MAB
MEDICAL ASSOCIATES OF BREVARD

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 _____

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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 _____

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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

_____

_____

MAB
MEDICAL ASSOCIATES OF BREVARD

1801 SARNO RD SUITE 6

MELBOURNE, FL 32935

Name: _____

Personal Medical History:

Do you have any of the following:

High Blood pressure	YES	NO	Cancer	YES	NO
High Cholesterol	YES	NO	If yes, Explain_____		
Type 2 Diabetes	YES	NO	_____		
Hypothyroidism	YES	NO	Back Pain	YES	NO
Hyperthyroidism	YES	NO	Neuropathy	YES	NO
Heart Condition	YES	NO	Enlarged Prostate	YES	NO
If yes, Explain_____			Urinary Incontinence	YES	NO
_____			Peptic Ulcer	YES	NO
Stroke	YES	NO	Anxiety	YES	NO
Asthma	YES	NO	Depression	YES	NO
COPD	YES	NO	ADHD	YES	NO
Sleep Apnea	YES	NO	Insomnia	YES	NO
Gerd	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:

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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

_____

_____

_____

_____

LATE CANCELLATION, LATE RESCHEDULING AND NO-SHOW POLICY

We understand that situations arise when you must cancel or reschedule your appointment. It is therefore requested that if you must change your appointment, you provide more than 24 hours' notice. This will enable another person who is waiting for an appointment to be seen. If you cancel or reschedule your appointment with less than 24 hours' notice, we are unable to offer that appointment time to another patient.

Office appointments which are canceled or rescheduled with less than 24 hours' notice may be subject to a **$30.00 cancellation fee.**

Patients who do not show up for their appointment will be considered a **NO SHOW** and may be subject to a **$30.00 no show fee.**

The late cancellation, late rescheduling and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communication. Questions about late cancellation, late rescheduling and no-show fees should be directed to the Billing Department at (321) 726-1623.

Please sign that you have read, understand and agree with this policy.

Patient Name (Please Print) Date of Birth

Signature of the patient or patient representative

1800 Sarno Rd Ste 6 Melbourne, FL 32935. Phone (321) 384-3200. Fax (321) 321 610-7929