



(Please Print)

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

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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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 \_\_\_\_\_

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 and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

**LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED**

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Hepatitis / Liver Disease	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Asthma / Allergies	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> GERD / Peptic Ulcers	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Diabetes (Type I / II)	<input type="checkbox"/> Gout	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Disease / MI	<input type="checkbox"/> Stroke / TIA	<input type="checkbox"/> 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	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# of meals you eat in an average day?			
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Socially <input type="checkbox"/> With dinner <input type="checkbox"/> Habitually			
	How many drinks per week?			
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
Personal Safety	Do you live alone?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

### FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>FATHER</b>			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>MOTHER</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>GRANDMOTHER</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>GRANDFATHER</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>GRANDMOTHER</b> <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>GRANDFATHER</b> <i>Paternal</i>		

### MENTAL HEALTH

Is stress a major problem for you?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> Very High			
Do you feel depressed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping, Insomnia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**REVIEW OF SYMPTOMS**

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

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