New Patient Registration

MEDICAL ASSOCIATES OF BREVARD

Patient Information

Patient Name

_____

First MI Last

DOB ___/___/_____ SS# _____

Marital Status_____ ◯ MALE ◯ FEMALE

Address _____

_____

Home Phone _____ Cell _____

Work Phone _____

Employer _____

Occupation _____

Name of Spouse _____

Address: _____

_____

◯ Check if same as patient's address

Race

◯ American Indian or Alaska Native ◯ Asian
◯ Native Hawaiian ◯ Black or African American ◯ White
◯ Other Pacific Islander ◯ Prefer not to answer

Ethnicity

◯ Hispanic/Latino ◯ Non-Hispanic/Latino
◯ Prefer not to answer

Preferred Language

◯ English ◯ Spanish Other _____

Preferred Pharmacy _____

Location _____

Family Doctor _____

Phone _____

Insurance Information

Primary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/_____ SS# _____

Secondary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/_____ SS# _____

Complete below if patient is a minor

Father's Name (or Guardian) _____

DOB ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

◯ Check if same as patient's address

Employer _____

Mother's Name (or Guardian) _____

DOB ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

◯ Check if same as patient's address

Employer _____

MEDICAL ASSOCIATES OF BREVARD

New Patient Registration

HIPAA Release

Patient Name

First MI Last

Do you have a Living Will? ◯ Yes ◯ No
Do you have an Advance Directive? ◯ Yes ◯ No
If you answered yes to either, please provide us a copy.

Emergency Contact:

Name Relationship

Phone #

I authorize Medical Associates of Brevard LLC to discuss my healthcare information with the below:

Name Relationship

Phone #

Name Relationship

Phone #

Preferred appointment reminder notification:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Preferred medical information notification:
I authorize Medical Associates of Brevard LLC to leave a detailed message which may contain personal health information via:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine.

Your HIPAA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.

YOU MUST READ BELOW FOR IMPORTANT INFORMATION AND NOTICES

Financial Policy

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of-pocket, deductibles and noncovered services.
I authorize the payments from my insurance company(s) according to my medical benefits be made payable to ***Medical Associates of Brevard LLC*** for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Medical Associates of Brevard as well as to my insurance company(s).

LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

NOTE: You will electronically sign for this Financial Policy agreement on the signature pad in your doctors' office to be stored in your electronic medical chart.

Notice of Privacy Practices

I acknowledge that I have received a copy of the **Provider Notice of Privacy Practices** for Medical Associates of Brevard LLC. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

NOTE: You will electronically sign for this Notice of Privacy Practices on the signature pad in your doctors' office to be stored in your electronic medical chart.

Consent to Obtain External Prescription History

I authorize Medical Associates of Brevard LLC and its physicians and staff to view my external prescription history via the electronic medical records system Medent, and the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.
MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

NOTE: You will electronically sign for this Consent to Obtain External Prescription History on the signature pad in your doctors' office to be stored in your electronic medical chart. **You will have the option to give consent or deny this access upon electronically signing.**

Community Chart Consent

I give consent to Medical Associates of Brevard LLC to access the Community Chart in order to access and share my medical records if available through other entities operating under the Carequality Interoperability Framework, including Surescripts. This includes demographic information as well as other relevant clinical documentation.

NOTE: You will electronically sign for this Community Chart Consent on the signature pad in your doctors' office to be stored in your electronic medical chart. **You will have the option to give consent or deny this access upon electronically signing.**

Pavana K. Beerelli, M.D.

ALLERGY HISTORY FORM

DATE: _____

TO BE COMPLETED BY PATIENT

NAME: _____ AGE: _____
BIRTHDATE: _____ OCCUPATION: _____
HOBBIES: _____
DESCRIBE THE REASON FOR YOUR VISIT: _____
_____
_____
HAVE YOU HAD A PAST ALLERGY WORK UP? _____ YEAR: _____
DOCTOR: _____ WHERE: _____
RESULT: INJECTIONS? _____ HOW LONG? _____ HELPFUL? _____
SPECIAL DIET? _____
_____ SUCCESSFUL? _____
INSECT ALLERGY? _____
DATE OF INSECT STING: _____
LOCATION OF STING: _____
REACTION (HOW SOON AFTER STING): _____
TYPE OF TREATMENT FOR PREVIOUS STING REACTIONS: _____

SYMPTOMS	**None**	**Mild**	**Moderate**	**Miserable**
SNEEZING	[ ]	[ ]	[ ]	[ ]
ITCHY EYES	[ ]	[ ]	[ ]	[ ]
ITCHY NOSE	[ ]	[ ]	[ ]	[ ]
ITCHY THROAT	[ ]	[ ]	[ ]	[ ]
STUFFY NOSE	[ ]	[ ]	[ ]	[ ]
RUNNY NOSE	[ ]	[ ]	[ ]	[ ]
COUGH	[ ]	[ ]	[ ]	[ ]
WORSE W/ EXERCISE/ACTIVITY	[ ]	[ ]	[ ]	[ ]
WORSE AT NIGHT	[ ]	[ ]	[ ]	[ ]
WHEEZE IN CHEST	[ ]	[ ]	[ ]	[ ]
EYE IRRITATION	[ ]	[ ]	[ ]	[ ]
POSTNASAL DRIP	[ ]	[ ]	[ ]	[ ]
SORE THROAT	[ ]	[ ]	[ ]	[ ]
MUCUS	[ ]	[ ]	[ ]	[ ]
CLEARING OF THROAT	[ ]	[ ]	[ ]	[ ]
HOARSENESS	[ ]	[ ]	[ ]	[ ]
RASH	[ ]	[ ]	[ ]	[ ]

WHEEZING/COUGHING

Do you wheeze? _____
Do you cough?_____
_____
_____
Color of sputum (cough secretions): _____
Do you have chest pain? _____

APPETITE: **[ ] Good [ ] Fair [ ] Poor**

Any weight change in the past 6 months?_____
Describe any food reactions: _____
_____
_____
_____

ALLERGIC PROBLEMS

YES	NO	CHECK ALL ITEMS
		Asthma
		Hospital visit(s) for Asthma
		Any other breathing problems?
		Hay fever (runny, stuffy, itchy nose, sneezing)
		Hives or swelling
		Eczema or other rashes
		Frequent infections
		Food reactions
		Drug reactions
		Insect reactions
		Latex Allergy
		Previous sinus x-rays

PLEASE DO NOT WRITE IN SPACE BELOW

SENSE OF SMELL: _____
HEADACHES: _____
DISCOLORED NASAL DRAINAGE: _____

EXCESSIVE EXPOSURES (home, work, school, etc.):

[ ] INDOOR DUSTS [ ] ANIMALS
[ ] OUTDOOR DUSTS [ ] INSECTICIDES
[ ] FUMES [ ] DETERGENTS
[ ] DAMPNESS [ ] PAINTS
[ ] MILDEW [ ] CHALK
[ ] CHEMICALS [ ] ODORS
[ ] COSMETICS [ ] OTHER: _____
[ ] TOBACCO SMOKE

ENVIRONMENT

Age of home you live in _____ [ ] House [ ] Apt. [ ] _____
Your home is in the: [ ] City [ ] Country
Cooling at home: [ ] Air Conditioner [ ] Water Cooler
Heating: [ ] Forced Air (gas) [ ] Electric [ ] Wood
Filters changed: [ ] Regularly [ ] Irregularly
Number of beds in bedroom: _____
Type of bed(s): [ ] Spring [ ] Waterbed [ ] Other: _____
How old is your mattress? _____
Pillows: [ ] Synthetic [ ] Feather
Is there carpeting in bedroom? _____ if so, how old? _____
How dusty is bedroom? [ ] Not [ ] Somewhat [ ] Very
How cluttered is bedroom? [ ] Not [ ] Somewhat [ ] Very

BIRTH HISTORY

City, State: _____ Birth weight: _____
Significant illnesses the first year of life _____

PAST MEDICAL HISTORY

SURGERY _____
_____
_____
_____

DRUG _____
ALLERGIES _____
_____
_____

MEDICATIONS _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

CAUSES (check those appearing suspicious)

[ ] HOUSE DUST [ ] FOODS [ ] DAMPNESS [ ] HEAT
[ ] TREES [ ] COSMETICS [ ] DRYNESS [ ] COLD
[ ] WEEDS [ ] GARAGE [ ] TOBACCO [ ] WIND
[ ] GRASSES [ ] OPEN FIELDS [ ] CLOTHING [ ] ASPIRIN
[ ] FLOWERS [ ] ALCOHOL [ ] FARMS [ ] SULPHITES
[ ] MOLDS [ ] ODORS [ ] WEATHER CHANGE [ ] MSG
[ ] ANIMALS [ ] SUN [ ] TEMPERATURE CHANGE
[ ] UPSET FEELINGS [ ] OTHER

EXPOSURE TO ANIMALS (home and away)

Types of animals: _____
How much indoor contact? _____ Outdoor contact? _____

TOBACCO/ALCOHOL

Number of years smoked: _____ Average pack/day: _____ Date stopped: _____
Do you have smokers cough? _____ Does anyone in the family smoke? _____
Who? _____ Most recent chest x-ray: _____
Alcohol consumption per week: _____

DESCRIPTION

What season(s) is condition WORSE? _____
What season(s) is condition BETTER? _____
Approximate total days absent from school or work in the past 12 months due to illness? _____
Condition is worse: [ ] Day [ ] Night [ ] Indoors [ ] Outdoors

FAMILY HISTORY

MOTHER: _____

FATHER: _____

FAMILY'S ALLERGIC HISTORY (list relationship to patient)

Asthma _____ Sinus _____ Headaches _____
Rashes _____ Hay Fever _____ Food _____
Insects _____

NAME:_____ **DATE:**_____ **DOB:** _____

REVIEW OF SYMPTOMS - ***Check only the ones you NOW have or have had WITHIN 48 HOURS.***

SLEEP HISTORY	SKIN	NOSE/EARS	GI	LUNGS
☐ Snoring	☐ Skin rashes	☐ Sneezing	☐ Nausea	☐ Shortness of breath
☐ Trouble falling asleep	☐ Hives	☐ Earache	☐ Vomiting	When:_____
☐ Trouble staying asleep	☐ Itching skin	☐ Nasal congestion	☐ Heartburn	☐ Wheezing
☐ NONE	☐ Skin dryness	☐ Runny nose	☐ Diarrhea	☐ Chest congestion
	☐ Skin sores	☐ Yellow/greenish drainage	☐ Poor appetite	☐ Cough
PET EXPOSURE	☐ Skin color changes	☐ Sore throat	☐ NONE	☐ Phlegm
☐ Cat	☐ NONE	☐ Postnasal drip		☐ Coughed blood
☐ Dog		☐ Pressure	MOUTH	☐ Tobacco use:
☐ Other: _____	HEAD	☐ Nose bleeds	☐ Mouth breathing	_____
☐ NONE	☐ Headaches	☐ Loss of smell	☐ Oral blisters	☐ NONE
	☐ Head injuries	☐ Itching ears	☐ Oral ulcers	
GENERAL	☐ NONE	☐ Dizziness	☐ Bad taste	HEART
☐ Weakness		☐ Ear ringing	☐ Loss of taste	☐ Chest pain: Sharp/Dull
☐ Fatigue	EYES	☐ Hoarseness	☐ Bad breath	☐ With activity
☐ Chills	☐ Itching/watery eyes	☐ NONE	☐ NONE	☐ After eating
☐ Night sweats	☐ Eye redness			☐ Rapid heartbeat
☐ Fainting	☐ Burning eyes		SHOTS - LAST:	☐ NONE
☐ NONE	☐ Eye pain		☐ Flu_____	
	☐ Blurred vision		☐ Pneumococcal____	
	☐ NONE		☐ Shingles_____	

ALLERGIES:_____

_____