Jupiter Medical Specialists, LLC
GENERAL SURGERY

PATIENT REGISTRATION FORM

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ZIP: _____

Home Phone: _____ Cell: _____ Race/Ethnicity: _____

Marital Status: _____ SS#: _____Drivers Lic #:_____

Employer: _____Occupation: _____Work #: _____

Spouse Name:_____ Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Insurance Company: _____

Subscriber's Name & Date of Birth: _____

Primary Care Doctor's Name: _____ Phone: _____

Referred by: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Location: _____

Email Address: _____

Guarantee of Payment:
I fully understand that I am directly responsible for payment to the Physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

Authorization to Release Information:
I hereby authorize the physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

Assignment of Insurance Benefits:
If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the physicians in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by the insurance. I permit a copy of the authorization to be used in place of the original.

Print Name:_____ **Signature:** _____ **Date:** _____

Medications AND Supplements AND Over the Counter Drugs

Medication	Dosage and Frequency

Past Medical History: Are you now or have you ever been treated for any of the following? **Please add any not specifically noted.**

❑ Coronary Artery Disease	I25.83	❑ Aortic Valve Disease	I06.9
❑ Mitral Valve Disease	I34.9	❑ Heart Valve Replaced?	Z95.4
❑ Elevated Cholesterol/Triglycerides	E78.0	❑ High Blood Pressure	I10
❑ Type II Diabetes	Ell.9	❑ Asthma	J45.909
❑ Shortness of Breath	R06.02	❑ Sleep Apnea Syndrome	G47.30
❑ Emphysema	J43.9	❑ Do you use home oxygen	❑ Y ❑ N
❑ COPD	J44.9	❑ Use of CPAP?	❑ Y ❑ N
❑ Heartburn	R12	❑ Low Back Pain	M54.9
❑ Hiatal Hernia	K44.9	❑ Chronic Fatigue Syndrome	R53.82
❑ Leak of Urine w/Cough / Sneeze	R39.81	❑ Anxiety Disorder	F41.1
❑ Low Thyroid Function	E03.9	❑ Depression	F33.9
❑ Fibromyalgia	M79.7	❑ Bipolar Disorder	F31.81
❑ Personal History of Breast Cancer	Z85.3	❑ Personal History Colon Cancer	Z85.038
❑ Hepatitis C	Z22.52	❑ Irritable Bowel Disease	F45.8
❑ Gout	M10.00	❑ Esophageal Reflux	K21.9
❑ Osteoarthritis	M15.0	❑ Gallstones	K80.20

Allergies: I have no known drug allergies **OR** I am allergic to the following DRUGS:

		Latex Allergy? ❑ Y ❑ N

Surgical History - <u>Please add any not specifically noted.</u>

Please list any and all operations you have had in your entire life, **including cosmetic or plastic**

OPERATION	YEAR(S)	OPERATION	YEAR(S)
Tonsillectomy / Adenoidectomy		Appendectomy	
Laparoscopic Gallbladder		Open Incision Gallbladder	
Total Abdominal Hysterectomy		Vaginal Hysterectomy	
Coronary Bypass (CABG)		Carotid Endarterectomy	
Colon / Large Intestine Surgery		Prostate Surgery	
Breast Biopsy ❑ R ❑ L ❑ Both		Mastectomy ❑ R ❑ L ❑ Both	
Breast Enlargement		Breast Reduction	
Liposuction		Tummy Tuck	
Hernia Repair		Spleen Removal	
Hip Replacement ❑ R ❑ L ❑ Both		Knee Replacement ❑R ❑L ❑Both	
Heart Valve Replacement		Coronary Artery Stenting	

Family Medical History: Which of the following diseases "**run in your family**".

Please add anything not listed.

Disease	Family Member	Disease	Family Member
Heart Disease		High Blood Pressure	
High Cholesterol		Obesity	
Diabetes		Lung Disease	
Stroke		Kidney Disease	
Breast Cancer		Colon Cancer	
Bleeding Problems		Prostate Cancer	
Other:		Other	

Social History

Do you have any children? ❑ Yes ❑ No If so, how many? _____

Are you disabled? ❑ Yes ❑ No If so, why? _____

Who Lives at home with you? ❑ Alone ❑ Spouse ❑ Family ❑ Domestic Partner ❑ Roommate

Do you have any pets? ❑ Yes ❑ No If yes, what type? _____

Do you exercise? ❑ Yes ❑ No If so, what type and how often? _____

Do you use any of the following?

Substance	Amount	How Often	How Many Years
Alcohol			
Tobacco			
Street Drugs / Type			
Caffeine			

Personal Physicians: If you would like for us to communicate your progress with your other physicians, **please provide their names.**

Specialty	Physician Name	Phone & Fax Number
Cardiologist		
Pulmonologist		
Mental Health		
Other		

Review of Systems: Please check all symptoms that you frequently experience

1. General: ❑ Change in appetite ❑ Chills ❑ Fatigue ❑ Fever ❑ Weight gain ❑ Weight loss
2. Eyes: ❑ Diminished visual acuity ❑ Dry eye ❑ Eye pain ❑ Itching and redness
3. Ears/Nose/Throat: ❑ Ear pain ❑ Hoarseness ❑ Ringing in the ears ❑ Sinus trouble ❑ Sore throat
4. Endocrine: ❑ Excessive thirst ❑ Heat intolerance ❑ Frequent urination ❑ Thyroid problems
5. Respiratory: ❑ Blood in sputum ❑ Cough ❑ Shortness of breath ❑ Other: _____
6. Breast: ❑ Breast lump ❑ Breast pain ❑ Breast swelling
7. Cardiovascular: ❑ Chest pain ❑ Palpitations ❑ Other: _____
8. Gastrointestinal: ❑ Bloating ❑ Cirrhosis ❑ Gallbladder problems ❑ Abdominal Pain ❑ Bowel changes ❑ Constipation ❑ Diarrhea ❑ Nausea ❑ Rectal bleeding ❑ Vomiting
9. Hematology / Lymphatic: ❑ Anemia ❑ Bleeding problems ❑ Groin mass ❑ Easy bruising ❑ Swollen glands
10. Genitourinary: ❑ Blood in urine ❑ Frequent urination ❑ Painful urination ❑ Genital problems
11. Musculoskeletal: ❑ Arthritis ❑ Back problems ❑ Muscle aches ❑ Painful joints
12. Skin: ❑ Cyst ❑ Dry skin ❑ Itching ❑ Masses ❑ Rash ❑ Skin cancer ❑ Skin oozing
13. Neurological: ❑ Confusion ❑ Dizziness ❑ Headache ❑ Memory loss ❑ Tingling/Numbness

Psychiatric: ❑ Anxiety ❑ Depressed mood ❑ Eating disorder ❑ Suicidal thoughts

Patient Name (Print): _____ **Date:**_____

Physician's Signature: _____ **Date:**_____

ANNUAL QUESTIONNAIRE

Patient Name: _____ Date: _____

1. Have you had a Pneumonia Vaccination? ❒ Yes ❒ No If yes, When: _____
2. Have you had a Flu Vaccination? ❒ Yes ❒ No If yes, When: _____
3. Do you have little interest or pleasure in doing things? ❒ Yes ❒ No

   If yes, check one: ❒ Several Days ❒ More than half the days ❒ Everyday
4. Are you feeling down, depressed or hopeless? ❒ Yes ❒ No

   If yes, check one: ❒ Several Days ❒ More than half the days ❒ Everyday

IF "NO" TO QUESTIONS 3 and 4, SKIP TO QUESTION #5

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several Days 1	More than Half the days 2	Everyday 3
Trouble falling or staying asleep or sleeping too much?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television.				
Moving or speaking so slowly that other people could have noticed. Or the opposite? Being so fidgety or restless that you have been moving around a lot more than usual.				
Thoughts that you would be better off dead and/or of hurting yourself in some way.				

5. Have you fallen in the past year (If 65 or older please answer)? ☐ Yes ☐ No

   If yes, please complete:
   - ❒ 1 fall with injury in the past year
   - ❒ 1 fall without injury in the past year
   - ❒ 2 or more falls with injury in the past year
   - ❒ 2 or more falls without injury in the past year

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Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices for the company and its subsidiaries and affiliates. I understand that copies of the Notice of Privacy Practices are available on the company's website and paper copies are out and available in the office and that I can take one of these copies with me. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and any implementing regulations.

Effective Date of Notice: September 23, 2013

Patient: _____ Date: _____

(print name)

Patient Signature:_____

or

Patient's Representative: _____ Date: _____

Relationship to Patient: _____

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PATIENT REFERRAL FORM

Patient Name: _____ Date: _____

Which doctor will you be seeing? _____

Who referred you to our practice? _____

How did hear about us if other than doctor's office? (Please check off all that apply)

- ❒ Referral from a family member/friend (Name:_____)
- ❒ Insurance Plan, Plan Directory Listing and/or Plan Website _____
- ❒ Newspaper Ad (Which newspaper?) _____
- ❒ Yellow pages_____
- ❒ Online _____
- ❒ Seminar or Lecture_____
- ❒ Other (Please explain: _____