PALMA SOLA MEDICAL ASSOCIATES REGISTRATION FORM

***Please PRINT. Complete ALL sections as this info will replace current data in your chart! ***

_____ _____ _____

FIRST NAME MIDDLE INITIAL LAST NAME

SOCIAL SECURITY NO: _____ DOB: ____/____/____ ☐ Male ☐ Female

ADDRESS: _____

☐ HOME PHONE: _____ ☐ CELL PHONE: _____ [Check Contact Preference]

EMAIL ADDRESS: _____ ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

SPOUSES NAME: _____ CONTACT PHONE: _____

POLICYHOLDER NAME: _____ POLICYHOLDER DOB: ____/____/____

NORTHERN ADDRESS: _____

Dates of Northern Stay: FROM:_____TO: _____ NORTHERN PHONE: _____

EMPLOYER: _____ PHONE: _____

RACE: [check all that apply] ☐ White/Caucasian ☐ Black/African American ☐ Hispanic

☐ Asian/Pacific Islander ☐ Native American LANGUAGE PREFERENCE: ☐ English ☐ Spanish ☐ Other _____

ETHNICITY: ☐ NOT Hispanic or Latino ☐ Hispanic or Latino

IN CASE OF EMERGENCY CONTACT

NAME: _____ RELATION: _____ PHONE: _____

I AUTHORIZE PALMA SOLA MEDICAL ASSOCIATES TO ACCESS MY MEDICATION HISTORY ☐ YES ☐ NO

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for the balance. I also authorize Palma Sola Medical Associates to share medical information with insurance company/attorney necessary to process claims.

Patient or Guardian Signature: _____ Date: _____

C: My doc/registration form

PALMA SOLA MEDICAL ASSOCIATES ACKNOWLEDGEMENT OF PRIVACY ACT

Acknowledgment:

I acknowledge that I have had an opportunity to review the Notice of Privacy Practices and Doc/ACO Program displayed in lobby.

Patient Name PLEASE PRINT Date

AUTHORIZATION TO RELEASE OR NOT RELEASE MEDICAL INFORMATION

In accordance with HIPAA [Healthcare Portability Act of 1996] mandated by the government, **in order for our practice to discuss your condition with others, we must obtain your authorization to do so.** The law also stipulates that these rules may be waived due to the severity of your medical condition.

☐ I **DO NOT** AUTHORIZE THE PRACTICE TO RELEASE INFORMATION REGARDING MY MEDICAL CARE EXCEPT AS SET FORTH ABOVE.

☐ I **DO** AUTHORIZE THE PRACTICE TO RELEASE VERBALLY AND/OR PHOTOCOPIES OF MY MEDICAL CARE TO THE FOLLOWING INDIVIDUALS:

Name	**Phone**
Name	**Phone**
Name	**Phone**

Patient or Personal Representative Signature Date

Palma Sola Medical Associates

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Palma Sola Medical Associates for medical services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Palma Sola Medical Associates to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. The order will remain in effect until revoked by me in writing.

I have requested medical services from Palma Sola Medical Associates on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature **Date**

_____ _____

Witness **Date**

Palma Sola Medical Associates
Medical History Form

Name_____ Age_____ Birth date_____ Sex ☐ M ☐ F
Occupation_____ Emergency Contact Person and Phone #_____
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If married, Spouse's name_____
Children's name and ages_____
Allergies to Medications, X-Ray Dyes, or other substances ☐ No ☐ Yes(please list and explain) _____

Please check the appropriate box if you have had or are currently having any of the following problems:

PROBLEM	PAST	NOW	PROBLEM	PAST	NOW	PROBLEM	PAST	NOW
1. HIGH BLOOD PRESSURE			17. HAY FEVER			33.HEAD/NECK RADIATION		
2.DIABETES			18. ABDOMINAL PAIN			34.HEADACHES		
3.CANCER			19. INDIGESTION			35.KIDNEY DISEASE		
4.HEART DISEASE			20. NAUSEA			36.KIDNEY STONES		
5.CHEST PAIN/ TIGHTNESS			21.CONSTIPATION			37.DIFFICULTY URINITATING		
6.SHORTNESS OF BREATH			22.VOMITING			38.ARTHRITIS		
7.SWOLLEN ANKLES			23.DIARRHEA			39.LOW BACK PROBLEMS		
8.PALPITATIONS			24.BLOOD IN STOOL			40.SKIN DISEASE		
9.LIGHTHEADEDNESS			25.CHANGE IN BOWEL HABITS			42.BLOOD DISORDERS		
10.FREQUENT URINATION			26.UNEXPLAINED WEIGHT GAIN/LOSS			42.VENERAL DISEASE		
11.LEAKAGE OF URINE			27.HEMORRHOIDS			43.ANXIETY		
12.ASTHMA			28.GALLBLADDER DISEASE			44.DEPRESSION		
13.BRONCHITIS			29.COLITIS			45.ALCOHOL ABUSE		
14.PNEUMONIA			30.HEPATITIS/JAUNDICE			46.DRUG ABUSE		
15.PERSISTANT COUGH			31.THYROID DISEASE			47.GOUT		
16. TIA/STROKE			32.ANEMIA					

Describe above problems:

_____
_____

49. During the past month, have you often been bothered by feeling down, depressed of hopeless? ☐ Yes ☐ NO
50. During the past month, have you been bothered by little interest or pleasure doing things? ☐ Yes ☐ NO

Please list and supply dates of operations:_____
_____
_____

Hospitalizations other than surgery: _____
_____
_____

CONTINUED ON OTHER SIDE

When was your last:
Stool check for blood?_____Cholesterol check?_____

Females Only

Gynecologic and obstetric history:
Age at onset of periods_____Frequency_____Length of period_____
Pregnancies_____Births_____Miscarriages_____LMP_____

Prolonged or abnormal bleeding: ☐ Yes ☐ No(describe)_____
Pelvic Pain: ☐ Yes ☐ No(describe)_____
Abnormal Discharge: ☐ Yes ☐ No(describe)_____
History of Abnormal Pap: ☐ Yes ☐ No(describe)_____

When was your last:
Pap Smear? _____ Breast Exam? _____
Mammogram? _____ Bone Densitometry? _____

Males Only

When was your last:
Prostate exam? _____
PSA? _____
Erection Difficulties ☐ Yes ☐ No

Immunization History Have you had:
Hepatitis B Immunization? ☐ Yes ☐ No Date_____ Pneumovax Immunization? ☐ Yes ☐ No Date_____
Tetanus Immunization? ☐ Yes ☐ No Date_____ Flu Immunization? ☐ Yes ☐ No Date_____

Family History
Has any member of your family (including parents, grandparents & siblings) ever had the following:

	Which Family Member & Age When Diagnosed?		
High Cholesterol	_____	Drug or Alcohol Addiction	_____
Heart Disease	_____	Diabetes	_____
Cancer (describe)	_____	Bleeding diseases	_____
Stroke	_____	High Blood Pressure	_____
Mental Disease	_____	Other	_____
Glaucoma	_____	Other	_____

Medication (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug_____	Dose_____	Drug_____	Dose_____
Drug_____	Dose_____	Drug_____	Dose_____
Drug_____	Dose_____	Drug_____	Dose_____

Prevention
Do you wear seat belts? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No if yes, do you smoke cigarettes, pipe, or cigars? How much? _____And for how long? _____. If former smoker, how long did you smoke?_____ When did you quit? _____
Please rate your interest in quitting from 1 to 10, 1 being no interest:_____
Do you drink alcoholic beverages? ☐ Yes ☐ No
Do you use illegal drugs? ☐ Yes ☐ No
Do you know of any possible exposure to HIV (AIDS virus)? ☐ Yes ☐ No
Do you want to be tested for HIV? ☐ Yes ☐ No
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ☐ Yes ☐ No
Are you in a relationship in which your partner has physically hurt you? ☐ Yes ☐ No
Do you practice a method of birth control, if yes, which method? ☐ Yes ☐ No Method: _____

Please list any other concerns you would like to discuss with your doctor:_____
_____
_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

To release my PROTECTED HEALTHCARE INFORMATION for the purpose of medical treatment to:

Palma Sola Medical Associates / Adnan K. Sammour, MD ●Angela Robison, DO ● Jason V. Fielding, DC

2227 59th Street West, Bradenton, FL 34209 P: [941] 795-5922 F: [941] 761-1682

Patient Name: _____ Previous Name: _____

DOB: _____ Social Security No: _____

RECORDS FROM: _____

Phone: _____ FAX: _____

This request and authorization applies to:

☐ Healthcare information ONLY pertaining to the following treatment, condition, or date[s]:

_____

☐ All protected health information in your possessions; related to the treatment and/or coordination of care and/or management of care by the above named entity.

☐ Other: _____

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing.

☐ Yes ☐ No I authorize the release of my drug, alcohol, or mental health treatment.

My signature below signifies my request and authorization to release medical information to PALMA SOLA MEDICAL ASSOCIATES. I understand I may revoke this authorization at any time by giving written notice to the Privacy Officer in your office. I have had the chance to read and think about the content of this authorization form and agree with all statements made in this authorization.

_____ _____

Patient Signature Date Signed [expires >90 days]