MEDICAL REGISTRATION
(PLEASE PRINT)

Today's Date: ____________ Who can we thank for referring you? ______________________________

PATIENT INFORMATION

Name: ____ Date of Birth: ____________
Last Name First Name Middle Initial

SS#: ______________________ Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Address: ____ Apt #: __________

City: ______________________ State: ________ Zip: ______________ Email: ______________________

Home Phone: ______________________ Work: ____________________ Cellular: ____________________

Is today's visit work related? ☐Yes ☐No Auto Accident? ☐Yes ☐No Date of Accident: ____________________

PRIMARY INSURANCE

Policy Holders Name: ____ Date of Birth: __________
Last Name First Name Middle Initial

SS#: ______________________ Sex: ☐Male ☐Female Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Address: (if different from above) ____ Apt #: __________

City: ______________________ State: ________ Zip: ______________

Insurance Company Name: ______________________ Policy#: ______________________ Group#: __________

Employer: ______________________________________ Work Phone: ______________________________

Employer Address: ______________________________________ City: ____________ State: _____ Zip: ______

SECONDARY INSURANCE

Policy Holders Name: ____ Date of Birth: __________
Last Name First Name Middle Initial

SS#: ______________________ Sex: ☐Male ☐Female Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Address: (if different from above) ____ Apt #: __________

City: ______________________ State: ________ Zip: ______________

Insurance Company Name: ______________________ Policy#: ______________________ Group#: __________

Employer: ______________________________________ Work Phone: ______________________________

Employer Address: ______________________________________ City: ____________ State: _____ Zip: ______

Patient Name: ______________________________________ Date of Birth:____________________

EMERGENCY CONTACT

Full Name: ______________________________________ Relationship to Patient: ____________________

Address: ____ Apt: ________________

City: ____________________________ State: ________ Zip: ___________ Phone: _________________________

CONSENT FOR TREATMENT:

The undersigned hereby consent to the provision of examination, treatments, medical laboratory procedures, drugs, and supplies to the patient as ordered or requested by the patients' physician and acknowledges that no guarantee or assurance has been made as to the results of such treatments, procedures or examinations.

Patient Signature: ____ Date: ____________________
(PHOTOCOPY AS VALID AS ORIGINAL)

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:

I, the undersigned, authorize payment of medical benefits to Medical Alternatives of America, Inc. for any services furnished by the physician, physician assistant and/or nurse. I understand that I am financially responsible for any amount not covered by my plan. I also authorize you to release to my insurance company information concerning health care, advice, or treatment provided to me. This information will be used for the purpose of evaluating and administrating claims of benefits.

Patient Signature: ____ Date: ____________________
(PHOTOCOPY AS VALID AS ORIGINAL)

(FOR MEDICARE BENEFICIARIES) MEDICARE LIFETIME SIGNATURE ON FILE:

I request that payment of authorized Medicare benefits be made on my behalf to Medical Alternatives of America, Inc. for services furnished me by the physician, physician assistant and/or nurse. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services.

Patient Signature: ____ Date: ____________________
(PHOTOCOPY AS VALID AS ORIGINAL)

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Name: ____ Birth Date: _________________

Signature: ____ Date: _____________________

MEDICAL HISTORY

Date: ________________

Patient Name: _____________________________________ Date of Birth: _______________ Gender: ☐Male ☐Female

SOCIAL HISTORY

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

With whom do you live? ____

Use of Alcohol:	☐ Never	☐ <1 per week	☐ 1-5 per week	☐ Other: ___________
Use of Recreational Drugs:	☐ Never	☐ <1 per week	☐ 1-5 per week	☐ Other: ___________
Use of Tobacco:	☐ Never	☐ <1 per day	☐ 1-5 per day	☐ Other: ___________
Coffee:	☐ Never	☐ <1 per day	☐ 1-5 per day	☐ Other: ___________
Tea:	☐ Never	☐ <1 per day	☐ 1-5 per day	☐ Other: ___________

Current Medications: ____

____

Please List any allergies: ____

Employment: ☐Full Time ☐Part Time Job Position: ____

Are you exposed to fumes, dusts or solvents? ____

HISTORY OF ILLNESS
(Please check only those which you have had a personal history)

☐Asthma
☐Anemia
☐Arthritis
☐Bursitis
☐Cancer – Type: ____________________
☐Chicken Pox
☐Congenital Abnormalities
☐Diabetes
☐Eczema

☐Endocarditis
☐Frequent Infections
☐Frequent Colds
☐Gastritis
☐Genital Disease
☐Gonorrhea
☐Heart Disease
☐Heart Murmur
☐High Blood Pressure
☐HIV
☐Hives

☐Kidney Disease
☐Liver Disease
☐Lung Disease
☐Lyme Disease
☐Malaria
☐Measles
☐Meningitis
☐Mental Illness
☐Migraine
☐Mumps
☐Osteomyelitis

☐Pneumonia
☐Rheumatic Fever
☐Scarlet Fever
☐Sickle Cell
☐Thyroid Disease
☐Tuberculosis
☐Ulcer
☐Other: ______________________

PLEASE LIST YOUR HOSPITALIZATIONS/ADMISSIONS (Not Including pregnancies):

YEAR	ILLNESS/SURGERY	LOCATION(Hospital/City/State)

Patient Name: ____ Date of Birth: ____________________

VACCINES **YEAR OF LAST** **TEST/EXAM** **YEAR OF LAST**

Tetanus	________________	Rectal/Stool	________________
Influenza	________________	Cholesterol	________________
Pneumonia	________________	Eye	________________
Hepatitis	________________	Stress Test	________________
Tuberculosis(TB)	________________	Colonoscopy	________________

FAMILY HISTORY: (If any of your blood relatives have suffered any of the following, please check the box and write his/her relationship to you)

☐Alcoholism: ______________________________

☐Anemia: ______________________________

☐Arthritis: ______________________________

☐Asthma: ______________________________

☐Bleeds easily ______________________________

☐Cancer: ______________________________

☐Diabetes: ______________________________

☐Epilepsy: ______________________________

☐Glaucoma: ______________________________

☐Gout: ______________________________

☐Hay Fever: ______________________________

☐Heart Disease:______________________________

☐Hepatitis: ______________________________

☐High Blood Pressure: ______________________________

☐Hypertension: ______________________________

☐Lipid Disorder: ______________________________

☐Mental Illness: ______________________________

☐Migraine: ______________________________

☐Osteoporosis: ______________________________

☐Sickle Cell: ______________________________

☐Stroke: ______________________________

☐Suicide: ______________________________

☐Thyroid Disease: ______________________________

☐Tuberculosis: ______________________________

☐Other: ______________________________

☐Other: ______________________________

INJURIES:

Have you ever been seriously injured in a motor vehicle accident? If yes, When and what Injuries? ☐Yes ☐No

____

Have you ever had any head injuries or concussions? If yes, when and describe incident? ☐Yes ☐No

____

Have you ever been knocked unconscious? If yes, when and describe incident?________________________________

____

Patient Name: ____ Date of Birth: ________________________

REVIEW OF SYSTEMS: (Please check any of the following you have experienced or are currently experiencing)

☐Agitation
☐Allergies
☐Back Pain: ☐Recurrent
☐Bloody or Tarry Stools
☐Bronchitis
☐Bruise Easily
☐Chest Pain
☐Chronic Abdominal Pain
☐Jaundice

- Chronic Cough
- Cold/Numb Feet
- Concentration Difficulties
- Constipation
- Decreased Hearing
- Depression
- Diarrhea
- Difficulty Swallowing
- Dizzy Spells
- Double or Blurred Vision
- Ear Infections: Frequent
- Eczema
- Eye Pain
- Failing Vision
- Fainting Spells
- Fatigue
- Feelings of Worthlessness
- Foot Pain
- Gout
- Hair Loss: Progressive Recent
- Hay Fever
- Headaches: Frequent
- Heartburn
- Hemorrhoids
- Hernia
- Hives
- Hoarseness: Prolonged
- Irregular Pulse
- Leg Pain: When Walking
- Loss of Appetite
- Memory Loss
- Moodiness
- Nervousness
- Nose Bleeds
- Numbness/Tingling Sensations
- Palpitations
- Persistent Nausea/Vomiting
- Phobias
- Psoriasis
- Rashes
- Ringing In Ear
- Shortness of Breath: On Exertion
- Lying Flat
- Sinus Trouble
- Sleeping Difficulties
- Sore Throats: Frequent
- Stress
- Suicidal Thoughts
- Swollen Ankles
- Tremors
- Urination Problems
  - Overactive Bladder
  - More Than 8 times/day
  - Urgency to Urinate
  - With Leakage
  - Decrease in Flow/Force
  - Painful
- Urine Infections: Frequent
- Blood in Urine
- Varicose Veins/Phlebitis
- Weight Gain
- Weight Loss
- Wheezing
- Other: ____________________
- Other: ____________________

FEMALES (Please Complete)

Menstrual Flow: Regular Irregular Pain/Abnormal Cramps

Date of first day of your last period: ___________________ Pain or Bleeding During or After Sex

Date of last Mammogram: ____________________ Normal Abnormal Where Complete: __________________________

Number of Pregnancies: _________ No. of Miscarriages: _________ No. of Live Births:________ No. of Abortions: _______

Birth Control Method: __________________________________

Date of last PAP: Normal Abnormal

5979 Vineland Road, Ste 209, Orlando, FL 32819 ▪Phone: (407)352-1030 Fax: (407)352-2884

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: ____

Date of Birth: ____

SSN: ____(optional)

I authorize: (Organization Name) ____

(Address) ____

____

(Phone & Fax) ____

(A): to release ALL information contained in my medical record concerning treatment provided between the dates of ____________________ to ____________________.

These records are also to include: *(initial all that apply)*

_______ Psychiatric History/Mental Illness

_______ History of drug and/or alcohol abuse

_______ HIV and/or Aids testing

(B): to release ONLY the records listed below:

____

____

These records are also to include: *(initial all that apply)*

_______ Psychiatric History/Mental Illness

_______ History of drug and/or alcohol abuse

_______ HIV and/or Aids testing

I understand that this is a required consent and I voluntarily and knowingly sign this authorization for release of information to:

Medical Alternatives of America, Inc.
5979 Vineland Rd., Ste. 209
Orlando, FL 32819
Phone: 407-352-1030 Fax: 407-352-2884

Patient Signature: ______________________________________ Date:________________________

Information released is confidential and protected by federal laws that prohibit re-disclosure of patient information without the prior consent of the patient. This consent is valid for up to one year from the date of its authorization and is revocable upon written notice except in the extent that action has already been taken.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: ____

Date of Birth: ____

SSN: ____(optional)

I authorize: Medical Alternatives of America, Inc.
5979 Vineland Rd., Ste. 209
Orlando, FL 32819
Phone: 407-352-1030 Fax: 407-352-2884

(A): to release ALL information contained in my medical record concerning treatment provided between the dates of ___________________ to ___________________.

These records are also to include: *(initial all that apply)*

_______ Psychiatric History/Mental Illness
_______ History of drug and/or alcohol abuse
_______ HIV and/or Aids testing

(B): to release ONLY the records listed below:

____

____

These records are also to include: *(initial all that apply)*

_______ Psychiatric History/Mental Illness
_______ History of drug and/or alcohol abuse
_______ HIV and/or Aids testing

I understand that this is a required consent and I voluntarily and knowingly sign this authorization for release of information to:

(Organization Name) ____

(Address) ____

____

(Phone & Fax) ____

I release Medical Alternatives of America, Inc. from any liability arising from the release of information to the individual or agency stated above.

Patient Signature: ____ Date:________________________

Information released is confidential and protected by federal laws that prohibit re-disclosure of patient information without the prior consent of the patient. This consent is valid for up to one year from the date of its authorization and is revocable upon written notice except in the extent that action has already been taken.

Dear Patient:

Listed below are some of our most commonly used office policies and fees. We appreciate your cooperation and understanding of these guidelines.

Policies:

All payments of co-pays, co-insurances, and/or deductibles are required at time of service.

Self-pay patients: All payments for services rendered are required in full at time of service.

It is mandatory that all patient appointments have a 24-hour cancellation notice. All no-shows will result in a $25.00 fee.

Please allow 48-hours for all prescription refills. Be aware that not all refills will be honored without an office visit.

Special Request Fees:

Completion of medically-necessary letters and forms (e.g. FMLA): $25.00

Copy of medical records/billing records: $25.00 for the first 25 pages, 0.25 per additional page.
(1 week notice is required. An additional fee will be charged if requested sooner)

I have read and understand the above policies.

Patient Name: ____

Patient Signature:____

Date: ________________________

SELF DETERMINATION ACT QUESTIONAIRE

LIVING WILL

_______ **I HAVE** A LIVING WILL

____ I HAVE DECLARED TO **DECLINE** LIFE-PROLONGING PROCEDURES

____ I HAVE DECLARED TO **ACCEPT** LIFE-PROLONGING PROCEDURES

________ **I DO NOT HAVE** A LIVING WILL

HEALTHCARE SURROGATE

DURABLE POWER OF ATTORNEY

If you have any of the legal documents listed above, please provide us with a copy.
If you have any further questions, you may contact your family attorney or local hospital for additional information.

Patient Name: ____ Date of Birth: ________________________

Patient Signature: ____ Today's Date: _______________________

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐Home Telephone _______________________________
- ☐O.K. to leave message with detailed information
- ☐Leave message with call-back number only

☐Written Communication
- ☐O.K. to mail to my home address
- ☐O.K. to mail to my work/office address

☐O.K. to fax to this number

☐Work Telephone ______________________________
☐O.K. to leave message with detailed information
☐Leave message with call-back number only

☐Cell Phone _____________________________
☐O.K. to leave message with detailed information
☐Leave message with call-back number only

______________________________ Patient Signature

______________ Date

______________________________ Print Name

______________ Birth Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for Treatment Records, Payment Information, and Healthcare Operations (TPO) may be permitted without prior consent in an emergency.

Dear: ________________________________

Welcome to our office. We are dedicated to providing quality personal healthcare to each of our patients.

In order to get to know you better and to make your first visit more comfortable, we have enclosed a CONFIDENTIAL PATIENT INFORMATION PACKAGE which we would like you to complete. Please bring it with you to your first visit along with your health insurance card and your driver's license.

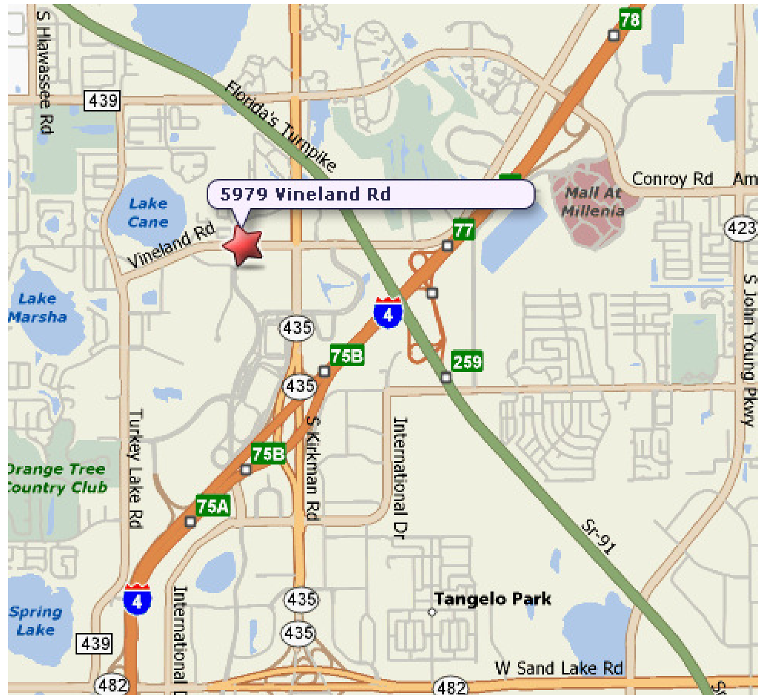
Please feel free to contact our office staff should you have any questions regarding insurance plans, methods of payment and appointment availabilities. Our office accepts most insurance plans and VISA / MASTER CARD. As is customary, payment is expected at time of service, including any co-payments.

Our office is located in the Studio Plaza Building on Vineland Rd., just across from the Portofino Bay Hotel at Universal Studios. There is a map below for your convenience.

Thank you for your confidence. It is our goal to provide you with the best medical care in a friendly atmosphere. We always try to take into consideration your particular needs.
Please feel free to discuss any issue you may have with us. We look forward to meeting you.

Your appointment is on ______________________________at ______________________.

Please arrive 20 minutes before your scheduled appointment time. Thank-you.



5979 Vineland Road, Ste 209, Orlando, FL 32819 ▪Phone: (407)352-1030   Fax: (407)352-2884

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Name: ____ Birth Date: ________________

Signature: ____ Date: ____________________