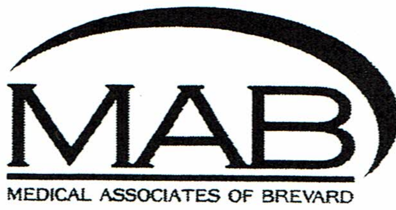

New Patient Registration

Patient Information

Patient Name

____
First MI Last

DOB ___/___/___ SS# ____________

Marital Status________ ○ MALE ○ FEMALE

Address ____________________

____

Home Phone ____________ Cell ____________

Work Phone ____________

Employer ____________________

Occupation ____________________

Name of Spouse ____________________

Address: ____________________

____

○ Check if same as patient's address

Race
○ American Indian or Alaska Native ○ Asian
○ Native Hawaiian ○ Black or African American ○ White
○ Other Pacific Islander ○ Prefer not to answer

Ethnicity
○ Hispanic/Latino ○ Non-Hispanic/Latino
○ Prefer not to answer

Preferred Language
○ English ○ Spanish ○ French ○ Indian (includes Hindu & Tamil) ○ Other ____________

Preferred Pharmacy ____________________

Location ____________________

Family Doctor ____________________

Phone ____________________

Insurance Information

Primary Insurance Co ____________________

Policy #: ____________________

Policy holder information, if not same as patient:

Name ____________________

DOB ___/___/___ SS# ____________

Secondary Insurance Co ____________________

Policy #: ____________________

Policy holder information, if not same as patient:

Name ____________________

DOB ___/___/___ SS# ____________

Complete below if patient is a minor

Father's Name (or Guardian) ____________________

DOB ___/___/___ SS# ____________

Home Phone ____________ Cell ____________

Work Phone ____________

Address: ____________________

____

○ Check if same as patient's address

Employer ____________________

Mother's Name (or Guardian) ____________________

DOB ___/___/___ SS# ____________

Home Phone ____________ Cell ____________

Work Phone ____________

Address: ____________________

____

○ Check if same as patient's address

Employer ____________________

New Patient Registration

HIPAA Release

Patient Name

____
First MI Last

Do you have a Living Will? ◯ Yes ◯ No
Do you have an Advance Directive? ◯ Yes ◯ No
If you answered yes to either, please provide us a copy.

Emergency Contact:

______________________________ ______________________________
Name Relationship

____
Phone #

I authorize Medical Associates of Brevard LLC to discuss my healthcare information with the below:

______________________________ ______________________________
Name Relationship

____
Phone #

______________________________ ______________________________
Name Relationship

____
Phone #

Preferred appointment reminder notification:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Preferred medical information notification:
I authorize Medical Associates of Brevard LLC to leave a detailed message which may contain personal health information via:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine.

Your HIPAA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Print patient's legal name____ Birth date ____________

Social Security# ______________________ (optional) Phone number______________________________

1. **Please release my records from:** (Who has your records?)
   Clinic or organization:____
   Address: ____________________________________ City: _______________________________
   State: ________ Zip Code: ___________ Phone _____________________ Fax _______________

2. **Please release my records to:** (Who needs your records?)
   Clinic or organization:____
   Address: ____________________________________ City: _______________________________
   State: ________ Zip Code: ___________ Phone _____________________ Fax _______________

3. **These are the records I would like to release:**
   - ☐ All records
   - ☐ Xray/ Radiology Reports
   - ☐ Lab Reports
   - ☐ Office Notes

For condition or dates of treatment: _________________ (If blank, we will release 1 year's worth of most recent records.)

Date records are needed by: _________________________________ Will records be picked up? _______

4. **Purpose:**
   - ☐ Continued care by another physician
   - ☐ Attorney
   - ☐ Insurance Purposes
   - ☐ Personal use
   - ☐ Other ____________________________

5. **I understand the following:**
   - To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered. This form expires one year after I sign it or if I revoke the authorization in writing sooner.
   - This does not authorize release to any third party, only the specific entity listed above.
   - There may be a fee for releasing these records.

Signature of Patient or authorized person ___________________________ Date _________________

Name:________________________________

Family History:

Family Member	Age (If Living)	Health GOOD POOR	List any Illnesses	If deceased, Cause of Death	Age at Death
Father					
Mother					
Brother/Sisters					

Social History:

Married Single Divorced Separated

Who do you live with? Spouse Significant Other Parent Children Other Caretaker Alone

Number of Children age/gender

____

____

Occupation___________________________

Do You Smoke? Y/N ________per day

If not, did you smoke in the past? Y/N

Do you drink alcohol? Y/N How often? ______

Have you used recreational drugs? Y/N

Do you have a living will? Y/N

Current Medications:

1)____

2)____

3)____

4)____

5)____

6)____

7)____

8)____

9)____

10)_______________________________________

Allergies ____________________________________

____

1801 SARNO RD SUITE 6

MELBOURNE, FL 32935

Name: ____________________

Personal Medical History:

Do you have any of the following:

High Blood pressure YES NO

High Cholesterol YES NO

Type 2 Diabetes YES NO

Hypothyroidism YES NO

Hyperthyroidism YES NO

Heart Condition YES NO

If yes, Explain____________________

____

Stroke YES NO

Asthma YES NO

COPD YES NO

Sleep Apnea YES NO

Gerd YES NO

Cancer YES NO

If yes, Explain____________________

____

Back Pain YES NO

Neuropathy YES NO

Enlarged Prostate YES NO

Urinary Incontinence YES NO

Peptic Ulcer YES NO

Anxiety YES NO

Depression YES NO

ADHD YES NO

Insomnia YES NO

Kidney Disease YES NO

Other____________________

____

Surgical history:

Name of Surgery/Year Performed	Name of Surgery/Year Performed
1:	6:
2:	7:
3:	8:
4:	9:
5:	10:

Name:______________________

GENERAL

Recent weight gain	Y	N
Recent weight loss	Y	N
Loss of appetite	Y	N
Tiring easily	Y	N
Night sweats	Y	N
Excessive thirst	Y	N
Excessive hunger	Y	N

HEAD

Frequent headaches	Y	N
Painful sinuses	Y	N

EYES

Blurry Vision	Y	N
Sudden loss of Vision	Y	N
Cataracts	Y	N

EARS

Hearing difficulties	Y	N
Ringing in ears	Y	N

NOSE

Frequent congestion	Y	N
Frequent nosebleeds	Y	N

THROAT

Hoarse voice	Y	N

MOUTH

Dental problems	Y	N
Bleeding gums	Y	N

NECK

Neck pain	Y	N
Neck stiffness	Y	N

LUNGS

Wheezing	Y	N
Shortness of breath	Y	N
Cough	Y	N

HEART

Chest pain or heaviness	Y	N
Racing heartbeat	Y	N
Dizzy spells	Y	N
Swollen feet or ankles	Y	N
Leg cramps walking	Y	N
History of heart murmur	Y	N

DIGESTIVE

Difficulty swallowing	Y	N
Heartburn	Y	N
Vomiting	Y	N
Bloating	Y	N
Diarrhea	Y	N
Black stools	Y	N
Constipation	Y	N

URINARY TRACT

Frequent urination	Y	N
Frequent Night urination	Y	N
Wet pants involuntarily	Y	N
Burning on urination	Y	N
Kidney stones	Y	N
History of UTI	Y	N

MUSCULOSKELETAL

Painful joints	Y	N
Swollen joints	Y	N
Joint stiffness	Y	N
Back pain	Y	N
History of falls	Y	N
Muscle aches	Y	N

SKIN

Skin itching/ rash	Y	N
Bruising easily	Y	N

NEUROLOGICAL SYSTEM

Fainting spells	Y	N
Lightheadedness	Y	N
Seizures/convulsions	Y	N
Tremors	Y	N
Loss of memory	Y	N
Loss of sensation	Y	N
Focal weakness	Y	N

PSYCHOLOGICAL HISTORY

Problems with memory	Y	N
Hallucinations	Y	N
Sleeping difficulties	Y	N
Feel down or depressed	Y	N
Excessive worry	Y	N

OTHER

____

____

____

____