Adult Registration Form

Internal Medicine & Pediatrics of Tampa Bay

Patient Information

Legal First Name _____ MI _____ Gender: M / F

Legal Last Name _____ Marital Status: S / M / D / W

Date of Birth _____ Age: _____

Language: _____ Race: _____ Ethnicity:_____

Home Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

**Primary Phone # :_____ **Secondary Phone #: _____
(Circle one) HOME CELL **(Circle one)** HOME CELL

Employer: _____ Work Phone #: _____ Ext: _____

Personal E-mail Address: _____

** **Contact #'s will be used for appointment confirmation calls, billing inquiries and lab or test results.**

We will leave a voicemail if unable to speak directly with you.

INSURANCE INFORMATION--- PLEASE PRESENT ALL INSURANCE CARDS

Insurance Company Name: _____ Full Name of Insured: _____

Date of Birth: _____(Insured) Relationship to Patient: Self Spouse Child (circle one)

Do you have secondary insurance? Yes / No If Yes, Insured Name: _____

Insurance Company Name: _____ Relationship to Patient: Self Spouse Child (circle one)

Date of Birth: _____(Insured)

*****NOTICE** Physician and staff are not responsible for determining if practice is in or out of network with your insurance plan. I understand I must contact my insurance to determine my benefits and coverage for care at this office. Initial _____**

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 all 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 fees, court costs and collection fees.

Appointments missed or rescheduled with less than 1 business day notice will be subject to a possible $35.00 fee.

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 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?

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

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

Patient Signature: _____ Date: _____

Patient Name: _____

DOB: _____

Internal Medicine & Pediatrics of Tampa Bay

Patient Medical History

Confidentiality Disclaimer: *All of the following information is confidential and may not be reproduced or distributed without patient permission with the exception to those individuals listed (if any) and as allowed by law according to the notice of privacy practices.*

General Medical History

Please list previous and current **medical issues**, including **hospitalizations**, **surgeries**, and **procedures.** Please list dates if known.

_____
_____
_____

Please list any **medications** the patient is currently taking: (Please include dose and frequency)
(Please include any herbals and over the counter meds)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please list any **allergies**, and the type of reaction: _____
_____

Review of systems.

Please circle any of the following items that are a recurrent problem for the patient. (not acute issues)

fatigue/weakness	lower extremity swelling	joint pain/muscle aches	frequent urination
weight loss / weight gain	cough	dry skin	poor urine stream
problems with vision	wheezing	rash	erectile dysfunction
hearing loss	shortness of breath	acne	absence of menses
ringing in ears	mouth / lip sores	dizziness	breast masses / lumps
nasal discharge	heartburn	headaches / migraines	nipple discharge
nose bleeds	nausea	memory loss	enlarged lymph nodes
frequent sore throats	vomiting	depression	bruising
itchy eyes	abdominal pain	anxiety	bleeding from gums
chest pain	diarrhea or constipation	difficulty sleeping	
palpitations	blood or mucus in stools		other: _____

Social History

Are you a current smoker? No Yes If yes, how many packs per day? _____
& for how many years? _____

Have you ever used **tobacco**? No Yes Quit Date? _____

Do you or have you ever used **alcohol**? No Yes If yes, how much? _____

Have you ever used any other **drugs**? No Yes If yes, please list: _____

What is your **marital status**? single married divorced separated widow

How many **children** do you have? Please list names and ages: _____

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
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Siblings	M / F			
(list all)	M / F			
	M / F			
	M / F			

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? _____