New Patient
Registration Packet

Tel: (772) 388-9155
Fax: (772) 388-9154
sebastianidcare@gmail.com

7955 Bay Street, Suite #2
Sebastian, Florida
32958-3282

Dear Patient,

Welcome to Sebastian ID Care. Thank you for allowing us the opportunity to assist with your health-care needs. We value all our patients and are committed to providing you with the highest quality health-care services.

This packet contains all the new patient forms that we will need to assist in your treatment.

1. Financial Policy
2. New Patient Registration Form
3. Authorization to Release Medical Information
4. Confidentiality & Privacy of Medical Records
5. Medical History Form
6. Review of Systems Form
7. Immunization record

Please take a few moments to review and complete the documents. You can preferably email them back via our secure platform in advance of your appointment, or you can also fill them out and return them to the front desk at out office along with your insurance card.

We are looking forward to assisting with your health care needs. If you have any questions, please contact us and we will be happy to serve you.

Yours sincerely,

Aisha Thomas MD

Financial Policy

Insurance Enrollment. As a courtesy to our patients, we have enrolled as a provider with numerous insurance companies. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly.

Insurance Restrictions & Lapses. It is not possible for us to keep track of the requirements for each insurance plan. Therefore, it is the responsibility of each patient to know the details of his/her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. If you do not inform us of special requirements in your plan and we provide or order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges.

Inability to Verify Insurance. If current insurance coverage cannot be verified prior to an appointment, we may require payment at the time of service.

Services Rendered by Other Providers. We bill only for the services that we render. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill please contact them or your insurance company directly.

Co-Payments & Deductibles. Co-payments and deductibles are required at the time of service.

Uninsured Patients. We offer an adjusted rate for uninsured patients, but the payment is usually required at the time of service.

Installments: We may allow payments to be made in installments for outstanding balances that exceed $100.

Administrative Forms. We may charge a fee for completing certain administrative forms. Disability documents, insurance and medical records requests are examples of such forms. Please be aware that these services may require 2-3 days to complete.

Delinquent Accounts. If an account is not paid in full within 90 days, a 25% collection processing fee may be added to the outstanding balance and the account may be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

Returned Checks. Checks returned for any reason will be assessed a $35.00 service fee in addition to the amount of the check. *Non-Sufficient Fund* (NSF) checks must be redeemed with certified funds and checks will no longer be permitted as payment.

No-Show. We attempt to contact every patient to remind them of their appointment. However, it is the responsibility of the patient to arrive for their appointment on time. We reserve the right to charge a no-show fee for patients who miss appointments without calling to cancel within 24 hours of the appointment. The no-show fee is $45.00.

I hereby authorize Sebastian ID Care to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to Sebastian ID Care for their services.

______________________________	______________________________	___________________
Patient Name	Patient Signature	Date

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New Patient Registration Form

PATIENT INFORMATION					
First Name	Middle	Last Name	Preferred Pharmacy		
Address	Apt. #	City	State	Zip	
Social Security No.	Sex	Marital Status	Date of Birth	Driver's License #	State Issued
Email (For Office Use Only)	Home Phone	Work Phone	Cell Phone		
Name of Primary Care Physician (PCP)	Contact Information for Primary Care Physician (Phone / Address)				
Employer Name	Employer Address	Occupation			
List the persons with whom we are authorized to share your medical information					
Were you referred by a physician? ( ) Y ( ) N	If yes, what is the name of the physician? ___________________________________				

SPOUSE'S INFORMATION N/A ( )			
First Name	Middle	Last Name	
Occupation	Employer Name	Home Phone	Cell Phone

INSURANCE INFORMATION		
Primary Insurance Company Name	Group No.	ID/Certificate No.
Policy Holder's Name	Policy Holder's DOB	Policy Holder's Social Security No.
Secondary Insurance Company Name	Group No.	ID/Certificate No.
Policy Holder's Name	Policy Holder's DOB	Policy Holder's Social Security No.

EMERGENCY INFORMATION			
Person to Notify in Case of Emergency	Relationship	Home Phone	Cell Phone

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___________________________________ ___________________________

Patient / Guarantor Signature Date

Authorization to Release Medical Information

Release to:
Sebastian ID Care
7955 Bay St., Suite # 2., Sebastian, FL 32958
Tel. # 772 388 9155 / Fax # 772 388 9154

1. **Information to be released**: (Check all applicable)
   □ All information □ All progress notes □ Lab reports □ Imaging Reports
   □ Discharge Summaries □ Microbiology □ Immunization Records □ Other _________________

2. **Special Authorization**: (Check applicable box[es] and sign below immediately).

   By signing below, I am authorizing the release of any and all information regarding:

   □ Alcohol □ Drug □ Mental Health □ STDs □ HIV/AIDS □ Minor <18

   Note: Federal rules require special authorization for the release of alcohol, drug, or mental health information (42 CFR part2). A general authorization for the release of medical or other information is not sufficient for the release of alcohol, drug, or mental health information. Federal rules also restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

3. Patient's Signature: _____________________________ Date: ________ / ________ / ________

4. **Records from the time period**: ______/ ______/ ______ through ______/ ______/ ______

5. **Purpose of disclosure**: (Check all applicable)
   □ Continued Medical Care □ Payment of Insurance Claim □ Legal
   □ Personal □ Workers' Compensation Claim □ Other: ________________

6. I understand that this authorization shall be valid for five (5) years.
7. I understand that I have no obligation to disclose information from my record and that I may revoke this consent at any time by submitting a request in writing to the Practice Manager of this office. I understand that any action already taken with respect to this authorization cannot be reversed and my revocation will not affect such actions.
8. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.
9. I understand that a copy of this form will be used to authorize the release of my protected health information.

Patient's Name: ____ Date: __________ / __________ / ___________

Patient / Guardian Signature: ______________________________ Date of Birth: ________ / ________ / _________

Home Phone: (________) _________________________________ Work Phone: (________) _________________

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Confidentiality and Privacy of Medical Records

This notice describes the privacy practices of our office. Please review carefully.

Our Pledge Regarding Health Information
The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) was drafted, in part, to control the privacy of, access to, and maintenance of confidential information. We understand that information about you, your health, and your health care is personal. We are committed to protecting your personal health information (PHI).

We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal physician or others working in this office. This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights to the PHI we keep about you, and describe certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

a. Make sure that health information that identifies you is kept private
b. Give you this notice of our legal duties and privacy practices with respect to your PHI
c. Follow the terms of the notice that is currently in effect

How We May Use and Disclose Your PHI
The following describe different ways that we use and disclose health information.

Treatment. We may use your health information to provide you with health care treatment or services. We may disclose health information about you to others involved in your healthcare treatment including other physicians, hospitals, labs, pharmacies, or other health care providers to whom we may have referred you.

Payment. We may use and disclose information about treatment and services we provided to you for billing purposes. These fees may be collected from you, your insurance company, or a third party and include requests for payment / reimbursement and prior authorization for treatment.

Appointment Reminders. We may use and disclose health information to contact you as a reminder that you have an appointment or that you missed an appointment and should contact us to reschedule. Please let us know if you do not wish to have us contact you for this purpose or if you wish to use a different method to contact you.

As Required by Law. We will disclose health information about you when required to do so by federal, state, military, or local law.

Organ and Tissue Donation. If you are an organ donor, we may release health information to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to the health and safety of you or another individual(s).

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you for public health reporting purposes. These activities generally include but are not limited to the following: Birth, death, abuse, neglect, communicable disease prevention and / or notification, medication adverse reactions, and product recalls.

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Coroners, Health Examiners, and Funeral Directors. We may release health information to a coroner, health examiner, or funeral directors as necessary to carry out their duties.

SEBASTIAN ID CARE

MEDICAL HISTORY

Please check the applicable boxes

GENERAL
□ fever
□ night sweats
□ weight loss
□ Enlarged lymph nodes
□ Transfusion (Dates) ___________________

HEME/ONC
□ Anemia Type/Treatment________________
□ Cancer Type/Treatment________________
□ Blood Clots / DVT's

HEART
□ High Cholesterol
□ Hypertension
□ Heart Murmur □ Valve replacement
□ MI / Heart Attack
□ Heart Failure
□ Arrythmia/Atrial Fibrillation
□ Pacemaker / Defibrillator

LUNGS
□ Asthma
□ Emphysema / COPD / Bronchitis
□ Pneumonia
□ Sleep Apnea
□ +PPD
□ Chronic lung disease

ENDOCRINE
□ Hypothyroid
□ Hyperthyroid
□ Diabetes

GI
□ Ulcers
□ GERD
□ Cirrhosis
□ Colon Polyps
□ Crohn's / Ulcerative Colitis
□ Irritable Bowel Syndrome
□ Gall Bladder disease
□ Hemorrhoids

GU
□ Prostate Problems
□ Hernia
□ Kidney Stones
□ Urinary Tract Infection
□ Urinary Incontinence
□ Chronic kidney disease

GYN (Women Only)
Live births (No.) _______
Abortions / Miscarriages (No.) _______
□ C-Sections____________
Last Menstrual Period ___________________
Contraception _________________________

INFECTIOUS DISEASES
□ MRSA
□ C-Diff
□ VRE
□ Lyme
□ Shingles / Chickenpox
□ Gonorrhea
□ Syphilis
□ HIV / AIDS when _______________________
□ Cellulitis
□ Meningitis
□ Herpes □ Genital □ Anal □ Oral
□ Tuberculosis
□ Hepatitis □ A □ B □ C
□ Mononucleosis
□ Sinusitis
□ Ear infections
□ Endocardidits
□ Influenza
□ Last use of antibiotics ___________________

DERMATOLOGIC
□ Skin Cancer (Type/Location) ______________
□ Hives/Edema
□ Eczema
□ Psoriasis
□ Rash
□ Other_____________________________

RHEUMATOLOGIC
□ Osteoarthritis
□ Osteoporosis
□ Arthritis □ Rheumatoid □ Other _______
□ Gout
□ Lupus
□ Fibromyalgia
□ Broken bones______________________

PSYCHIATRIC
□ Depression
□ Anxiety
□ Schizophrenia
□ ADD/ADHD
□ Anorexia / Bulimia
□ Bipolar
□ Suicide attempt

NEUROLOGIC
□ Migraines
□ Multiple Sclerosis
□ CVA / Strokes / TIA
□ Seizures / Epilepsy
□ Dementia

SURGICAL HISTORY
□ Gallbladder □ heart valve □ Prostate
□ Appendix □ Pacer/AICD
□ Hernia □ Vascular________
□ Vasectomy □ CABG □ Cataract
□ Hysterectomy □ Sinus □ TURP
□ Hip replacement____ □ Vasectomy
□ Tubal Ligation □ Knee surgery______
□ Back______ □ Gastric bypass
□ Other ____________________
□ Other ____________________
□ Other ____________________

MEDICATION ALLERGIES (Describe Reaction)
____
____
____
____

MEDICATIONS
Name Dose Frequency
____
____
____
____
____
□ See list

SOCIAL HISTORY
□ Did you ever smoke? □ No □ Yes
How long? _____Years
□ Do you smoke now? □ No □ Yes
How much do you smoke per day? ___ Cigarettes
□ Do you use alcohol? □ No □ Yes
How much per week? ______ Drinks
□ Have you ever used recreational drugs – other than marijuana? □ No □ Yes
□ Do you have tattoos? □ No □ Yes
□ Have you ever been treated for addiction to alcohol or drugs? □ No □ Yes
□ Marital Status: □ Single □ Married □ Divorced
□ How many children do you have? ____
□ Travel history (countries)____________________
____
□ Pets/Animal exposures______________________

FAMILY - MEDICAL HISTORY
Do you have a family history of the following?
□ Cancer (Type) _______________
□ Infection (Type) _______________
□ Diabetes
□ Heart Trouble/Hear Attack
□ High Blood Pressure
□ Stroke
□ COPD/Asthma

FAMILY - CAUSE OF DEATH
Father ____________________________________
Mother ____________________________________
Siblings ___________________________________

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REVIEW OF SYSTEMS

Please check any condition that you have, or have had, in the past 6 months

GENERAL
☐ Loss of Appetite
☐ Fatigue
☐ Weight change _______
☐ Change in Mood
☐ Insomnia
☐ Night sweats
☐ Fevers

SKIN
☐ Rash
☐ New Lesions
☐ Dryness of Skin
☐ Easy Bruising
☐ Change in Hair / Skin
☐ Itching
☐ Wound (Location) ____________________________________

HEAD & NECK
☐ Change in Vision
☐ Ear Problems
☐ Nose / Gum Bleeds
☐ Frequent Colds / Sinusitis
☐ Loss of Taste
☐ Hoarseness / Laryngitis
☐ Recurrent Sore Throat
☐ Mouth Sores
☐ Enlarged Glands

LUNGS
☐ Shortness of Breath
☐ Chronic Cough
☐ Painful Breathing
☐ Coughing blood

HORMONAL
☐ Hot Flashes
☐ Flushing
☐ Heat / Cold Intolerance

GI
☐ Belching / Burping
☐ Heartburn/Indigestion
☐ Trouble Swallowing
☐ Food Intolerances
☐ Nausea / Vomiting
☐ Vomiting Blood
☐ Black-Colored Stool / Melena
☐ Jaundice/turning yellow
☐ Diarrhea / Constipation
☐ Abdominal Pain / Cramps
☐ Rectal Pain

GU
☐ Frequent Urination
☐ Painful Urination
☐ Urination at Night
☐ Blood in Urine
☐ Discharge

JOINTS / MUSCLES
☐ Backaches
☐ Joint Pain / Swelling

NEURO
☐ Weakness
☐ Altered Sensation
☐ Seizures
☐ Dizziness
☐ Depression
☐ Anxiety

HEART
☐ Angina
☐ chest pain ____________
☐ Palpitations/ Fluttering
☐ Leg Cramps on walking
☐ Swelling / Edema
☐ Vein Problems

Note: This is a confidential record of your medical history and will be kept in this office. Information contained in these documents will not be released to any person, except when you have authorized us to do so.

____

Patient Signature ____ Date ________ / ________ / ________

Reviewed By: ____ Date ________ / ________ / ________

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IMMUNIZATION RECORD

Record the vaccinations that have been administered to you. If you are unsure, please provide information about your Primary Care Provider (PCP) below, so we can request your vaccination records.

Vaccine	Type	Date Given (M/D/YY)	Administered By (Clinic/DR)	Next Dose Date
Hepatitis B (Hep B, Hib – Hep B, DTap-HepB-IPV)				
Diptheria, Tetanus, Pertussis (DTap, DTP, DT, Td, Tdap, DTaP-HepB-IPV, DTap-IPV/Hib, DTap-IPV, DTap-Hib)				
Haemophilus Influenzae Type B (Hib, Hib-Hep B, DTaP-IPV/Hib, DTap/Hib)				
Pneumococcal (PCV7, PCV13, PPSV23)				
Polio (IPV, OPV, DTaP-HepB-IPV, DTap-IPV/Hib, DTap-IPV)				
Rotavirus (RV1, RV5, RV Unknown)				
Measles, Mumps & Rubella (MMR, MMRV)				
Varicella (Chicken Pox) (VAR, MMRV)				

Vaccine	Type	Date Given (M/D/YY)	Administered By (Clinic/DR)	Next Dose Date
Hepatitis A (Hep A, Hep A-Hep B)				
Meningococcal (MCV4, MPSV4)				
Human Papillomavirus (HPV4, HPV2)				
Zoster (Shingles)				
Influenza (Yearly) (TIV, LAIV)				
Other				

Primary Care Provider ____ Ph. #. ______________________________________

Patient Name ____ Signature _________________________________

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