Joseph C. & Ann S.
Day Medical Center

Please return this packet before an appt can be scheduled.

900 SE Salerno Rd, Stuart, FL 34997
Telephone: (772) 223-7864 Fax: (772) 781-2963

Patient Registration Form

Please bring the following items to your first appointment: picture ID, insurance card, all medication bottles (including over-the counter medications) and any Advance Directives.

Date: _____

Name _____**Birth Date** _____ **Sex: MALE** ☐ **FEMALE** ☐
Address _____**City** _____**State** _____**Zip** _____
Alternate Address _____**City** _____**State**____ **Zip** ____
Home Phone _____ **Cell Phone** _____ **Social Security No.** ____-___-____
Email Address _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Other**
Living Situation: ☐ **Alone** ☐ **Spouse** ☐ **Children** ☐ **Caregiver** ☐ **Other**
Race: _____ **Ethnicity:** _____
Current Occupation: _____

Person to contact in case of emergency:
Name _____**Phone** _____**Relationship**_____

Insurance Information (YOU MUST bring picture ID and insurance card to appointment)

Primary Insurance: Name_____
Member ID # _____ Group # _____
Insured Birth date _____Relationship to you: **SELF** ☐ **SPOUSE** ☐ **OTHER** ☐
Secondary Insurance: Name_____
Member ID # _____ Group # _____
Insured Birth date _____Relationship to you: **SELF** ☐ **SPOUSE** ☐ **OTHER** ☐
Name of Previous Primary Care Dr _____
Phone (____) _____Fax (____) _____

List any other physician/specialist currently treating you: _____
_____

Advance Directives do you have any of the following? (if YES, please bring in copy to your appointment)

1. Livings will: yes ☐ no ☐
2. Health care surrogate: yes ☐ no ☐
3. Power of attorney: yes ☐ no ☐
4. Advanced directive: yes ☐ no ☐
5. Do not resuscitate: yes ☐ no ☐

How did you hear about this practice? _____

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Medication/Supplements/Vitamins List

Please list all medications and **over the counter medications** you are currently taking- (or attach list)

Please BRING your medication bottles to EVERY appointment.

Name of Medication	Strength	How many times a day
Example:Atorvastatin	***20mg***	***One a day***

PHARMACY:

LOCAL**:** _____ PHONE#:_____

MAIL ORDER: _____ PHONE #: _____

- **I authorize and give consent to the Day Medical staff to check my prescription history from external sources. (please check and initial) _____**

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Medical History: (Please circle)

Abnormal mammogram	*Diabetes*	*Mental illness*
Abnormal pap smears	*Head injury*	*Migraines*
Addiction problems	*Heart attack*	*Overweight/Obesity*
Allergies	*Heart murmur/valve problems*	*Postmenopausal bleeding*
Arthritis	*Hepatitis*	*Seizures*
Atrial Fibrillation	*High blood pressure*	*Shingles*
Balance problems	*High cholesterol*	*Stomach ulcers*
Blood clots	*HIV*	*Skin problems*
Cancer (type_____)	*Kidney problems*	*Thyroid disorder*
Depression	*Memory problems/Dementia*	*Vision problems*

OTHER: _____

Allergies and Reaction: (ex: penicillin- rash)

_____

Surgery & Procedure History (Include the year):

_____

_____

_____

Describe any hospitalizations or recent illnesses:

_____

_____

Family History: Who in your family has/had any disease or illness? (Example: Diabetes, High blood pressure, Cancer, Heart Disease, Thyroid Disease, and Mental Illness)

Family Member	Medical Problem	Living or Deceased	Age at death
Mother		Living ☐ Deceased ☐	
Father		Living ☐ Deceased ☐	
Siblings		Living ☐ Deceased ☐	
Other:			

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Social History:

1. How is your Diet? Poor ☐ Average ☐ Good ☐ Excellent ☐
2. Do you currently smoke? Yes ☐ No ☐ If yes, start date _____ How much per day_____
   If former smoker, when did you quit? _____How many years did you smoke? _____
   How much did you smoke? _____Is there any tobacco exposure at home? Yes ☐ No ☐
3. Do you drink? Yes☐ No ☐ Beer_____Wine_____Liquor_____
   How often? _____ How much? _____
4. Do you exercise? Yes ☐ No ☐
   If yes, what exercise do you do? _____
   How often? _____For how long? _____

Preventative Screening: (Please date the last time you had one of the following)

Influenza vaccine_____
Pneumovax 23 _____
Prevnar 13 _____
Prevnar 20_____
Shingrix vaccine_____
Tetanus vaccine _____

Bone density (DEXA)_____
Colonoscopy _____
Stool test for blood_____
Mammogram _____
Pap smear _____
Covid-19 vaccines _____

Skin exam _____
Eye Exam _____
Dental Exam _____

Women

Age of first period _____ Date of last normal period _____
Birth control method _____ Are you sexually active currently? _____
No. of pregnancies _____ No. of live births _____

Men

Last PSA _____ Rectal Exam _____ No. of children: _____
Are you sexually active currently? _____

What do you want to discuss with your healthcare provider at today's visit?

_____

_____

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Insurance Benefits and Information Release/ Office Policies

SIGNATURE REQUIRED ON THIS FORM

I understand that the physician services of the Day Medical Center are to be billed by the Council on Aging of Martin County, Inc. Medical information regarding my visit at the Day Medical Center will be available to the Day Medical Center staff.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any service rendered that are not paid for directly by me.

I understand that the Day Medical Center has a no-show policy as well as a late arrival policy. As a courtesy to our office as well as to our patients who are waiting to schedule with the physician, please give us at least a 24 hour notice. If you do not cancel or reschedule your appointment with at least a 24 hour notice, we may assess a $25.00 “no-show” service charge to your account. We strive to provide longer appointment times for our patients, therefore, patients who arrive 15 minutes or later may be rescheduled to a different date/time in order to maintain the highest level of care during each visit.

I understand that the Day Medical Center does not prescribe the use of long-term controlled medications and if necessary, I will discuss the options with my provider during my initial visit.

_____
Patient’s Name (PRINT)

_____
Patient’s Name (SIGNATURE)

_____
DATE

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Permission for Verbal Communication

The Health Insurance Portability and Accountability Act (**HIPAA**)

THIS IS A REQUIRED FORM – PLEASE FILL OUT AND SIGN

_____ _____ _____

Print name of Patient **Date of Birth** **Last 4 digits of Social Security Number**

I wish to be contacted in the following manner:

Primary choice telephone number: _____Home Work Cell
Secondary choice telephone number: _____Home Work Cell

Please indicate if you authorize us to leave a message or fax information:

☐ YES ☐ NO This includes results, name of physician, date and time of appointment and any instructions.

I permit Day Medical Center, their physicians, nurses, and other personnel to discuss my health information including billing and payment information, test results or lab results in person or by telephone, with the following family members or friends involved in my medical care.

In an attempt to preserve the confidential nature of the doctor-patient relationship, please select the different locations/persons with whom or where we may leave messages regarding appointments or other administrative matters. I authorize Day Medical Center to send my records to any referring physician and or specialist to coordinate care and treatment in the future.

This may include information related to psychiatric care, drug and alcohol use, HIV testing and/or AIDS.
Limit discussions to the following medical condition(s) or services(s): _____

Name	Phone	Relationship
1._____	_____	Home Work Cell _____
2._____	_____	Home Work Cell _____
3._____	_____	Home Work Cell _____

_____None, I do not wish my information discussed with anyone other than myself.

Release of information under this document is limited to verbal discussions as indicated above and/or limited paper records or business office documents as necessary for my immediate assistance.

This authorization is valid unless revoked. If at any time I do not want verbal discussions to be permitted between my health care providers or facility and any of the individuals name above (provided that the information has not yet been released) I must notify my Health Care Provider or contact the Day Medical Center.

_____ _____

Patient or Authorized Signature **Date**

Relationship to Patient (Explain and/or attach Legal Documentation) _____

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Note: Medical records exceeding 25 pages cannot be received via fax. Mail to Day Medical Center. **CDs cannot be accepted.** Thank you.

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Authorization for Release of Medical Records

1. **I Authorize:**
_____
Name of sending person/organization
_____
Street Address
_____
City State Zip Code
_____
Phone Fax

2. **To Release to:**
DAY MEDICAL CENTER
Name of receiving person/organization
900 SE SALERNO ROAD
Street Address
STUART, FL 34997
City State Zip Code
(772) 223-7864 (772)781-2963 (772)221-1794
Phone Fax

3. **INFORMATION TO BE RELEASED:** (Check all applicable)
☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-Ray Reports
☐ Electrocardiogram (ECG) ☐ Allergy Records ☐ Other _____

SPECIAL AUTHORIZATION: Check applicable box (es) and sign immediately below.
By signing below, I am authorizing the office to release any and all information regarding:
☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: _____ Date: _____

4. Records from the time period:___/___/___ through ____/____/____

5. Purpose of Disclosure: (Check applicable purpose)
☐ Continue Medical Care ☐ Payment of Insurance Claim ☐ Legal
☐ Personal ☐ Other: _____

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee will be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Date of Birth: _____ Home Phone: _____