

# Patient Registration

James D. Kearney MD

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name	Today's Date	Date of Birth	Sex	Age
Parent if Patient is a Minor				
Patient's Social Security Number				
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
Home Telephone Number		Work Telephone Number		
Occupation		Employer's Name		
Employer's Address	City	State	Zip	
Spouse Name		Employer		
Other Physician's Name				
Whom May We Thank for Referring You to Our Practice?				
<b>NOTIFY IN CASE OF EMERGENCY</b>				
Name		Relationship		
Address	City	State	Zip	
Home Telephone		Work Telephone		
Nearest Relative (not living with you)				
Home Telephone		Work Telephone		
<b>FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES</b>				
Name		Telephone		
Address	City	State	Zip	
Insurance Company		Claim Address		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#		
Insurance ID No.				
Secondary Insurance		Claim Address		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#		
Were You Injured on the Job?	YES	NO	Have you Informed Your Employer?	YES NO
Date of Original Injury:				
Worker's Compensation Carrier Name		Address		

**Please Read Our Financial Policy Statement and Agreement of Reverse**

## Assignment of Benefits:

I hereby assign all medical and /or surgical benefits, to include major or medical benefits to which I am entitled including Medicare, and private insurance and any other health plans to James D. Kearney, MD

Signature of Patient or Responsible Party: \_\_\_\_\_ Date \_\_\_\_\_

## Authorization for Medical and/or Minor Surgical Procedures

I understand that the proper diagnosis and treatment may require a physician to perform minor surgical and medical procedures and treatments and to administer local anesthetics, medicines, x-rays, and other tests and medical procedures. I therefore authorize such medical procedures, treatments, and administrations, which are considered necessary and advisable by the physician. I understand further that nurses, technicians, or other medical personnel may perform some procedures and treatments. I authorize them to do so whenever the physician considers it necessary or advisable.

I am fully aware of the contents of the form I am signing.

Signature of Patient or Responsible Party: \_\_\_\_\_ Date \_\_\_\_\_

**Patients Name:**

**Today's Date:**

**Date of Birth:**

**PAST MEDICAL HISTORY**

List all ALLERGIES to Medications or Food:

List all Medical conditions you have:

List all Surgeries you have had:

List all of your medications, including eye drops:

Name	Dose	How often taken a day	Reorder amount you get:
1.			30 day 90 day 100 day other
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

**SOCIAL HISTORY:**

Job Description (or unemployed, retired):

Do you smoke? Yes  No  If so, number of packs a day:

Do you drink Alcohol? Yes  No  Beers \_\_ a day Wine \_\_ a day Other \_\_ a day

Do use marijuana or cocaine Yes  No

**FAMILY HISTORY:**

Father Alive  Deceased  Unknown  Age (or age at death) \_\_

Father's Medical Conditions:

Mother Alive  Deceased  Unknown  Age (or age at death) \_\_

Mother's Medical Conditions:

Brother (do not list half brothers) Alive  Deceased  Unknown  Age (or age at death) \_\_

Brother's Medical Conditions:

Sister (do not list half sisters) Alive  Deceased  Unknown  Age (or age at death) \_\_

Sister's Medical Conditions:

List any other full brothers and sisters and their age and health if not listed above:

**Patient Name:**

**Date of Birth:**

**Review of Systems** (Please check all that apply)

**Constitutional:**

- Weight gain
- Weight loss
- Fatigue
- History of cancer (What organ and what treatment)

**Eyes:**

- Vision problems
- Glaucoma
- Cataract surgery

**Ears, Nose Throat:**

- Hearing problems
- Ringing in the ears
- Nosebleeds
- Dental or mouth disease
- Tonsils removed

**Respiratory:**

- Shortness of breath
- Wheezing or asthma
- Cough
- Tuberculosis

**Cardiovascular:**

- High blood pressure
- Chest pain
- Heart skipping beats or racing
- Heart attack
- Heart surgery

**Gastrointestinal:**

- Difficulty swallowing
- Indigestion or heartburn
- Belly pain
- Ulcers
- Nausea or vomiting
- Blood in bowel movement
- Black bowel movement
- Diarrhea
- Hepatitis or cirrhosis
- Gallbladder removed
- Appendix removed
- Hernia surgery

**Musculoskeletal:**

- Back pain
- Back surgery
- Neck pain
- Leg swelling
- Arthritis
- Varicose veins
- Muscle weakness

**Today's Date:**

**Genito-urinary:**

- Kidney stones
- Losing urine when laughing or coughing
- Urination accidents- not able to get to bathroom in time
- Urinating more than 2 times at night
- Frequent urination
- Painful urination
- Blood in urine
- Sexually transmitted diseases
- Painful intercourse
- Loss of sexual libido
- Genital drainage or lesions
- Males-erectile dysfunction
- Males-prostate problems
- Females-gynecology problems
- Females- still with regular periods

**Neurological:**

- Fainting
- Headache
- Head injury
- Tremors
- Strokes

**Skin:**

- Rashes or moles
- Skin lesions
- Breast lumps
- Breast surgery

**Hematological:**

- Easy bruising
- Anemia
- Bleeding problem

**Endocrine:**

- Diabetes
- Thyroid problems

**Psychiatric:**

- Depression
- Panic attacks
- Mental hospitalizations
- Bipolar disorder
- Other

**Allergic:**

- Sinus or allergy problems
- Hay Fever

**List Artificial Devices implanted in your body:**

**HIPAA Notice of Privacy Practices**

**MEDICAL ASSOCIATES OF BREVARD, P.A.**

**James D. Kearney, MD**

**580 North Wickham Road, Suite A Melbourne, FL 32935**

**Phone (321) 255-7118 Fax (321) 255-8391**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services, For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

***We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of***

**Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.**

**Other Permitted and Required Uses and Disclosures** Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

**You may revoke this authorization**, at any time, in writing; except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information**

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14.2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_