NEW PATIENT REGISTRATION

Date:

<table>
<tr><td rowspan="9">PATIENT INFORMATION</td><td>Name (Last)</td><td>(First)</td><td>(MI)</td><td>Home Phone (Area Code)
( )</td></tr>
<tr><td colspan="3">Home Address</td><td>APT. #</td></tr>
<tr><td>City</td><td>State</td><td colspan="2">Zip Code</td></tr>
<tr><td colspan="4">Mailing Address if different from above</td></tr>
<tr><td>City</td><td>State</td><td colspan="2">Zip Code</td></tr>
<tr><td colspan="3">If visiting the Tampa Bay area – please give address and telephone number where you are staying.</td><td>First Visit to the Clinic?
☐ Yes ☐ No</td></tr>
<tr><td>Date of Birth</td><td>Sex
M F</td><td>PATIENT STATUS
☐ Single ☐ Married ☐ Other</td><td>Social Security No.</td></tr>
<tr><td>☐ Employed ☐ Leased Employee
☐ Part-Time Student ☐ Full-Time Student</td><td colspan="2">Employed by</td><td>Occupation</td></tr>
<tr><td colspan="3">Employer's Address</td><td>Work Phone No.
( )</td></tr>
<tr><td>REASON FOR VISIT</td><td colspan="4"></td></tr>
<tr><td rowspan="2">IF AN ACCIDENT</td><td colspan="2">When did accident happen</td><td colspan="2">Where did accident happen</td></tr>
<tr><td colspan="4">If Workers Comp – Did you Notify Your Employer?</td></tr>
<tr><td>METHOD OF PAYMENT</td><td>☐ CHECK (Provide copy of Drivers License)
☐ CASH
☐ CREDIT CARD</td><td colspan="2">☐ EMPLOYER
☐ MEDICARE
☐ HMO NAME:__________
☐ PPO NAME:__________</td><td>☐ WORKER'S COMP. INSURANCE Verification Required
☐ MEDICAL INSURANCE</td></tr>
<tr><td rowspan="4">RESPONSIBLE PARTY INFORMATION</td><td>Your Relation to Patient</td><td colspan="2">Name</td><td>Street Address</td></tr>
<tr><td>City</td><td>State</td><td>Zip Code</td><td>Home Phone (Area Code)
( )</td></tr>
<tr><td>Social Security No.</td><td colspan="2">Date of Birth</td><td>Sex
☐ MALE ☐ FEMALE</td></tr>
<tr><td>Employer</td><td colspan="2">Employer's Address</td><td>Employer's Phone #</td></tr>
</table>

AUTHORIZATION AND AGREEMENT FOR MEDICAL TREATMENT

☐ **THE UNDERSIGNED HEREBY MAKES THE FOLLOWING ACKNOWLEDGEMENTS AND AGREEMENTS REGARDING THE MEDICAL TREATMENT TO BE PROVIDED THE PATIENT WHOSE NAME APPEARS ON THIS FORM HEREOF:**

AGREEMENT TO PAY SERVICES

1. For and in consideration of the care and treatment provided to the patient, I promise to pay________________ all charges for services rendered to or in behalf of the patient.

2. I hereby authorize ________________________to release any medical information in connection with these services for health insurance purposes or to the patient's personal physician.

☐ **THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE ABOVE, AND IS THE PATIENT, GUARANTOR, OR THE PATIENT'S REPRESENTATIVE DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS:**

DATE:____ X____

Signature of Patient or Representative

____ ____

Representative Name (Print) Telephone Permission for Minor Granted By: Witness

____ ____

Representative's Relationship Reason for Representative Signatures

Revised 7/99

PATIENT 1

PERSONAL HEALTH HISTORY

Name ______________________________ **Date** ______________

Please check any of the following medical conditions you have or have had:

	Yes	No		Yes	No
Anemia / Blood Disease	❑	❑	Tonsils / Adenoids / Ear Surgery	❑	❑
Sickle Cell Anemia	❑	❑	Asthma / Emphysema	❑	❑
Bronchitis / Chronic Cough	❑	❑	TB / History of Positive Skin Test	❑	❑
Loss of Consciousness / Dizziness	❑	❑	Seizures / Epilepsy	❑	❑
Hepatitis / Liver Disease / Jaundice	❑	❑	Frequent or Severe Headaches	❑	❑
Neck / Back Problems	❑	❑	Kidney Disease / Kidney Stones	❑	❑
Cancer / Tumor / Leukemia	❑	❑	Thyroid Disease / Goiter	❑	❑
Arthritis / Rheumatism	❑	❑	Knee or Joint Problems	❑	❑
Color Blindness / Glaucoma	❑	❑	Stroke / Paralysis	❑	❑
Heart Disease / Heart Murmur	❑	❑	Deafness / Hearing Loss / Ringing in the Ears	❑	❑
High Blood Pressure	❑	❑	Ulcer / Digestive Problem / Bowel Disease	❑	❑
Sinus Problems / Hay Fever / Allergies	❑	❑	History of Alcohol or Drug Abuse	❑	❑
Immune Deficiency Syndrome	❑	❑	Gyn. (female) Problems / Infections	❑	❑
Removal of Spleen	❑	❑	Hysterectomy / Gyn. (female) Surgery	❑	❑
Gall Bladder Surgery	❑	❑	Ulcers / Stomach Surgery	❑	❑
Hernia Repair	❑	❑	Appendectomy	❑	❑
Rectal / Bowel Surgery	❑	❑	Breast Surgery	❑	❑
Major Bone / Joint Surgery	❑	❑	Heart / Lung Surgery	❑	❑
Prostate Surgery	❑	❑	Cataract Surgery	❑	❑
Diabetes	❑	❑	Leukemia	❑	❑

Please list any other medical / surgical condition, or comment on any of the above:

____

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PERSONAL HEALTH HABITS

Do you smoke? YES ❑ NO ❑ How Much?________ How Long? (years)________ Cigarettes ❑ Cigars ❑ Pipe ❑

Do you drink alcoholic beverages? YES ❑ NO ❑ What kind?__________________ How often?__________________

FOR FEMALES ONLY

Are you pregnant? YES ❑ NO ❑ Date of last menstrual cycle?__________________

X ____

Signature of person completing Health History

Revised 1/96

PATIENT 2

CONFIDENTIAL CASE HISTORY

PLEASE CIRCLE OR MARK ANY AREA OF PAIN OR CONCERN