Ocala Family Physicians

New Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Other

Ethnic Group: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Name: ______________________ ______________________ ________
Last name First name Initial

Date of Birth: _______ / _______ / _______ Social Security #: _______ - _______ - _______

Home Phone: (_____) _______________ Work Phone: (_____) _______________ Cell Phone: (_____) _______________

Address: ______________________ Apt. #: ______ City: _____________ State: ____ Zip: __________

Email: ______________________ Preferred Pharmacy (name & location): ______________________

Preferred Contact Method: ☐ Home ☐ Work ☐ Cell Preferred Appointment Reminder Method: ☐ Home ☐ Work ☐ Cell

PATIENT'S RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _______________

Name: ______________________ ______________________ ________
Last name First name Initial

Date of Birth: _______ / _______ / _______ Social Security #: _______ - _______ - _______

Home Phone: (_____) _______________ Work Phone: (_____) _______________ Cell Phone: (_____) _______________

Address: ______________________ Apt. #: ______ City: _____________ State: ____ Zip: __________

PATIENT'S INSURANCE INFORMATION

Please present ALL insurance cards to receptionist

PRIMARY Insurance Name: ______________________________________

Address: ______________________ City: _____________ State: ____ Zip: __________

Name of insured: ______________________ Date of Birth: ___________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: ______________________ Group #: ______________________ Copay: $ _________

SECONDARY Insurance Name: ______________________________________

Address: ______________________ City: _____________ State: ____ Zip: __________

Name of insured: ______________________ Date of Birth: ___________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: ______________________ Group #: ______________________ Copay: $ _________

PATIENT'S REFERRAL INFORMATION

Who may we thank for your choice to come to our office?

☐ Family member ☐ Friend ☐ Yellow Pages ☐ Website ☐ Magazine _______________

RELEASE OF INFORMATION

Please indicate the name(s) of anyone you give permission for us to release medical information to:

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

EMERGENCY CONTACT

Name: ______________________________ Relationship: ______________________________

Address: ______________________ City: _____________ State: ____ Zip: __________

Home Phone: (_____) _______________ Work Phone: (_____) _______________ Cell Phone: (_____) _______________

Consent to Treat • Assignment of Benefits • Financial Agreement

I herby give consent for treatment and authorize this healthcare provider to release all medical history and treatment information to other physicians, hospitals, or medical facility that may be included in my care and may be necessary to secure payment of benefits including, but not limited to; medication history, drug and alcohol abuse, psychiatric information, and testing for HIV and AIDS. I give lifetime authorization for payment of insurance benefits to be made directly to Ocala Family Physicians, P.A. and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _______________ Patient or Patient Representative Signature: ______________________________

PATIENT HISTORY FORM

Patient's Full Name ______________________ Date of Birth ______________ Sex ☐ M ☐ F

Spouse's Name ______________________ Date of Birth ______________

Hospital Preference ______________________ Pharmacy Preference (Name & Location) ______________________

Do you have a living will? No ☐ Yes ☐

Patient Medical History:

Have you experienced any unexpected weight loss or gain? No ☐ Yes ☐ - # pounds? __________

When was your last EKG? ________________ Chest x-ray? _______________ Tetanus shot? _______________
Colonoscopy ____________ Eye Exam __________________ Hearing Test _______________

Please explain any abnormal results: ____

Have you ever been, or are you currently being, treated for any of the following?
(If yes, please give details)

Ear Problems	☐ N ☐ Y	
Eye Problems	☐ N ☐ Y	
Hypertension	☐ N ☐ Y	
High Cholesterol	☐ N ☐ Y	
Cancer	☐ N ☐ Y	
Thyroid Disease	☐ N ☐ Y	
Lung Disease	☐ N ☐ Y	
Chest Pain	☐ N ☐ Y	
Ulcers	☐ N ☐ Y	
Hemorrhoids	☐ N ☐ Y	
Other Bowel Diseases	☐ N ☐ Y	
Urinary Tract Infection	☐ N ☐ Y	
Sexual Dysfunction	☐ N ☐ Y	
Frequent Nighttime Urination	☐ N ☐ Y	
Chronic Back Pain	☐ N ☐ Y	

Tuberculosis	☐ N ☐ Y	
Diabetes	☐ N ☐ Y	
Hay Fever	☐ N ☐ Y	
Asthma	☐ N ☐ Y	
Heart Disease	☐ N ☐ Y	
Dark Tarry Stools	☐ N ☐ Y	
Rectal Bleeding	☐ N ☐ Y	
Gallbladder Disease	☐ N ☐ Y	
Kidney Stones	☐ N ☐ Y	
Decreased Urinary Flow	☐ N ☐ Y	
Arthritis	☐ N ☐ Y	
Anemia	☐ N ☐ Y	
Chronic Skin Conditions	☐ N ☐ Y	
Psychiatric Problems	☐ N ☐ Y	
Other Medical Problems	☐ N ☐ Y	

Current Medications:

Name ______________________ Dosage ______________

Name ______________________ Dosage ______________

Name ______________________ Dosage ______________

Name ______________________ Dosage ______________

Name ______________________ Dosage ______________

Name ______________________ Dosage ______________

Allergies:

Name of Medication ______________________ Reaction ______________

Name of Medication ______________________ Reaction ______________

Name of Medication ______________________ Reaction ______________

Name of Medication ______________________ Reaction ______________

Name of Medication ______________________ Reaction ______________

Surgeries:

Reason	Date	Name of Facility / Hospital
Reason	Date	Name of Facility / Hospital
Reason	Date	Name of Facility / Hospital

Hospitalizations (other than surgeries listed above):

Reason	Date	Name of Hospital
Reason	Date	Name of Hospital
Reason	Date	Name of Hospital

Other Medical Providers/ Specialists:

Provider Name	Date Seen	Reason for Visit
Provider Name	Date Seen	Reason for Visit
Provider Name	Date Seen	Reason for Visit
Provider Name	Date Seen	Reason for Visit
Provider Name	Date Seen	Reason for Visit

Females Only:

# of Pregnancies ______ Miscarriages ______ Births ______ - complications? ____________________________

Type of Birth Control Used ____

Menstrual Cycle: How Often? _____ Duration _____ ☐ Heavy ☐ Moderate ☐ Light

Date of Last Menstrual Cycle ______________ Pap Smear ________________ Mammogram ________________

Have you ever had an abnormal pap smear? ☐ No ☐ Yes - If yes, please specify:

Date of pap smear: ___________________________________

Explain abnormality: _________________________________

Treatment given: ____________________________________

Are you still undergoing treatment? ☐ No ☐ Yes

Was your last mammogram abnormal? ☐ No ☐ Yes - Please explain: ________________________________

Family Medical History:

	Living	Deceased	Age	Medical History
Father	______	________	____	__________________________
Mother	______	________	____	__________________________
Brother(s)	______	________	____	__________________________
Sister(s)	______	________	____	__________________________

List anyone in your family with the following conditions:

High Blood Pressure	______________________	Cancer	______________________
Heart Disease	______________________	Diabetes	______________________
Kidney Disease	______________________	Lung Disease	______________________
Tuberculosis	______________________	Other Disease	______________________

Patient Social History:

Current or previous occupation: _______________________________ ☐ Retired

Smoker? ☐ Never ☐ Current - # packs per day______ ☐ Quit # of years ago ____

Alcohol? ☐ Never ☐ Current - How often __________ ☐ Quit - # of years ago ____

Patient Well-Being History:

Do you take vitamins or herbal supplements? ☐ No ☐ Yes – please specify ________________________________

Do you participate in daily exercise? ☐ No ☐ Yes – please specify ____________________________________

What concerns do you have about your skin? (please check all that apply)

- ☐ To continue a youthful look
- ☐ To treat skin problems
- ☐ To help prevent skin cancer
- ☐ Other _____________________________________

What skin regimen do you currently use to keep a youthful look, treat skin problems and to help prevent skin cancer?

____

OCALA FAMILY PHYSICIANS, P.A.
FINANCIAL AGREEMENT

1. Payment is expected at time of service. This includes co-pays, co-insurances and deductibles. There is an annual charge of $200.00 for the preventative exam. Medicare and some insurances do not cover this. If you have this benefit, and it can be verified, we will bill your insurance for the charge. If not, payment is expected at time of check-out.

2. At check-out, our staff will ask you for payment for any past due balances, as well as your portion of your payment for today's services. Failure to meet your financial obligations could result in being discharged from the practice.

3. We will submit your claim for services rendered to any insurance company in which we are in-network providers. **We do NOT file secondary claims unless there is an automatic crossover from your primary insurance company.** You will be responsible for any charges not paid by your insurance company.

4. As your medical care providers, our relationship and concern is with you and your health, not the the insurance company. Your insurance is a contract between you and/or your employer, and the insurance company. Not all services are covered by your insurance. All charges for services rendered are your responsibility.

5. It is your responsibility to inform us of any changes to your insurance and provide a copy of your most current insurance card(s).

6. There will be a $35.00 charge on all returned checks.

7. All past due accounts will be charged a late fee of $15. Collection action will be taken on past due balances. If it becomes necessary to collect any sum due through an attorney or collection agency, the patient/guarantor agrees to pay all reasonable costs of collection, including attorney and collection agency fees.

8. For all services rendered to minor patients (under age 18), the adult accompanying the patient is responsible for payment in full at the time of service, regardless of whom is legally responsible.

9. If you are unable to keep your appointment, it is important that you notify us prior to your appointment. This will allow us to open your appointment time for other patients. You will be charged a "no show fee" if you fail to notify us 24 hours in advance; a $60.00 fee for Comprehensive Physical appointments, and $30.00 for all others. Adult patients who do not show up for a scheduled appointment 3 times within a 12 month period, and fail to notify us prior to the appointment, will be discharged as a patient. Patients under the age of 18 may be discharged for the same.

10. Some insurances require that your labs be performed in a different location other than our doctor's office. If you choose to have the test(s) performed at our physician's office, you will be expected to pay the fee for this service. Your insurance cannot be billed in those instances.

11. If we prescribe a medication for you that is not on your formulary, and you don't inform us at the time of your visit, there will be a need for you to schedule an appointment with the provider to select another medication that is on your formulary. There will be a charge for this service.

________________________ ________________________ ____________

Signature of Patient/Parent | Print Name | Date

Acknowledgment of Advance Directives and Notice of Privacy Practices

I hereby acknowledge that I received Ocala Family Physicians, P.A.'s Advance Directives and Notice of Privacy Practices.

____ ____________________

Name of Patient (please print) Date of Birth

____ ____________________

Signature of Patient or Patient Representative Date

Documentation of Good Faith Efforts

To obtain patient's acknowledgment that they received provider's Advance Directives and Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient)

The patient presented to the office and was provided with a copy of Ocala Family Physicians, PA's Advance Directives and Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of these documents. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:
  ____
  ____
- ☐ The patient had a medical emergency and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ☐ Other reason (describe below):
  ____
  ____

____ ____________________

Signature of Employee Completing Form Date