Mid-Florida Medical & Chiropractic Center

General Medicine * Chiropractic Care * Physical Rehabilitation * Weight Loss Programs

100 Park Place Blvd Suite 201 Kissimmee, FL 34741

Phone: 407-847-8900 * Fax: 407-931-3500

PATIENT REGISTRATION FORM

TODAYS DATE: _____/_____/_____

PATIENTS NAME: _____ ☐MR. ☐ MRS. ☐ MISS. ☐ MS.

IS THIS YOUR LEGAL NAME: ☐ YES ☐ NO **IF NOT WHAT IS YOUR LEGAL NAME:** _____

Height_____ **Weight**_____ **Right Handed** ☐ **Left Handed** ☐

MARITAL STATUS: (Please check one) SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOW ☐

DATE OF BIRTH: _____/_____/_____ **AGE:** _____ **SEX:** MALE ☐ FEMALE ☐ SS# _____

STREET ADDRESS: _____ **CITY:** _____ **STATE/ZIP:** _____

CELL PHONE: (_____) _____ **HOME PHONE: (_____)** _____

WORK PHONE: (_____) _____ **E-Mail:** _____

IN CASE OF EMERGENCY: NAME OF LOCAL FRIEND OR RELATIVE

NAME: _____ **RELATIONSHIP:** _____ **PHONE # (_____)** _____

Are you: employed ☐ unemployed ☐ retired ☐ disabled ☐ student ☐

(If you are employed please complete the following:)

Where are you employed: _____What type of work do you do?_____

Do you: Work on a computer ☐ Have long sitting periods ☐ Have long standing periods ☐ Do a lot of bending ☐

Social History

1. Do you presently Smoke	Yes ☐	No ☐	If yes :: # Packs/day ____ # Years___
2. Have you ever smoked	Yes ☐	No ☐	If yes :: #Packs/day ____ # Years___
3. Do you drink alcohol	Yes ☐	No ☐	If Yes :: # Drinks _____ per week
4. Have you ever used any addictive substances?	Yes ☐	No ☐	If Yes :: (Substance: _____)
5. **Do you have any children:**	Yes ☐	No ☐	if yes please state # of children _____

Insurance Company: _____ Phone # _____

ID # _____ Group #_____

Primary Insured Name: _____ Your relation to insured: _____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance not paid by my insurance company. I authorize Mid-Florida Medical & Chiropractic Center, Inc to release my medical records and appointment information to my insurance company and/or my attorney to help process my case and/or claim. I also authorize the release of my medical records from Mid-Florida Medical & Chiropractic Center to other physicians who treat me for my condition whilst under the care of Mid-Florida Medical & Chiropractic Center.

Patient's Signature: _____ Date: _____/_____/_____

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PERSONAL HEALTH HISTORY

Patient's Name _____ **DOB** _____ **Date** _____

Place a check in a box for any symptom you currently have or have had

General
- ☐ Allergy
- ☐ Chills
- ☐ Convulsions
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness, depression
- ☐ Neuralgia
- ☐ Sweats
- ☐ Tremors

Cardiovascular
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Slow heartbeat
- ☐ Swelling of ankles

Genitourinary
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of kidney control
- ☐ Kidney infection
- ☐ Painful urination
- ☐ Prostate trouble
- ☐ Pus in urine

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficult breathing
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Wheezing

Eye, Ear, Nose and Throat
- ☐ Asthma
- ☐ Colds
- ☐ Crossed eyes
- ☐ Deafness
- ☐ Dental decay
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear noise
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Eye pain
- ☐ Failing vision
- ☐ Far sightedness
- ☐ Gum trouble
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Near sightedness
- ☐ Nose bleeds
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis

Gastrointestinal
- ☐ Belching or gas
- ☐ Colitis
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergy
- ☐ Itching
- ☐ Skin eruptions (rash)
- ☐ Varicose veins

Women only
- ☐ Congested breasts
- ☐ Cramps or backache
- ☐ Excess menstrual flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Painful menstruation
- ☐ Vaginal discharge

Are you pregnant? ☐Yes ☐No

If yes, how many months?____

How many children do you have?___

Check any of the following conditions you currently have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diptheria
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

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Please explain the reason for your visit today:

_____

_____

_____

Please check all that apply as it relates to your condition -- Do you have/feel any of the following:

Headache ☐ Fainting ☐ Ringing in ears ☐ Loss of smell ☐ Pain behind eyes ☐ Dizziness ☐
Nausea ☐ Confusion ☐ Fatigue ☐ Tension ☐ Irritability ☐ Loss of taste ☐
Depression ☐ Anxious ☐ Chest pain ☐ Shortness of breath ☐ Any sleeping problems ☐
Loss of normal vision ☐ Loss of ability to hear ☐ Any Difficulty swallowing ☐ Any hoarseness in your voice ☐

OTHER (please describe)

_____

_____

Please list any prior Hospitalization/Operations

Date	Reason/Procedure	Hospital

Please list your current Medication(s) (Please include any Vitamins or Herbal Medications)

Name	Dose	Frequency

Medication Allergies

List any Medication Allergies and the type of reaction: If none are known please check here: ☐

_____

I certify that I have read and understand all of the information requested of me concerning my medical history and health problems and that my answers are true and accurate to the best of my knowledge. I further certify that I do have the indicated health problem(s) and that I desire an appropriate medical examination, treatment and/or advice necessary.

Patient's Signature: _____ **Date:** _____

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Medical Release Form

Patient's Name: _____ D.O.B: _____

I request and authorize the following provider(s) and/or physician(s) to release healthcare information and medical records to:

Mid-Florida Medical & Chiropractic Center 100 Park Place Blvd Suite 201 Kissimmee FL 34741

Phone: 407-847-8900 **Fax**: 407-931-3500

(name of provider/office)_____

Fax #: _____ Notes: _____

(name of provider/office)_____

Fax #: _____ Notes: _____

(name of provider/office)_____

Fax #: _____ Notes: _____

(name of provider/office)_____

Fax #: _____ Notes: _____

This request and authorization applies to:

- ☒ **Full** medical records held by the office **for all dates of service**
- ☐ A specific portion/section of the record as follows: _____
- ☒ MRI/X-Ray Reports
- ☐ Medical Records for the period of _____ through _____
- ☐ Other diagnostic studies: _____

Purpose of the requested disclosure: At the patient's request ☐ Continuing Care ☒

I understand that I have the right to revoke this authorization at any time. my revocation must be in writing in a letter provided to the privacy officer. I am aware that my revocation is not effective to the extent that the person I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that Mid-Florida Medical & Chiropractic Center may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the release information may be re-disclosed and would no longer be protected by Federal Privacy Regulations. I agree that a copy of this release of fax of this release shall be as valid as the original release. If I authorize Mid-Florida Medical & Chiropractic Center to fax information, I realize there are inherit risks in faxing protected health information.

Patient's / Guardian's Signature _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 365 DAYS FROM THE DATE IT IS SIGNED

Federal Law (HIPPA) says that an individual's health information cannot be shared without the individuals consent except in certain situations. This form must be completed and signed by the patient or by the appointed representative for the patient (parent of minor, legal guardian, trustee, power of attorney, personal representative of the state). If you sign this form you are consenting for the medical providers to share the information indicated above.

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Patient's copy.. Patient's please keep this copy..

Notice of Privacy Practices

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

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR OBLIGATION

We are required by law to maintain the privacy of your health information, we are also required to give you this Notice about our privacy practices, our legal obligation, and your rights concerning you health information. We must follow privacy practices that are described in this Notice while it is in effect. This Notice takes effect on April 14 2003 and will remain in effect until we replace it

We reserve the right to change our privacy practices and the terms of this Notice at any time provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practice, we will change this notice and make the new Notice available you upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCCLOSURES OF HEALTH INFORMATION

We use and disclose your health information about you for our treatment, payment and health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider, providing treatment to you.

Payment: We may use or disclose your information to your health insurer to obtain payment for services we provided to you.

Health Care Operations: We may use or disclose you health information in connection with our health care operations. Health care operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. For example, we may use or disclose your health information in order to conduct an internal assessment to the quality care we provide **Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification (including identifying or locating) a family member, your personal representative or another person responsible for your case, to the extent necessary to help with your health care or with payment of your health care, if you agree that they may do so. We may also advise these persons of your locations your general condition, or death. If you are present, the prior to use or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person`s involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disclosure Permitted or Required by Law: We are permitted and in some cases required, by law to make certain other disclosures of health information without your consent, We may disclose the health information, if appropriate, to the following entities under the following circumstances:

1. the public health agencies to satisfy certain reporting requirements, such as births and deaths, certain communicable diseases, child abuse and other public health issues:
2. the health oversight agencies such as government auditors, the Florida Agency of Health Care Administration, the Florida Department of Health and other agencies when required;
3. to any individual when Mid Florida Medical and Chiropractic Center is ordered by court or other legal process to do so.
4. to law enforcement officials when necessary for law enforcement purposes and required by law;
5. to a coroner or medical examiner when necessary to enable them to perform their duties;
6. to organ procurement organizations, to enable them to make suitability determination.
7. in case of emergency; or
8. To researchers if their research has been approved by an institutional review board and they take certain steps to protect your privacy.

Appointment Reminder: We may use or disclose your health information to provide you with appointment reminders (such as a voicemail message, postcards, or letters - or information about treatment alternatives or other health- related benefits and services that may be if interest to you.

Marketing Health-Related Services: We will not use your health information for marketing communications without written authorization.

Your Authorization: Other uses and disclosures of your health information will be made if you give us written authorization to do so. If you give us and authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

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ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have received a copy of this office`s notice of Privacy Practices.

Please print name----------

Signature----------

Date----------

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)
