

Central Florida Internists, Inc.

Patient Registration Information

Date: _____

Account #: _____

Personal Information:

Marital Status: Single Married Divorced Widowed

Social Security #: _____

Name: _____ DOB: _____

Address: _____ Apt/Lot#: _____

City/State/Zip: _____

Alternate Address: _____ Apt/Lot#: _____

City/State/Zip: _____

Home Phone: (_____) _____ OK to leave messages: _____ Work Phone (_____) _____

Email Address: _____

Spouse's Name: _____ Phone #: _____

Responsible Party Information:

Social Security #: _____ Phone #: (_____) _____

Name: _____ DOB: _____

Address: _____ Apt/Lot#: _____

City/State/Zip: _____

Relationship to Patient: Self Spouse Parent Other _____

Insurance Information:

Primary Insurance Company: _____

Policy Holder's Name: _____ DOB: _____

SS#: _____ Relationship: Self Spouse Child Other _____

Policy ID: _____ Group Name/#: _____

Secondary Insurance Company: _____

Policy Holder's Name: _____ DOB: _____

SS#: _____ Relationship: Self Spouse Child Other _____

Policy ID: _____ Group Name/#: _____

Emergency Contact Information:

Name of person not living with you: _____

Relationship: _____ Phone #: (_____) _____

Address/City/State/Zip: _____

How did you hear about our office? Newspaper Ad Phone Book Hospital _____

Friend/Family Member _____ May we thank him/her? Yes No

Other: _____

Central Florida Internists, Inc.

MEDICAL HISTORY

DATE: _____

NAME _____ SEX F M
 DOB _____
 SOCIAL SECURITY NO. _____

EMERGENCY CONTACT
Name: _____
Telephone #: _____

HEALTH HISTORY OF THE PATIENT

	YES	NO
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Serious Injuries		
Lung Disease		
Tuberculosis		
Phlebitis		
Anemia		
Stomach Trouble/Ulcers		
Liver Trouble		
Thyroid Trouble		
HIV/AIDS		
Other Illnesses _____		

Explain all YES Answers:

Last Dental Exam _____

Last Eye Exam _____

FAMILY HISTORY

	YES	NO
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Other _____		

REVIEW OF SYSTEMS

Have you recently had or do you now have:

	YES	NO
Reading Glasses		
Change of Vision		
Loss of Hearing		
Ear Pain		
Hoarseness		
Nosebleeds		
Difficulty Swallowing		
Morning Cough		
Shortness of Breath		
Chills or Fever		
Heart or Chest Pain		
Abnormal Heartbeat		
Badly Swollen Ankles		
Calf Cramps with Walking		
Poor Appetite		
Toothache		
Gum Trouble		
Nausea or Vomiting		

REVIEW OF SYSTEMS, CONT.

	YES	NO
Stomach Pain		
Ulcers		
Frequent Belching		
Freq. Loose Bowel Movements		
Blood in Bowel Movements		
Frequent Constipation		
Hemorrhoids		
Frequent Urination (pass water)		
Burning on Urination		
Difficulty Starting Urination		
Get Up Every Night to Urinate		
Frequent Headaches		
Blackouts		
Seizures		
Frequent Rash		
Hot or Cold Spells		
Recent Weight Change		
Nervous Exhaustion		
Insomnia		
Depression		
Nervous Tension		

WOMEN ONLY:

	YES	NO
Irregular Periods		
Vaginal Discharge		
Frequent Spotting		
Are you Pregnant?		
Are you Nursing?		
Date of Last Pap Smear: _____		
Date of Last Mammogram: _____		
Date of Last Hepatitis Vac.: _____		
Date of Last Pneumonia Vac.: _____		
Date of Last Tetanus Vac.: _____		
Hot Flashes: _____		
Night Sweats: _____		

Doctor's Signature _____ Date: _____

Name: _____ DOB _____

ALLERGIES TO MEDICINE: (NONE)

List Allergies:

List all Surgeries (include approximate dates):

Current Medications and Dosage:

Cause of death of parents, brothers, and sisters:

Father _____

Mother _____

Brother(s) _____

Sister(s) _____

SOCIAL HISTORY

Most Recent Occupation _____

Married Single Divorced Widowed

Number of Children Living _____

Number of Pregnancies _____

Presently Living Alone? Yes No

Smoke _____ packs per day/years _____

Alcohol: Never Occasional Moderate to Heavy

Drug Addiction: None Presently Past Problem

Central Florida Internists, Inc.
OUR FINANCIAL POLICY

PATIENT NAME

DATE OF BIRTH

ACCOUNT #

IF YOU HAVE MEDICARE:

We are happy to accept assignment on all Medicare claims. Medicare pays 80% of the allowable amount after your \$_____ deductible has been met. Please understand that **you** are responsible for payment of the 20% coinsurance and the deductible amount. Additionally, if you have supplemental coverage, we will bill your supplemental insurance as a courtesy to you. If for any reason your supplemental coverage does not pay, we must request payment directly from you.

IF YOU HAVE OTHER INSURANCE COVERAGE:

We will bill your insurance company for you, and request payment to be sent directly to us. We will make all reasonable attempts to collect appropriate payment from your insurance company, but payment in full is required within 60 days of the date of service. Please understand that **you** are responsible for payment of any coinsurance, deductible, and any charges not covered by your insurance.

FINANCIAL AGREEMENT: (Please initial)

___ I understand and agree that, regardless of my insurance status, I am fully responsible for the balance of my account for any professional services rendered to me by Central Florida Internists, Inc., physicians and staff. I understand and agree that unless other payment arrangements are made, payment is expected at the time of service. Failure to make proper and timely payment on my account could result in my account being referred to an outside source for collection action, and I will be responsible for any additional charges incurred.

___ If my account is turned over to a collection agency, I will have thirty (30) days from the date my account is turned over to select a new primary care physician.

NO SHOW POLICY: (Please initial)

___ I understand and agree that if I fail to cancel an appointment within 24 hours notice, I will be charged \$30 for that visit. The full amount due for the missed appointment must be received prior to my next scheduled appointment. Failure to cancel three appointments will result in dismissal from the practice for noncompliance.

___ I understand and agree that if I fail to cancel an appointment within 24 hours notice for the nutritionist or an ultrasound procedure (Echo, Carotid, Venous, etc.) I will be charge \$30. The appointment will not be reschedule until payment is made in full.

CONSENT FOR TREATMENT: (Please initial)

___ I consent to the provision of examinations, treatments, medical and laboratory procedures, drugs and supplies to the patient, as ordered or requested by the patient's physician(s) and acknowledges that no guarantee has been made as to the results of such treatments, procedures or examinations. This also includes injections of medication and/or vitamins.

Patient's Signature

Today's Date

CFI Representative

**FAMILY/FRIENDS
MEDICAL INFORMATION RELEASE**

I, _____ GIVE PERMISSION TO THE STAFF OF CENTRAL FLORIDA INTERNISTS, INC. TO DISCUSS MY MEDICAL INFORMATION WITH THE FOLLOWING PEOPLE:

- IT **MAY** INCLUDE INFORMATION RELATED TO HIV/AIDS OR STDS
 IT **MAY NOT** INCLUDE INFORMATION RELATED TO HIV/AIDS/STDS

- IT **MAY** INCLUDE INFORMATION ON MY MENTAL HEALTH.
 IT **MAY NOT** INCLUDE INFORMATION ON MY MENTAL HEALTH.

- IT **MAY** INCLUDE INFORMATION ON DRUG OR ALCOHOL ABUSE.
 IT **MAY NOT** INCLUDE INFORMATION ON DRUG OR ALCOHOL ABUSE.

<u>NAME</u>	<u>RELATIONSHIP</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

THIS REQUEST WILL REMAIN IN EFFECT UNTIL REVOKED BY THE ABOVE NAMED PERSON **IN WRITING.**

PATIENT SIGNATURE

DATE

WITNESS



CENTRAL FLORIDA INTERNISTS

Name: _____

Date: _____

Account #: _____

Please complete the following questionnaire to help us keep your medical records up to date and accurate.

ALL PATIENTS:

When was your last Lung Function test done (only if you smoke or have shortness of breath)?

When was your cholesterol checked? _____

Have you had any blood tests done recently? _____

When was your vision checked? _____

When was an EKG done? _____

When was your last ultrasound of your heart? _____

When was your last dental exam? _____

Do you have high blood pressure? _____

Do you have diabetes? _____

Have you received the pneumonia vaccine, if so when? _____

Have you received a flu shot this year? _____

If you are 50 or older, have you had a colonoscopy, if so when? _____

If you are 50 or older, when was your last Bone Density test? _____

If you are a male patient, when was your last prostate exam? _____

FEMALE PATIENTS:

If you are 18 or older, when was your last pap smear? _____

If you are 35 or older, when was your last mammogram? _____