

Adult Registration Form

Internal Medicine & Pediatrics of Tampa Bay



Patient Information

Name: _____ Gender: M / F
Date of Birth: _____ Age: _____ Social Security #: _____
(Circle one)
Home Address: _____ **Primary Phone #: _____ Home Cell
_____ Alternate Phone #: _____ Home Cell
E-mail Address: _____ (used for office update information only)
Employer: _____ Work Phone #: _____
Employer address: _____ Ext: _____
Occupation: _____

* **Primary # will be used for confirmation calls, billing inquiries and lab or test results.
We will leave a voicemail if unable to speak directly with you.**

Insurance information

Insurance Company Name: _____ Policy Type: HMO PPO PPC Other
Telephone #: _____ Effective Date: _____
ID# _____ Group # _____

Full Name of Insured: _____ Date of Birth: _____ (Insured)
Social Security# (Insured) _____ Relationship to Patient: Self Spouse Child (circle one)

Do you have secondary insurance? Yes No If Yes, Insured Name: _____
Ins. Carrier Name: _____ ID#: _____ Grp: _____

Please read the following statements and sign below:

I understand that payment of all medical care is due and payable at the time of service. I understand that it is my responsibility to pay a deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Internal Medicine & Pediatrics of Tampa Bay, PA to release any pertinent information to my insurance company upon request, and I also authorize payments directly to Internal Medicine & Pediatrics of Tampa Bay. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: _____

Date: _____



**Internal Medicine & Pediatrics
of Tampa Bay**

Consent for Release of Medical Information / Permission for Medical Treatment

Patient Name: _____ Date of Birth: _____

I understand that my medical information is confidential and can not be released without my authorization. I authorize Internal Medicine & Pediatrics of Tampa Bay to release my medical information to the following individuals both verbal and written:

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Emergency Contact Information

Who should we contact in case of an emergency if you cannot be reached? Please list someone who does not reside with the patient.

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Patient Signature: _____ Date: _____

What is your **occupation**? _____

Do you **travel** outside of the USA? If so, where? _____

Family History.

Do any family members suffer from the following? Please check Yes or No.

	Yes	No
High Blood Pressure		
Heart Disease		
High Cholesterol		
Strokes		
Diabetes		
Thyroid disease		

	Yes	No
Asthma		
Seizures		
Kidney Disease		
Gastrointestinal Disease		
Arthritis		
Cancer		

For any Yes responses, please describe: _____

Relatives		Living (Y / N)	Age	Please List All Medical Issues
Mother				
Father				
Siblings (list all)	M / F			
	M / F			
	M / F			
	M / F			
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

Gynecological History (if applicable)

Name of OB/GYN: _____ Age of menopause or date of hysterectomy: _____

Last Pap Smear: _____ Have you ever had an abnormal pap smear: _____

Last mammogram: _____ How many times have you been pregnant: _____

What birth control method do you currently use? _____

What methods have you used in the past: _____

Please describe your periods: (circle): regular or irregular light moderate heavy
frequency: occurs every ____ days duration: lasts for ____ days

How did you hear about our practice? _____

ALL PATIENTS:

This is to acknowledge that Internal Medicine & Pediatrics of Tampa Bay, PA has provided a Notice of Privacy Practices for me to review.

Signature: _____

Date: _____

Thank you for choosing Internal Medicine & Pediatrics of Tampa Bay!