PATIENT INFORMATION

Full Name:		Date:
Address:	Home Telephone Number:	
Mailing Address:(*if different from above)*	Mobile Phone #:	Work Phone #:
City:	Please indicate your preferred telephone contact number: Mobile / Home / Work	
State/Zip Code:	Do you agree to be contacted via (text) messaging Yes/No?	
Patient Date of Birth:	Marital Status: Single_____ Married _____ Separated _____ Divorced _____ Widowed_____	
	Age:	Gender: M/F
Patients email address:		May we contact you via email? YES/NO
Emergency Contact Name:	Their Relationship to you:	
Contact Phone Number:	Emergency Contact Address:	
City/ST/Zip		
Previous Primary Care Physician:	Office Phone: Office Fax Phone:	
PCP Address: City/ST/Zip:		

Preferred Pharmacy and Address:

INSURANCE INFORMATION

Primary Insurance Company:		Insurance Phone Number:	
Address: City/ST/Zip:			
Name of Insured:	Insured DOB:	Relationship to Patient	
Address: City/ST/Zip:			
Insurance ID Number:	Group Number:	Type of Insurance:	Effective Date:
Secondary Insurance Company:		Insurance Phone Number:	
Address: City/ST/Zip:			
Insurance ID Number:	Group Number:	Type of Insurance:	Effective Date:

IF YOU ARE COMPLETING THIS FORM FOR YOUR CHILD PLEASE ALSO PROVIDE THE FOLLOWING INFORMATION SO THAT WE CAN MATCH THEM TO YOUR RECORDS:

Child's previous name(s): *Any changes of name will require official proof documentation*	Child's Primary Carer: Primary Carer's Telephone No:	Primary Carer's Address
Child's Previous address:	Child's Mother's Name:	Child's Father's Name:

Child's Current School:	Mother's Address *if different from Primary Carer's Address above*	Father's Address *if different from Primary Carer's address above*
Child's Previous School:		

Ethnic Origin: *(please tick one)*	White (UK)	White (Irish)	White (Other)

African	Asian	Bangladeshi / British Bangladeshi	Chinese	Caribbean	Indian / British Indian
Pakistani / British Pakistani	Other Asian Background	Other Black Background	Other Mixed Background	Other:	Ethnic Category not stated

Main or first language Spoken / Understood:	English	French	German	Spanish	Polish	Other: *(Please Specify)*

Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?
Yes ____ or No _____

If "Yes", please state their name, address & phone number (*please ask front desk reception for a copy of the Power of Attorney Form*):

If you are the Caregiver, please state the name, address and phone number of the person you care for:	**Person Cared for Contact Details:**
If you have a Caregiver, please state their name, address and phone number and sign here if you wish us to disclose information about your health to your Caregiver.	**Caregiver Contact Details:** **Signed:** **Date:**

PLEASE COMPLETE A <u>SEPARATE FORM FOR EACH FAMILY MEMBER</u> TO BE REGISTERED AND RETURN THEM TO THE FRONT DESK RECEPTIONIST AND ANY DOCUMENTATION SPECIFIED. TO REGISTER WITH THE PRACTICE, YOU MUST COMPLETE ALL REGISTRATION FORMS FOR PRACTICE.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to Nurse Practitioners of Pinellas treatment.

MEDICAL HISTORY FORM

(All questions in this questionnaire are strictly confidential and will become part of your medical records.)

ALLERGIES

Type of ALLERGY	Allergic Reaction

MEDICATIONS

Please list All Medications	Dose	Times Per Day

If you need more room to list medications, please write them on a blank sheet of paper with the required information.

HEALTH MAINTENANCE SCREENING TEST HISTORY

Cholesterol	Date:	Facility/Provider:	Abnormal? Y / N
Colonoscopy/Sigmoid	Date:	Facility/Provider:	Abnormal? Y / N
Mammogram	Date:	Facility/Provider:	Abnormal? Y / N
Pap Smear	Date:	Facility/Provider:	Abnormal? Y / N
Diabetes Test	Date:	Facility/Provider:	Abnormal? Y / N
Prostate Check	Date:	Facility/Provider:	Abnormal: Y / N
Bone Density	Date:	Facility/Provider:	Abnormal: Y / N
Eye Exam	Date:	Facility/Provider:	Abnormal: Y / N

IMMUNIZATION

TYPE	YES	NO	YEAR
TD			
TDAP			
MMR			
Pneumonia			
Hepatitis A			
Hepatitis B			
Shingles			
Prevnar			
Flu			
Measles			
Mumps			
Rubella			
Chickenpox			
Rheumatic Fever			
Polio			

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Anemia			
Arthritis (rheumatoid)/(osteo.)			
Cancer (Type)			
Constipation			
COPD (Emphysema/Chronic Lung Disease)			
Diabetes (type: _____)			
Epilepsy/Seizures			
Fibromyalgia			
Heart Disease			
High Blood Pressure (Hypertension)			
High Cholesterol			
HIV			
Hyperthyroid/Hypothyroid			
Irritable Bowel Syndrome			
Mental Illness (Anxiety/Depression/Bipolar)			
Headaches			
Ovarian Cysts			
Pneumonia			
Pulmonary Embolism			
Renal (kidney) Disease			
Sickle Cell Anaemia/Trait			
STD/Herpes (Genital)			
Stroke/TIA			
Tuberculosis			

Ulcer (Stomach)			
Urinary Incontinence			
Other			

HOSPITALIZATIONS

Name of Hospital/Location	Reason	Year

Have you ever had a Blood Transfusion? YES: _____ NO: _____

SURGERIES

TYPE (specify left/right)	DATE	LOCATION/FACILITY

SOCIAL HISTORY

Occupation:	Retired	Unemployed	LOA	Disabled
Employer:		Years of Education:	Highest Grade Completed:	
Are You Sexually Active? Yes_____ No_____				

FAMILY HEALTH HISTORY					
		SIGNIFICANT HEALTH PROBLEMS			SIGNIFICANT HEALTH PROBLEMS
Father	Age:	Living/Deceased	**Children**	M/F AGE:	Living/Deceased
Mother	Age:	Living/Deceased		M/F Age:	Living/Deceased
				M/F Age:	Living/Deceased
Paternal Grandfather	Age:	Living/Deceased	**Paternal Grandmother**	Age:	Living/Deceased
Maternal Grandfather	Age:	Living/Deceased	**Maternal Grandfather**	Age:	Living/Deceased
Siblings:	Age:	Living/Deceased	**Siblings:**	Age:	Living/Deceased
Sibling:	Age:	Living/Deceased	**Sibling:**	Age:	Living/Deceased
Sibling:	Age:	Living/Deceased	**Sibling:**	Age:	Living/Deceased

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Births:
Pregnancy Complications	
Fibrocystic Breast Disease: Yes _____ No_____	

MEN HEALTH HISTORY

Do you usually urinate at night? Y or N	If yes, how many times?	Any pain or burning? Y or N
Any blood in urine? Y or N	Discharge from penis? Y or N	Any testicle pain or swelling: Y or N
Force of Urination decreased? Y or N	Difficulty with erection: Y or N	Difficulty with ejaculation? Y or N
Have you had any kidney, bladder, or prostate infections within the last 12 months? Y or N		
Date of last prostate and rectal exam:		
Do you have difficulty emptying your bladder completely? Y or N		

OTHER HEALTH ISSUES

Tobacco Use	Smoke Cigarettes? Y or N (*If you never smoked, please move to Alcohol/Drug Use)*		
Current Packs:	Day ___ # of Years ____/ Past: Quit Date: _____ Packs/day _____ Years: _____		
Other Tobacco:	(*check one*) Pipe____ Cigar____ Snuff____ Chew____ Vapor ____		
Alcohol/Drug Use	Do you drink alcohol: Y or N	Beer/ Wine/ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y / N	Have you ever used needles to inject drugs? Y / N		
Have you ever taken someone else's drugs? Y / N			

MENTAL HEALTH

Is stress a major problem for you?	Yes	No
Do you feel Depressed?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Do you cry frequently?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No
Do you have trouble sleeping?	Yes	No
Have you ever been to a counsellor?	Yes	No

I have read the above information and I understand and agree to the HIPPA policy and regulations provided to me from Nurse Practitioners of Pinellas, LLC.

_____

Print Name

_____ _____

Patient Signature Date

Financial Policy

Thank you for choosing Nurse Practitioners of Pinellas, LLC as your healthcare provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your office visit. The following statement explains our Financial Policy which we ask you to read, sign and return to us prior to your office visit.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at time of service.
- We accept cash, check, or credit cards.

Regarding Insurance

We participate in most insurance plans; however, we require that the guarantor, the person who is financially responsible, is personally liable for all balance not covered by insurance. It is your responsibility to understand and comply with any Pre-determination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicaid Program or by other medical insurance companies.

Initials: _____

Past Due Accounts

I/We agree to pay all attorneys fees, court costs, filing fees and all collections cost, up to 50% of the amounts owing, which may be assessed by a collection agency retained to pursue the matter.

Initials: _____

Co-Pay Balances

Payment for all co-pays and out of pocket expenses pre-determined is expected at time of service. This fee is not covered by insurance so it will be your personal responsibility.

Returned Checks

For checks returned to us as unpaid by your bank, we will charge a $35.00 fee.
Please contact our Billing Office if you have any questions or concerns at (727) 290-6116.

Appointment cancellation, rescheduling and no-shows

We verify appointments prior to your arrival via phone.
If you do not show for your appointment, cancel or reschedule within 24 hours of your appointment time you may receive an additional fee, that will need to be paid at your next appointment.

I have read the Financial Policy. I understand and agree to the Financial Policy.

_____
Print Name

_____ _____
Signature Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: Date: _____ Date: _____

Witness: Date: _____ Date: _____

Authorization for Release of Health Information

Use this form for release of medical information, information pertaining to Counselling, Psychiatry, Social Services, and Drug and Alcohol Counselling is released separately.

Name: _____ DOB: _____
Last First

DL/ID #_____

I authorize:
Nurse Practitioners of Pinellas, LLC
3551 42nd Avenue S, Suite B-107
St. Petersburg, FL 33711
Phone: 727-290-6116
Fax: 727-290-6762

To release health information to:
(Person or Facility to receive health information)
Name: _____
Address: _____
_____
Phone: _____ Fax: _____

Please specify the health information you authorize to be released:

Type(s) of health information:_____

Specify date(s) or treatment or time period: _____

Please describe the purpose of this release: _____

Please specify the health information you authorize to be released:

_____

_____

_____

Please read the important notice concerning your rights at the bottom of page.

_____ _____ _____
Signature (*Patient, Parent or Guardian*) Print Name Date

_____ _____ _____
Relationship to Patient Witness (*If patient unable to sign*) Phone Number

(Conservator/Patient Representative) or Interpreter

NOTICE: NP of Pinellas, LLC and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state of federal confidentiality laws.

YOUR RIGHTS: This Authorization to release health information is voluntary. Treatment, payment, enrolment or eligibility for benefits may not be conditioned or signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrolment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

YOU ARE ENTITLED TO RECEIVE A COPY OF THIS AUTHORIZATION