Patient Registration Form

Patient Information

Patient Name (Last, First, M.I.): _____ **Birth Date**: ____/____/___

Social Security Number: _____ **Sex** (Circle One): Male / Female

Race (Circle One): Asian/African American/American Indian/Native Hawaiian/Pacific Islander/White

Ethnicity: Hispanic/Non-Hispanic **Preferred Language**: _____

Street Address: _____ **Apt/Unit Number:** _____

City: _____ **State**: _____ **ZIP Code**: _____

Home Phone: _____ **Cell Phone**: _____ **Email Address**: _____

Referred By (Circle One)**:** Insurance Plan / Hospital / Family Member / Friend / Yellow Pages / Doctor / Other

If referred by a doctor, please specify which doctor:_____

In case of an emergency, please contact: _____

Phone Number: _____ **Relationship to Patient**: _____

Previous Primary Care Physician: _____ **Phone Number:** _____

Preferred Pharmacy: _____ **Pharmacy Phone Number**: _____

Insurance Information

(Please give your Photo ID & insurance cards to the receptionist)

Insured's Name: _____ **Birth Date**: ___/___/___ **SSN**: _____

Address: _____ **Relationship to Patient**: _____

Primary Insurance: _____ **Policy Number**: _____

Secondary Insurance: _____ **Policy Number**: _____

The above information is true to the best of my knowledge.

Patient/Guardian Signature: _____ **Date**: ____/____/_____

Patient Name: _____ **DOB:** _____**Date:** _____

Please answer the following questions:

Reason for the visit: ( ) Physical ( ) Vaccine Update ( ) Other Symptoms:_____

Are your child's vaccinations up to date: ( ) Yes ( ) No *(Please provide any records to Front Desk).*

Is your child taking any medications: ( ) Yes ( ) No

Current Medication(s): _____

What is the child's current living situation? ( ) Lives with both Parents ( ) Lives with one Parent
( ) Lives with Relatives ( ) Lives with Adopted Family ( ) Lives in Group Home

Birth History

( ) **I do not know the birth history**

Place of Birth (Hospital Name): _____

Was baby discharged from the hospital with mother? ( )Yes ( ) No If no, please explain: _____

Type of Delivery: ( )Vaginal ( ) Cesarean **If cesarean, why?** _____

Was the baby born: ( ) Term ( ) Early ( ) Late **If early, how many weeks gestation?** _____

Did your baby have any complications right after birth? ( ) Yes ( ) No Explain_____

Did mother have any illnesses or problems during pregnancy? ( )Yes ( ) No Explain_____

During pregnancy, did mother:

Smoke: ( )Yes ( ) No Drink Alcohol: ( )Yes ( ) No Use drugs or take medication(s): ( )Yes ( ) No

Which drug/medication(s): _____ **When:**_____

Initial Feeding: ( ) Breast Milk ( ) Formula ( ) Both If formula feeding, what type of formula? _____

Developmental Milestones:

What age child rolled over: _____ What age child sat up: _____ What age child stood up? _____

What age child walked alone: _____ What age child talked *(mama, dada, etc.)*: _____

What age child stop wearing diapers: _____ What age child started writing letters? _____

What school grade is your child currently enrolled: _____

For girls: At what age was her first period: _____ When was her last period: _____

Has your child ever been hospitalized? No ( ) Yes ( ) Explain: _____

Has your child ever had surgery? No ( ) Yes ( ) Explain: _____

Is your child currently suffering or had suffered from any illness? No ( ) Yes ( ) Explain:_____

Is your child allergic to any medication or food products? No ( ) Yes ( ) Explain: _____

_____

Patient Name: _____ DOB: _____Date: _____

Past Medical History

Does your child have, or has he/she ever had any of the following *(Please check all that apply.)***:**

	Chicken Pox/Measles/Mumps/Rubella		Frequent Ear Infections
	Problems with ears/hearing		Nasal/Environmental Allergies
	Problems with eyes/vision		Asthma/Wheezing
	Bronchitis/Bronchiolitis/Pneumonia		Heart Problems/Heart Murmur
	Seizures/Convulsions/Epilepsy		Anemia/Sickle Cell/Bleeding Disorder
	Frequent Headaches		Frequent Abdominal Pain/ Severe Constipation
	Diabetes/Elevated or Low Blood Sugar		Bladder/Kidney Infection
	Eczema/Other Chronic or Recurrent Skin Condition		Thyroid/Endocrine Conditions
	Bed-wetting (After Age 5)		Use of Drugs or Alcohol
	Immune Diseases ***(HIV or Aids)***		Cancer Type:_____

Any other significant medical problem: _____

Biological Family Medical History

Has any of your family members had any of the following *(Please check all that apply.)***:**

✓	**Illness/Condition**	**Family Member/Comment**
	Hypertension (Before Age 50)	
	High Cholesterol (Before Age 50)	
	Heart Disease (Before Age 50)	
	Diabetes (Before Age 50)	
	Cancer Type:_____	
	Nasal/Environmental Allergies	
	Tuberculosis	
	Liver Disease	
	Mental Disorders/Retardation	
	Deafness	
	Asthma	
	Anemia/Sickle Cell/Bleeding Disorder	
	Seizures/Convulsions/Epilepsy	
	Immune Diseases ***(HIV or AIDS)***	
	Bed-wetting (After Age 10)	
	Use of Drugs or Alcohol	

Any other significant medical problem: _____

Consent for Treatment, Diagnostic and/or Therapeutic Procedures

Patient Name: _____ Date of Birth: _____

I hereby consent to and authorize a physician of the Amicus Medical Centers and any other health professional as designated to perform a physical examination and routine diagnostic procedures upon me.

I also consent to and authorize Amicus Medical Centers to prescribe a therapeutic regime which I shall follow.

Unless I explicitly refuse, I consent that the diagnostic procedure(s) ordered by the Amicus Medical Centers physician can be performed on me despite the risks involved and complications that might be involved which were explained to me at the time they were ordered.

Signed: _____

Patient or Authorized Patient Representative

Printed Name: _____

Date/Time: _____

Witness: _____

Authorization to Bill Health Insurance/Assignment of Benefits

I _____ (print name) do hereby give full permission and authorize **Amicus Medical Centers – Corporate Billing Center**, to bill _____ (name of insurance company) for services rendered by **Amicus Medical Centers**. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to:

Amicus Medical Centers, LLC – Corporate Billing Center

1300 Concord Terrace

Suite 210

Sunrise, FL 33323

By signing this document, I also agree to the following statements below:

I understand that I am responsible for understanding information about my health insurance policy and providing such information to **Amicus Medical Centers**, for correct billing. I am also responsible to notify **Amicus Medical Centers** in the case of change of my health insurance status – inclusive benefits and any information I receive relating to care I have or will receive in this office.

I understand that **Amicus Medical Centers** will be providing services and billing my health insurance for those services at various times during the course of my care at this office. I understand that ultimately, I am responsible for all payment relating to any and all charges relating to treatment and services that I have received at **Amicus Medical Centers** during my care. I also understand that my insurance company and related policy plan may offer benefits for services provided at A**micus Medical Centers**, but that such benefits do not necessarily guarantee payment for those services.

I understand that the policy of **Amicus Medical Centers** requires payment in full for all services rendered at the time of visit, unless other financial arrangements have been made. If my account is not paid within 90 days of the date of service and no other financial arrangements have been made, I will be responsible for all legal fees, collection agency fees, and any other expenses incurred in collecting my account. I understand the above information and agree that my health history and related information was completed correctly to the best of my knowledge and understand that it is my responsibility to alert **Amicus Medical Centers** of any change in my medical status or insurance coverage.

The undersigned does agree to observe and abide by all of the statements made above.

_____ _____

Patient's Signature **Date**

_____ _____

Patient's Printed Name **Date**

E-Prescribing PBM Consent Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

- Formulary and benefit transactions-- Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions--Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that **Amicus Medical Centers** can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purpose.

Signed: _____

Print Patient's Name: _____

Patient's Date of Birth: _____

If signed by Representative,
State name of Representative: _____

Relationship to Patient: _____

Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received **Amicus Medical Centers' Notice of Privacy Practices** which provides a complete description of information, uses and disclosures**.** I acknowledge that I had an opportunity to review and ask questions concerning **Amicus Medical Centers' Notice of Privacy Practices** prior to signing this consent.

HIPAA Patient Information Consent

The following person(s) are allowed to receive and discuss my protected health information and/or pick up medications/prescriptions, results, reports and/or my billing information from **Amicus Medical Centers** on my behalf.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Patient or Patient's Representative

Signed: _____

Print Patient's Name: _____

Patient's Date of Birth: _____

If signed by Representative,
State name of Representative: _____

Relationship to Patient: _____

Date: _____

Consent for NonParent/Guardian

I _____, hereby give permission for the person(s) mentioned below to accompany my child(ren) for their initial examinations and/or any subsequent visits with Amicus Medical Centers. I authorize them to see all necessary medical records and make healthcare decisions of a routine nature, including treatment plans, medications and vaccinations administration. I authorize Amicus Medical Centers to discuss medical information about my child(ren) with the authorized person(s).

Additionally, I give the authorized person(s) the authority to make more serious or urgent health care decisions in the even that I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

This consent shall be effective from date of signature until revoked by myself.

Patient's Name(s): _____ **DOB:** _____

_____ **DOB:** _____

_____ **DOB:** _____

Person(s) Authorized to Accompany Minor/DOB	**Relationship to Minor**
_____	_____
_____	_____
_____	_____

Signature of Parent/Guardian _____ Date _____

Printed Name of Parent/Guardian _____ Contact Number of Parent/Guardian _____

*Authorized person(s) must provide photo identification at the time of the minors visit.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name (print): _____ **Date of Birth:** _____

Person(s) or facility authorized to use / disclose the information: _____

Address: _____

Phone: _____ Fax: _____

Please disclose the exact information to be disclosed, including dates of service: OR the specific records marked below:

Date(s) of Service: _____

- ☐ **All Medical Records**
- ☐ **History & Physical**
- ☐ **Pathology Reports**
- ☐ **Progress Notes**
- ☐ **Procedure Notes**
- ☐ **EKG**
- ☐ **Labs**
- ☐ **Radiology**
- ☐ **Other** _____

This information is to be released to:

- ☐ Amicus Medical Centers of Pembroke Pines
- ☐ Amicus Medical Centers of Pompano
- ☐ Amicus Medical Centers of West Palm Beach
- ☐ Amicus Medical Centers of East Boynton
- ☐ Amicus Medical Centers of West Boynton
- ☐ Amicus Medical Centers of Boca Raton
- ☐ Amicus Medical Centers of Plantation
- ☐ Amicus Medical Centers of Deerfield Beach

Address: _____

Phone: _____ Fax: _____

Acknowledge the following statements:

a) I understand that I may withdraw this Authorization at any time by sending a written request to Amicus Medical Centers. Such cancelation will not have any effect on any action taken by Amicus Medical Centers before the cancellation.

b) This authorization will expire six (6) months from the date of signature, or when revoked or on the following date: _____.

c) I understand that this information may include information relating to:

1) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection
2) Mental or behavioral health or psychiatric care.
3) Treatment of drug or alcohol abuse.

d) I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.

e) I understand that records in electronic form can be distributed on a wide scale with relative ease and losses or unintended releases of the requested information may occur under circumstances beyond the control of Amicus Medical Centers, its release of information vendor or the person making the request. By requesting records in this format, the Requestor is knowingly and voluntarily assuming this risk and all consequences, losses and damages that might result.

f) If Amicus Medical Centers has requested this Authorization, I understand that Amicus Medical Centers will give me a copy of this Authorization form after I sign it.

g) I understand that Amicus Medical Centers may not condition treatment, payment, enrollment or eligibility of benefits on the completion of this Authorization.

h) This information will be used / disclosed for the following purpose(s): _____

I hereby release Amicus Medical Centers from any liability which may arise as a result of the use of the information contained in the records released.

Name of Patient/Guardian: _____ Birthdate: _____

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____