5101 Brittany Drive South Saint Petersburg, FL 33715 Phone: (727) 954-7204 Fax: (877) 215-9813

NEW PATIENT REGISTRATION FORM

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Gender: ☐ Male ☐ Female

Address: _____ Apt/Unit/Condo #: _____

City: _____ State: _____ Zip: _____

Preferred Nickname: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Do you have any of the following? ☐ Advanced Directive ☐ Living Will ☐ Do Not Resuscitate Order

Emergency Contact Name: _____

Relationship to You: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

If Retired, How Many Years Did You Work? _____ Type of Work: _____

Primary Insurance Carrier: _____ ID #: _____

Group #:_____ HMO ___ PPO ___ POS ___ Other ___ Phone: _____

Insured's Name (if other than yourself): _____ Relationship: _____

Address of Insured (if other than yourself): _____

Secondary Insurance Carrier: _____ ID #: _____

Group #:_____ HMO ___ PPO ___ POS ___ Other ___ Phone: _____

Insured's Name (if other than yourself): _____ Relationship: _____

Address of Insured (if other than yourself): _____

(NEW PATIENT REGISTRATION - Continued)

Patient Full Name: _____ DOB: _____

PHARMACY INFORMATION:

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Do you use a Mail Order Pharmacy Service? Yes / No If Yes, Which One: _____

Mail Order Pharmacy Address: _____ Phone: _____

How did you hear about us? Personal Reference _____ Physician Reference _____ Friend _____ Other ____

Internet _____ Insurance Company _____ Name of Referring Doctor: _____

Phone # of Referring Doctor: _____ Type of Doctor: _____

Part of our responsibility as your health care provider is to respect your unique cultural and ethnic beliefs or practices as they impact your care. We are required by the federal government to gather some statistics within our electronic health record system. To help us, please indicate your race and ethnic group below:

RACE:

_____ American Indian / Alaska Native

_____ Asian

_____ Black / African American

_____ Hispanic

_____ Native Hawaiian / Other Pacific Islander

_____ White / Caucasian

_____ Unknown

ETHNICITY:

_____ Hispanic or Latino

_____ Non – Hispanic or Latino

_____ Unknown

_____ Prefer Not to Answer

I understand that I am financially responsible for all charges, whether paid by insurance, or not. It is my responsibility to pay any copay or deductible amount due at the time of service, or any other balance not paid by my insurance, within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give **Prawer Medical Group** consent to perform medical treatment.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Patient Full Name: _____ DOB: _____

We cannot discuss your Protected Health Information (PHI) with anyone other than yourself, unless you authorize us to do so. Please list below, the name(s) of the individual(s) with whom you authorize our office to discuss your care/information. Your PHI will be disclosed to the individual(s) listed below unless you notify us otherwise by verbal or face-to-face communication, or in writing to our office:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand this authorization extends to any or all parts of my medical record, and unless otherwise indicated, my authorization includes the release of the following items. Please strike through the items below, of which you wish to exclude, if any:

- My diagnosis and/or treatment for alcoholism and/or drug abuse or dependency.
- My diagnosis and/or treatment regarding any mental health issues/psychiatric information.
- My HIV antibody test results and/or AIDS diagnosis and/or treatment.
- My genetic counseling and/or test results and/or any related treatment.
- Other:

  _____

☐ By checking this box, I agree to allow messages containing personal health information on my answering machine/voicemail. If this box is not checked, only brief, non-specific messages may be left.

I further release and indemnify **Prawer Medical Group**, its affiliates, employees, officers, and directors from any and all liability, which in any way results from the disclosure of this information pursuant to the above instruction. This authorization shall remain in effect from the date signed until written revocation is received. I understand that I am under no obligation to sign this release of information and that it is my right to inspect all information disclosed, if I so request.

Parents / Guardians: Minor patients may consent to certain services and limit access to certain protected health information such as care related to pregnancy, birth control, STI's/STD's, and HIV under state law.

CONSENT TO TREAT:

The purpose of medical care is to facilitate the treatment of disease, injury, and disability. Medical services are provided through examination, testing, and use of procedures to aid the diagnosis or treatment of a medical condition(s). I request and authorize **Prawer Medical Group** to provide me with medical services as described above. I agree to cooperate fully and to participate in all medical procedures and to comply with the plan of medical care/services that is/have been/may be established therein.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____