FLORIDA HEALTHCARE ASSOCIATES

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: ____ **MI:** _____ **Last:** __________________________________

Address: ____

City: ____ **State:** _________ **Zip:** _________________

DOB:_____________________ **SSN:**________-______-__________ **Home Phone #:**________-________-________

Cell Phone #: ________-________-__________ **Email:** ____

(Out of State Address:)____

City: ____ **State:** ________ **Zip:**___________________

Preferred Reminder Notification: ☐ Phone ☐ Text

Gender: ☐ Male ☐ Female ☐ Transgender

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ White European ☐ Decline to specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to specify

Marital Status: ☐ Married Single ☐ Divorced ☐ Widowed ☐ Domestic Partner

Spouse Name (First & Last): ____

Occupation: ____**Employer:** ____

Preferred Pharmacy: ____ **Phone #:** _________________________________

Address: ____

EMERGENCY CONTACT

Name: ____________________________________**Phone:** ___________________ Relationship______________________

FLORIDA HEALTHCARE ASSOCIATES

MEDICAL INFOMATION

Previous Medical Doctor: ____

Address:____

City: ______________________________**State:** ______________ **Zip:**____________

Phone: ______________________________ **Fax:** ______________________________

INSURANCE INFOMATION

Primary Insurance: ____

Identification/ Policy Number: ______________________________**Group #:** ____________

Name of Policy Holder: ______________________________ **DOB of Holder:** ____________

SSN of Policy Holder: _______-_______-__________

Secondary Insurance: ____

Identification/ Policy Number: ______________________________**Group #:** ____________

Name of Policy Holder: ______________________________ **DOB of Holder:** ____________

SSN of Policy Holder: _______-_______-__________

ASSIGNMENT OF BENEFITS: I Authorize the release of any medical information necessary to process claims or, if necessary, for my medical benefit. I authorize the release of payment for medical benefits to Florida Healthcare Associates. I permit a copy of these authorizations to be used in place of the original. I accept the responsibility for all charges incurred and I am responsible for payment. Where applicable, regulations pertaining to Medicare assignment of benefits apply. I require that payment of authorized medigap benefits be made payable to the doctors.

SIGNATURE: ______________________________ **DATE:** ________________

FLORIDA HEALTHCARE ASSOCIATES

NAME: ____ **AGE:** ______________

REFERRED BY: ____

REASON FOR TODAY'S VISIT: ____

MEDICAL HISTORY

Health Problems (Include Year):

____
____
____
____

Previous Surgeries: (Please list all prior surgeries and approximate dates performed)

____
____
____
____

Medications: (Please list **ALL** and Milligrams that you are currently taking)

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____
10.____
11.____
12.____

☐ SEE MEDICATION LIST ATTACHED

FLORIDA HEALTHCARE ASSOCIATES

MEDICAL HISTORY CONT.

Does anyone in your family have a history of Heart Disease? ☐NO ☐YES
If Yes, who? ____

Does anyone in your family have a history of cancer? ☐NO ☐YES
If Yes, Who and what type of cancer?____
____

Do you have any allergies to medications? ☐NO ☐YES
If yes, please list. ____

Please Check All that apply to you:

- ☐ Ankle Swelling
- ☐ Arthritis
- ☐ Blood in Stool
- ☐ Blood in Urine
- ☐ Bruise Easily
- ☐ Cataracts
- ☐ Change in Bowel Habits
- ☐ Chest Pain
- ☐ Cold Intolerance
- ☐ Constipation
- ☐ Cough
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Excessive Thirst
- ☐ Fainting
- ☐ Other:________________
- ☐ Frequent Falls
- ☐ Frequent Urination
- ☐ Glaucoma
- ☐ Hearing Impaired
- ☐ Heartburn
- ☐ Heat Intolerance
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Itching
- ☐ Kidney Stones
- ☐ Nausea/Vomiting
- ☐ Night Swears
- ☐ Nose Bleeds
- ☐ Numbness
- ☐ Pain in Legs
- ☐ Painful Urination
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Rash
- ☐ Reflux
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Tremors
- ☐ Ulcers
- ☐ Vision Impaired
- ☐ Vertigo
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Alcohol? ☐Current ☐Past ☐Never Drinks/week: ____

Caffeine? ☐Current ☐Past ☐Never Type: ___________________________ Drinks/week: ___________________

Smoking/Tobacco use (cigarettes, vapes, chewing tobacco)? ☐ Current ☐Past ☐ Never
Type: ______________________________ Amount/day: _______________________ Number of Years: ___________

Illicit drugs? ☐ Current ☐Past ☐ Never Type: ____

FLORIDA HEALTHCARE ASSOCIATES

MEDICAL HISTORY CONT.

Have you ever had an Echocardiogram? ☐NO ☐YES **If yes, when?**____

Have you ever had a Stress Test? ☐ NO ☐YES **If yes, when?**____

Have you had any of the COVID-19 Vaccines? ☐NO ☐YES
If yes, date & type? ____

HEALTH MAINTENCE SCREENINGS

Please answer screenings that apply to you. Circle whether the results were normal or abnormal.

Last Menstrual Period	Date: _____________	Normal Abnormal
Colonoscopy	Yes/No Date:______________	Normal Abnormal
Mammogram	Yes/ No Date: ______________	Normal Abnormal
Bone Density	Yes/ No Date: ______________	Normal Abnormal
Pap Smear	Yes/No Date: ______________	Normal Abnormal

FLORIDA HEALTHCARE ASSOCIATES

RELEASE OF MEDICAL RECORDS

I, ______________________________________ request all medical records including but not limited to: Office visit notes, EKG's, Blood Results, Imaging Results, Operative Reports, and Cardiac Reports. This consent also includes authorization for sensitive documents that may contain information concerning HIV, Drug and/or Alcohol, STD's, or Psychiatric Care and any other health information be released to:

FLORIDA HEALTHCARE ASSOCIATES

Mitchell Lampert, MD
Rooptaz Sibia, MD
Alex Zopo, MD
Christopher Hunt, MD
Aaron Cohen, MD
Nicolle Melendez, PA-C
Orly Matheson, PA-C

11195 S JOG RAOD, SUITE 3
BOYNTON BEACH, FL 33437
P: (561) 733-9690
F: (561) 733-9626

709 S FEDERAL HIGHWAY, SUITE 5
BOYNTON BEACH, FL 33435
P: (561) 736-8600
F: (561) 736-7191

Patient Name (Print): ____

DOB: ____________________________________Last 4 digits of SSN: ________________________________

Patient Signature: ____

Witness: ____

FLORIDA HEALTHCARE ASSOCIATES

Acknowledgment of receipt of
Notice of Privacy Practices

****You may refuse to sign this acknowledgment****

I, (print name) ______________________________________, have received a copy of this office's Notice of Privacy Practices.

Signature:____

Date:_________/__________/_____________

For Office use only

Signature not obtained due to:

____ Individual refused to sign.

____ Communication barriers prohibited obtaining the acknowledgment.

____ An emergency situation prevented us from obtaining acknowledgement.

____ Other____

FLORIDA HEALTHCARE ASSOCIATES

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

The following information is required in order for us to provide a family member (i.e. spouse, parent, son or daughter) or caretaker with any of your personal medical information. This includes, but is not limited to, diagnosis(s), test results, medications, or anything else pertaining to your care within our practice. Please fill out the information below listing the person(s) name that is authorized to receive your private information. If this does not apply to you currently, please disregard; however, should the need arise for you to fill out this form in the future, please ask someone at the front desk and we will be happy to assist you.

Patient Name: ____

Patient Address: ____

Date of Birth: ____

I ______________________________ allow the following persons(s) to view my protected health information.

Name/ Relationship/ Telephone#: ____

____

____

____

Patient please note: The practice is not required to agree to your request. Please see our Notice of Privacy Practices for more information regarding such requests.

Patient's signature: ____ Date: ____/____/______