ E-cigarette

Recreational Drug Use
❒ Never ❒ Current ❒ Former, Quit: _____
Type: _____

Opioid Use
Do you take prescription pain medication? ❒Y ❒N
Any family or personal history of:
Alcohol Abuse ❒Family ❒Self ❒None
Illegal Drug Abuse ❒Family ❒Self ❒None
Prescription Drug Abuse ❒Family ❒Self ❒None
Any personal history of preadolescent sexual abuse?
❒Y ❒N
Have you ever been diagnosed with:
❒ ADD ❒ Bipolar Disorder ❒ Depression
❒ OCD ❒ Schizophrenia ❒ None

Alcohol Use
❒ Yes, _____ drinks per day ❒ No
Feel you should cut back your drinking? ❒Y ❒N
People annoy you/criticize your drinking? ❒Y ❒N
Ever feel guilty about drinking? ❒Y ❒N
Used alcohol to get going in the morning? ❒Y ❒N

Intercoastal **Medical Group** INCORPORATED

Patient Name:_____

Date of Birth:_____ Appt Date:_____

For everyone age 12 and older, please answer the following:

Over the last 2 weeks, how often have you been bothered by any of the following problems:	**Not At All** (0)	**Several Days** (1)	**More Than Half The Days** (2)	**Nearly Every Day** (3)
1. Little interest or pleasure in doing things	❒	❒	❒	❒
2. Feeling down, depressed, or hopeless	❒	❒	❒	❒
3. Trouble falling or staying asleep, or sleeping too much	❒	❒	❒	❒
4. Feeling tired or having little energy	❒	❒	❒	❒
5. Poor appetite or overeating	❒	❒	❒	❒
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	❒	❒	❒	❒
7. Trouble concentrating on things, like reading the newspaper or watching TV	❒	❒	❒	❒
8. Moving or speaking so slowly that other people have noticed or being so fidgety or restless that you have been moving a lot more than usual	❒	❒	❒	❒
9. Thoughts that you would be better off dead or of hurting yourself	❒	❒	❒	❒

Total = _____

If you checked off any problems above, how difficult have these problems made it for you to work, take care of things at home, or get along with others? ❒Not Difficult ❒Somewhat Difficult ❒Very Difficult ❒Extremely Difficult

For adults age 65 and over, please answer the following questions:

Activities Of Daily Living/Function		
Do you need assistance with dressing, bathing or feeding yourself?	❒ Yes	❒ No
Do you need help with shopping, preparing food, housekeeping, or transportation?	❒ Yes	❒ No
Do you need assistance handling your own money or finances?	❒ Yes	❒ No
Do you need assistance managing your medications?	❒ Yes	❒ No
Do you have any difficulty with mobility?	❒ Yes	❒ No
Balance		
Do you feel dizzy or lightheaded when standing up?	❒ Yes	❒ No
Have you fallen 2 or more times in the past year?	❒ Yes	❒ No
Hearing		
Do you have any difficulty understanding speech or conversations?	❒ Yes	❒ No
Do you have to listen to the television or radio at a high volume to hear it?	❒ Yes	❒ No
Nutrition		
Do you consume fruits and vegetables on a daily basis?	❒ Yes	❒ No
Do you consume high fiber or whole grain foods on a daily basis?	❒ Yes	❒ No
Do you consume fried or high-fat foods on a daily basis?	❒ Yes	❒ No
Cognitive		
Do you have difficulty remembering recent events?	❒ Yes	❒ No
Do you have difficulty finding the right words or using the wrong words often?	❒ Yes	❒ No
Advance directives		
Do you have an advance directive in place?	❒ Yes	❒ No
If no, do you want information about advance directives?	❒ Yes	❒ No

Intercoastal **Medical Group**
INCORPORATED

CONSENT FOR COMMUNICATION AND/OR DISCLOSURE
CONSENTIMIENTO PARA LA COMUNICACIÓN Y DIVULGACIÓN

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Intercoastal Medical Group. I understand that this HIPAA consent applies to ALL providers of Intercoastal Medical Group. It is my responsibility to notify Intercoastal Medical Group of any changes.

Vea las siguientes alternativas o limitaciones relativas a la comunicación con su proveedor de atención médica o empleado Intercoastal Médicos del Grupo. Entiendo que este consentimiento HIPAA se aplica a todos los proveedores Intercoastal Médicos del Grupo. Es mi responsabilidad de notificar al grupo de Intercoastal de cualquier cambio.

Please Print (Last Name/*Apellido*) (First Name/*Primer Nombre*) (M.I.) (DOB/*Fecha de Nacimiento*)

1st Phone Preference/*preferencia teléfono*: _____
Cell/*Celular* ☐ Home/*Casa* ☐ Work/ *Trabajo* ☐

2nd Phone Preference/*preferencia teléfono*: _____
Cell/*Celular* ☐ Home/*Casa* ☐ Work/ *Trabajo* ☐

Do we have permission to leave the following information on voicemail?*¿Tenemos permiso para dejar la siguiente información en el correo de voz?*
____Billing/*Cobro* ____ Medical/*Información Médica*

Would you like to use the Patient Portal as your preferred method of communication? ___Y___N
¿Prefiere usted usar el sistema portal del paciente en la computadora cómo su método preferido de comunicación?

I give my permission to share the following information with the person(s) listed below. *Yo doy mi permiso para compartir la información siguiente con la persona o personas que se nombran a continuación*.

Name/*Nombre*: _____ Relationship/*Relación*: _____
Appointment/*Cita* **Y or N** Billing/*Cobro* **Y or N** Medical/*Información Médica* **Y or N**

Name/*Nombre*:_____Relationship/*Relación*_____
Appointment/*Cita* **Y or N** Billing/*Cobro* **Y or N** Medical/*Información Médica* **Y or N**

Name/*Nombre*: _____ Relationship/*Relación*_____
Appointment/*Cita* **Y or N** Billing/*Cobro* **Y or N** Medical/*Información Médica* **Y or N**

Please note that if a person is not listed on this form Intercoastal Medical Group will not share information with him/her. *Por favor, tenga en cuenta que si una persona no aparece en este formulario Intercostal Medical Group no compartirá información con él/ella.*

_____
Signature of Patient/ *Firma del Paciente or Guardian* Date/*Fecha*

_____
Witness Signature/*Firma del Testigo* Date/*Fecha*

Intercoastal **Medical Group**
INCORPORATED

Acknowledgement of Notice of Privacy Practices Receipt

I, _____, (patient name) acknowledge that I have received the Notice of Privacy Practices that provides a more complete description on how my information will be used and/or disclosed.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature or Legal Representative Date

For Office Use Only

Documentation of Good Faith Efforts

The patient presented for his/her appointment on this date and was provided with a copy of Intercoastal Medical Group's Privacy Notice. A good faith effort was made to obtain a written acknowledgement of receipt of the notice. However, an acknowledgement was not obtained because:

- ☐ Patient refused to sign
- ☐ Due to a medical emergency
- ☐ Unable to communicate with the patient
- ☐ Other (describe below):

_____

_____

_____ _____
Employee Name (Please Print) completing form Date

_____
Employee Signature

PLEASE READ AND UNDERSTAND THIS INFORMATION

Our Policy Regarding Patient Financial Responsibility 08/20/10

Managed Care Plans. Intercoastal Medical Group files insurance claims for managed care groups with which we participate. We accept payment for covered services from these insurance plans in accordance with our contract. Our patients are responsible for applicable co-insurance and deductible amounts. Our patients are also responsible for any and all payments for services that are not covered by insurance. The patient is responsible for payment of amounts they owe at the time of the visit.

Medicare. Intercoastal Medical Group files insurance claims for Medicare on assignment. We accept Medicare allowable amounts as payment and the patient is responsible for charges applied to their deductible, any co-insurance and non-covered charges.

Other Insurance. If the patient's insurance is with a company with which we do not participate, the patient is responsible for payment of their bill at the time of service. We will, however, file non-assigned claims to these insurance companies as a courtesy for our patients, unless the insurance is a Medicare Advantage Replacement Plan. Unfortunately, we are unable to file claims with Medicare Advantage plans if we are not participating providers.

Self Pay. All services are required to be paid in full at time of service.

Cancellations. Intercoastal Medical Group asks that you notify your physician's office if you are unable to keep your appointment. This courtesy will allow us to schedule another patient who needs to see the physician. Patients who consistently fail to show for their appointments and/or fail to notify us may be asked to find another physician outside of Intercoastal Medical Group.

Summary. Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within the policies and guidelines of our patient's insurance plan. **It is, however, the responsibility of the patient to know and understand those policies and guidelines. It is also the responsibility of the patient to seek medical care only with physicians participating with their plan.**

I understand that I am responsible for the payment of this account, and hereby assume and guarantee payment of all expenses incurred during my office visit. In the event a credit (refund) balance appears on this account, I hereby irrevocably authorize the office to transfer and apply such credit on any outstanding account with IMG incurred by myself, or my dependents. Should legal action be required to secure payment of this account, I agree to pay a reasonable collection expense, all court costs and a reasonable attorney's fee incurred thereby.

I have read and understand the office policy stated above and agree to accept the responsibility described.

_____ _____

Patient/Responsible Party Date

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment under the insurance program be either made to myself or to the provider on any service furnished to me. I authorize the above named provider to release any information needed for this claim. I further permit a copy of this authorization to be used in place of the original and I authorize the use of a telefax or photocopy of the information. This signature will act as a lifetime authorization for Medicare.

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, including hospitalization and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or tests for HIV, to release to the Social Security Administration or its intermediaries or carriers, or to the billing agent of this physician or supplier any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am financially responsible for all charges whether or not paid by said insurance.

_____ _____

Patient/Responsible Party Date