HEALTHCARE ASSOCIATES
OF PALM BEACH

561- 877-1800 (Phone)
561- 742-4480 (Fax)
7730 W. Boynton Beach Blvd. Suite 3
Boynton Beach, FL 33437

PATIENT REGISTRATION FORM

Last Name:_____ First Name: _____

Street Address: _____

_____

City: _____ State:_____

ZIP Code:_____ Date of Birth: _____

Gender: M or F Marital Status:_____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Patient place of employment:_____

Race:_____ Ethnicity:_____ Preferred Language:_____

Email:_____ Pharmacy:_____ Pharmacy phone number:_____

Medical Insurance Information:

Primary Insurance:_____ ID#:_____

Secondary Insurance:_____

Social Security #:_____

In case of emergency Notify_____

Number:_____ Relation to patient:_____

Release

I grant permission to view my perfection history from other sources.

I consent to report and receive immunization information from the state of Florida.

I consent to have my claims filed to my insurance carrier and I understand that any balance and or copays are my reasonability and are due at the time of the visit.

I am aware that there will be a $25 charge for any no show or missed appointments without 24 notice.

I understand that it is my responsibility to notify the office if there is ever any change in my insurance coverage and or mailing address and phone number.

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GENERAL CONSENT TO TREAT

By signing below, I or my authorized representative authorizes HAPB, physicians or practitioners and staff to conduct any diagnostic exams, tests, and procedures and to provide medication to assess; diagnose and treat my Illness or injuries. I understand that it is the responsibility of my individual treating physician to explain to me the reasons for any diagnostic exam, test, procedure, the available treatment options, and the common risks and anticipated burdens or benefits associated with these options as well as alternative courses of treatment.

_____ _____

Patient/Guardian signature Date

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REVIEW OF SYSTEMS

Name:_____ Date:_____

Date of Birth:_____

PLEASE CIRCLE ANY CURRENT ACTIVE PROBLEMS AND GIVE A BRIEF EXPLANATION.

CONSTITUTIONAL
Fever
Chills
Feeling Poorly (Malaise)
Loss of Appetite
Anorexia
Lethargy
Unusual Change in Weight

ENT
Ear Ache
Facial Pane
Loss of Hearing
Nose Bleeds (Epistaxis)
Vertigo
Nasal Discharge
Sore Throat
Ringing in the Ears (Tinnitus)
Hoarseness

EYES
Visual Disturbance
Eye Pain
Conjunctival Injection
Discharge from the Eyes
Eye Dryness
Itching of the Eyes

SKIN
Itching (Pruritus)
Rash
Purple/Red Spots (Purpura)
Change in Skin Color

CARDIOVASCULAR
Chest Pain
Palpitations
Awakening with Difficulty Breathing (PND)
Leg Pain while Ambulating (Claudication)
Lightheadedness
Difficulty Breathing while Laying Down (Orthopnea)

GASTROINTESTINAL
Abdominal Pain
Heartburn
Difficulty Swallowing (Dysphagia)
Nausea/Vomiting
Rectal Bleeding
Change in Bowel Habits

GENITOURINARY
Change in Urinary Frequency
Incontinence
Hesitancy
Frequent Night Urination (Nocturia)
Painful Urination (Dysuria)
Weakness of the Urine Stream
Blood in Urine

ENDOCRINE
Excessive Urination (Polyuria)
Excessive Thirst (Polydipsia)
Temperature Intolerance
Excessive Eating (Polyphagia)
Thyroid Issues

HEME/LYMPH
Unusual Bleeding
Easy-Bleeding
Night Sweats
Unusual Infection
Cancer (Type)

MUSCULOSKELETAL
Joint Pain
Muscle Aches
Joint Swelling
Joint Stiffness

RESPIRATORY
Cough
Sputum
Hemoptysis (cough up blood)
Shortness of Breath
Wheezing

NEUROLOGICAL
Seizure
Muscle Weakness
Headaches
Change in coordination
Dizziness

PSYCHIATRIC
Anxiety
Depression
Insomnia

Explain any problems:_____

_____

_____

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HEALTH HISTORY

When was your last:

Fasting blood work?_____ PSA/ prostate check? _____

Stress test? _____ Colonoscopy? _____

Echocardiogram? _____ Bone Density test? _____

Mammogram? _____ Dilated Eye Exam? _____

Pap Smear? _____ Dermatology Visit? _____

Have you ever been hospitalized overnight?____Yes ____ No

Have you ever had surgery? If so, please list _____

_____

Do you regularly visit any doctors beside your primary care physician?

Doctor:_____ Specialty:_____

Doctor:_____ Specialty:_____

Doctor:_____ Specialty:_____

Doctor:_____ Specialty:_____

Do you exercise? _____Yes ____ No

Do you wear sunscreen? _____Yes ____ No

Do you wear a seat belt? _____Yes ____ No

Females:

Have you ever been pregnant? _Yes ____ No

How many times?_____

How many children have you given birth to? _____

Please list any Allergies to medications: _____

_____

What PRESCRIPTION medications do you take?

NAME	DOSE	FREQUENCY	NAME	DOSE	FREQUENCY

What OVER THE COUNTER medications do you take?

NAME	DOSE	FREQUENCY	NAME	DOSE	FREQUENCY

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FAMILY HISTORY

MOTHER

Alive: _____ Age _____ Present Illness? _____

Deceased If so what age?_____

Cause of death _____

FATHER

Alive: _____ Age _____ Present Illness? _____

Deceased If so what age?_____

Cause of death _____

SIBLING

Alive: _____ Age _____ Present Illness? _____

Deceased If so what age?_____

Cause of death _____

SIBLING

Alive: _____ Age _____ Present Illness? _____

Deceased If so what age?_____

Cause of death _____

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SOCIAL HISTORY

Do you smoke? _____Yes ___ No I quit _____

If so when?_____

How many cigarettes a day do you or did you smoke? _____

Are you interested in quitting? _____Yes ___ No

How many alcoholic beverages do you drink?

_____ Per Day _____ Per Week _____ Per Month____ I don't drink

Any recreational drug use now or in the past? _____

Are you?

_____Single _____Married _____Widowed _____Divorced _____Domestic partnership

Have you ever had a sexually transmitted disease? _____Yes ___ No

HEALTHCARE ASSOCIATES
OF PALM BEACH

NOTICE OF PRIVACY PRACTICES

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice does comply with HIPAA regulations.

What is HIPAA and how does the Privacy Rule affect you? The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to comply with the regulation. Under the Privacy Rule, you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information? Any health information you provide to our practice, including your mailing address. Information that is created and retained by our practice or received from another healthcare provider that relates to your treatment, healthcare operations, payment and /or that identifies you as an individual.

What is the Notice of Privacy Practice? Our official Notice of Privacy Practice is posted in our reception area and on our website and informs our patients about their rights surrounding the protection of their Individually Identifiable Health Information and our obligations concerning the use and disclosure of such information. This notice applies to all records created, obtained or retained by our practice. We may update our Notice of Privacy Practices at any time. The following categories describe the circumstances in which we may use and disclose your Individually Identifiable Health Information:

Treatment	Treatment Options
Appointment Reminders	Disclosures required by law
Payment	Health-related benefits and services
Health Care Operations	Release of information to Family/Friends

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HEALTHCARE ASSOCIATES
OF PALM BEACH

The following categories describe unique situation in which we may disclose your individually Identifiable Health Information:

Public Health Risks Health Oversight Committees Lawsuits and Similar Activities Deceased Patients Organ and Tissue Donation Serious Threats to Health or Safety Military National Security Inmates Worker's Compensation Law Enforcement Research

What are your rights concerning your Individually Identifiable Health Information?

You have rights regarding the Individually Identifiable Health Information that we maintain about you. The policies and procedures for the following circumstances are listed in our Notice of Privacy Practices:

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a paper copy of this notice
7. Right to file a complaint
8. Right to provide an Authorization for other uses & disclosures

I have read the short notice provided on the previous page provided by HAPB Group and have been informed of how to obtain more information regarding the practice's Notice of Privacy.

_____ _____

Signature **Date**

_____ _____

Print Name **Date**

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HIPAA PATIENT PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have read the notice of HEALTH CARE ASSOCIATES OF PALM BEACH'S Notice of Privacy Practices and HIPAA regulations on the previous page.

While completing my registration process I hereby acknowledge:
I have read the information contained and I can ask my healthcare staff if I need assistance in understanding my rights, or if I would like them to be explain these materials to me in more detail.

I understand the following:
1) These materials are to inform me of my privacy rights as a patient.
2) I understand that my personal "protected health information" (PHI) will be used and disclosed by my doctor or and his staff in the routine activities of treatment, payment and healthcare operations.
3) Before any other use or disclosure of my personal, protected health information is made, I will be asked for my written authorization.

I understand that I have the following rights:

- To confidential communications
- To request restrictions on Uses and Disclosures of my PHI.
- To request access to my personal protected health information
- To request amendments to my personal protected health information
- To have an accounting of any disclosures for purposes other than of treatment, payment and healthcare operations

I hereby authorize the following person(s) access to my health records:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

PATIENT SIGNATURE: _____**DATE:** _____

PATIENT NAME (PRINT): _____ **DATE:** _____

RELATIONSHIP: _____ **SELF OR OTHER:** _____

HEALTHCARE ASSOCIATES
OF PALM BEACH

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME:_____**DATE OF BIRTH:**_____

PATIENT SIGNATURE:_____**DATE:**_____

ADDRESS:_____

The information you may release subject to this signed release form is as follows:

- 2 years from the last date seen
- History and Physical, Progress Notes
- Care Plan, Lab Records, Radiology Reports
- Pathology Records, Treatment Records, Medication Records
- Other Records (Please Specify)

PHYSICIAN NAME: _____

ADDRESS/PHONE NUMBER: _____

Release my protected health information to the following physician, person, facility or entity and/or those directly associating in my medical care to:

HEALTHCARE ASSOCIATES OF PALM BEACH, LLC
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- Change of Insurance or Physicians
- Continuation of Care
- Referral
- Other: _____

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Your rights with respect to this authorization:

I understand that I must be provided with a sign copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how withdraw my authorization by contacting the office above. I understand that HAPB will not be able to release my records to someone without a signed consent. By signing this form, I do expressly and voluntarily consent to the disclosure of the information checked above. I understand that if the persons listed above are not mandated by the federal privacy standards the health information disclosed because of this authorization may be redisclosed without by obtaining my authorization. I understand that there may be a fee for copying of medical records.

_____ _____

Patient/Representative Signature Date

Physician Signature:_____

Date:_____