Patient Name:___________________________________ DOB:______________

(Please Print)

PATIENT INFORMATION						
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:	Home phone no.: ( )			
P.O. box:	City:	State:	ZIP Code:			
Cell phone no.: ( )	Preferred method of contact: ❑ Home Phone ❑ Cell Phone ❑ E-Mail	Preferred Language:				
Race: ❑ White ❑ Black or African American ❑ Hispanic ❑ Asian ❑ Pacific Islander ❑ American Indian ❑ Unreported/Refused ❑ Other		Ethnicity: ❑ Hispanic ❑ Non Hispanic ❑ Unreported/Refused to Report				
Email Address:	Employer:	Employer phone no.: ( )				
Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ______________ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other						

IN CASE OF EMERGENCY		
Name of friend or relative:	Relationship to patient:	Best contact phone #:
Do you have an Advanced Directive or Living Will: ❑ No ❑ Yes		

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Please indicate primary insurance Carrier Name					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

Patient Name:________________________________ DOB:_____________

CONSENT FOR TREATMENT/ FINANCIAL RESPONSIBILITY (REQUIRED)

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Jupiter Medical Group or insurance company to release any information required to process my claims.

I hereby voluntarily consent to the rendering of care, including treatment, administration of anesthesia and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of Jupiter Medical Group, PA and it is the responsibility of the staff to carry out instruction of its physicians/providers.

*Patient Signature*____ *Date* ____________________

PATIENT AGREEMENT

This AGREEMENT confirms your responsibilities and informs you about our Practice Policies

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES - HIPAA

______ (initials) I hereby acknowledge that I have access to a copy of the Notice of Privacy Practices of Jupiter Medical Group, PA which is available for me at this and subsequent visits to read and understand. I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan & direct my treatment and follow up among the multiple health providers involved in my treatment
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physical certifications
- I understand that as part of my health care, Jupiter Medical Group, PA may need to reach me by phone.

( ) I **DO** authorize Jupiter Medical Group, PA to leave a message on my ❑ Home Phone ❑ Cell Phone regarding laboratory/test results and imaging studies. ***However, I understand that sensitive information and/or results that will require medication follow-up or discussion will require that I make an appointment with the physician***.

( ) I **DO NOT** authorize Jupiter Medical Group, PA to leave message on my telephone (home, cell, or work) regarding any type of testing results. I will accept the responsibility of making an appointment with the physician to obtain the results.

Please list all relatives, friends, in which we may discuss your results with:

Name	Relation	Phone Number
1.		
2.		
3.		

Release of Information

_____ ***(initials)*** My physician and authorized staff may disclose all or part of the patient's records to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient of physician(s) charges, including but limited to, insurance companies, worker's compensation carriers, auto insurance carriers, attorney or the patient's employer.

Patient Portal

_____ (***initials)*** I am aware that by providing my doctor's office with my current email, I will have access to my secure medical chart via the patient portal. I will be able to access my appointment request or reminders, prescription refills, non urgent medical questions, lab results, and more.

Electronic Prescribing

_____ **(*initials)*** Jupiter Medical Group, PA is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to provide the best possible treatment. I give Jupiter Medical Group, PA permission to request and use my prescribing medication history from other healthcare providers.

Patient Name:__________________________________ DOB:_____________

Fee for Service

_____ ***(initials)*** Services are rendered to the patient, not the insurance company. Our office will file your insurance claim. All CO-PAYS and DEDUCTIBLES are due in full at the time of service. For unpaid claims over 45 days, it is the patient's responsibility to follow up with their insurance carrier and the balance due is considered the patient's responsibility. Payment will be due in full.

Non-Covered Services

_____ ***(initials)*** I understand that Jupiter Medical Group, PA, contracts with health care service plans (i.e., HMOs, PPOs) which specifically state services which are "covered" by the health care services plan. Accordingly, the undersigned accepts full financial responsibility for all services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Jupiter Medical Group, PA to obtain necessary health care service authorizations. I understand that not all services provided are considered medically covered services by my health plan and payment will be due at the time of service.

Assignment of Benefits

_____ ***(initials)*** I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to Jupiter Medical Group, PA . I understand that Jupiter Medical Group, PA, contracts with multiple but not all health care service plans. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Jupiter Medical Group, PA if I belong to a plan that does not contract with Jupiter Medical Group, PA .

Medicare Assignment of Benefits (Medicare Patients Only)

____ ***(initials)*** I request that payment of authorized Medicare benefits be made on behalf to Jupiter Medical Group, PA , for services furnished me by Jupiter Medical Group, PA . I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Jupiter Medical Group, PA accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Medigap (Medicare Patients Only)

____ ***(initials)*** I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Jupiter Medical Group, PA , if possible or otherwise to me

I HAVE READ AND FULLY UNDERSTAND AND ACCEPT THE TERMS OF THE JUPITER MEDICAL GROUP, PA PATIENT AGREEMENT AND THE INFORMATION CONTAINED IN THE REGISTRATION PACKET AS INITIALED BY ME.

*Patient Signature*____ *Date* ____________________

Medical Records Consent

Today's Date:_____________

Patient Name: _____________________________ **Patient Date Of Birth:**__________________
Address: __________________________________
City, State, Zip: _____________________________
Patient Phone Number: ______________________

Please send my medical information to:
Jupiter Medical Group
875 Military Trail, Suite 200
Jupiter, FL 33458
Office: 561-746-2411; Facsimile: 561-354-0012

Facility to Obtain/Send Records:
____
____
____
Phone:____________________ **Fax**: _________________

Reason for Request/Release: ____

❑ Request for Records ❑ Release of Records

Above- listed patient authorizes the following healthcare facility to the release/request record disclosure for continuation of care:

- ☐ Entire Record
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Psychiatry/Mental Health
- ☐ Lab Reports
- ☐ Discharge Summary
- ☐ Medication List
- ☐ Progress Notes
- ☐ Diagnostic Reports
- ☐ History and Physical reports
- ☐ Consultation Reports
- ☐ Other:_________________________

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire 180 days following the date of signature.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

Records release to another physician is free of charge, however, if we release records to you personally or to another entity other than a medical facility then there will be a $15.00 fee charge.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

________________________________ __________
Patient Signature Date

Patient Name:___________________________________ DOB:______________

PERSONAL HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

CHILDHOOD ILLNESS: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations: Include date and where performed		
	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

☐ Anemia	☐ Diverticulitis	☐ Hepatitis / Liver Disease	☐ Suicide Attempt
☐ Asthma / Allergies	☐ Emphysema/COPD	☐ High Cholesterol	☐ Thyroid Problems
☐ Anxiety	☐ Epilepsy / Seizures	☐ High Blood Pressure	☐ Other:____________
☐ Cancer ____________	☐ GERD / Peptic Ulcers	☐ Kidney Problems	☐ Other:____________
☐ Diabetes (Type I / II)	☐ Gout	☐ Pneumonia	☐ Other:____________
☐ Depression	☐ Heart Disease / MI	☐ Stroke / TIA	☐ Other:____________

SURGERIES ☐ CHECK HERE IF NO SURGICAL HISTORY

Year	Reason	Hospital

OTHER HOSPITALIZATIONS ☐ CHECK HERE IF NO HOSPITAL HISTORY

Year	Reason	Hospital

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS ☐ CHECK HERE IF NOT ON ANY MEDICATIONS

Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS ☐ CHECK HERE IF NO ALLERGIES

Name the Drug	Reaction You Had

Patient Name:___________________________________ DOB:______________

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting?		☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?		☐ Yes	☐ No
	# of meals you eat in an average day?			
	Rank salt intake	☐ Hi	☐ Med	☐ Low
	Rank fat intake	☐ Hi	☐ Med	☐ Low
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	☐ Socially ☐ With dinner ☐ Habitually			
	How many drinks per week?			
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		
Personal Safety	Do you live alone?		☐ Yes	☐ No
	Do you have frequent falls?		☐ Yes	☐ No
	Do you have vision or hearing loss?		☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			Children	☐ M ☐ F	
MOTHER				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**GRANDMOTHER** *Maternal*		
	☐ M ☐ F		**GRANDFATHER** *Maternal*		
	☐ M ☐ F		**GRANDMOTHER** *Paternal*		
	☐ M ☐ F		**GRANDFATHER** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you? ☐ Mild ☐ Moderate ☐ High ☐ Very High	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No

Patient Name:_________________________________ DOB:_____________

Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping, Insomnia?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

REVIEW OF SYMPTOMS

Check if you have any symptoms in the following areas to a significant degree and briefly explain.

☐ Weight loss/gain How many lbs: _________	☐ Shortness of Breath	☐ Acne
☐ Weakness	☐ Wheezing	☐ Intolerance to Cold / Heat
☐ Fever/Chills	☐ Joint Pain	☐ Excessive Thirst
☐ Fatigue	☐ Muscle Cramps	☐ Hair Loss
☐ Itchy Eyes	☐ Loss of Memory	☐ Urinary Frequency # _______ per day
☐ Runny Nose	☐ Numbness/Tingling	☐ Blood in Urine
☐ Sinus Congestion	☐ Gait abnormality	☐ Difficulty Urinating
☐ Blurry Vision	☐ Abdominal Pain	☐ Loss of Urine/Incontinence
☐ Loss of Vision	☐ Bloating/Gas	☐ Decreased Libido
☐ Headache	☐ Blood in Stool	☐ Erectile Difficulty
☐ Cough	☐ Constipation	☐ Abnormal Vaginal Bleeding Menopausal? Yes/ No
☐ Sore Throat	☐ Diarrhea	☐ Hot Flashes
☐ Hearing Loss	☐ Heartburn	☐ Vaginal Dryness
☐ Chest Pain	☐ Easy Bruising	☐ Other:
☐ Palpitations	☐ Swollen Glands	
☐ Dizziness	☐ Rash	
☐ Pain/Swelling in Legs	☐ Dry Skin	

LIST OF CURRENT PROVIDERS

Provider Name	**Specialty**	**Reason**

HEALTH MAINTENANCE
(LIST PHYSICIAN AND DATE LAST PERFORMED)

Bone Density:	
Mammography:	
Colonoscopy:	
Vision Screening:	
PAP:	