Michael C. Hsu, M.D. 201 Health Park Blvd, Suite 107 St Augustine, FL 32086 (904) 824-4277

New Patient Registration Information

Patient Signature

Patient Information												
Patient's Full Name											Hom	ne Phone
Address											Cell I	Phone
City						State					Zip C	Code
Social Security Number		Sex (Circl	le One) F)	Date of	Birth		A	ige			Race
Employer's Name and Address												
*Email Address								May	y we leav	e a mes	sage	
Work Phone No.	C	Occupation						Н	low Long	Emplo	yed?	
Marital Status (Circle One) Single Married Widow	wed Dive	orced	Spous	se's Naı	me				Work N	No.		
In Case of Emergency Notify				Relation	nship					ne No.)	
Referring Physician's?Person's Name	e?Address						List Date Seen			e No.)	
What are you seeing Dr. Michael Hsu	ı for?	THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TW										
Pharmacy Name	Pharm	acy phone #	#		Pharma	acy Loca	ition					
Insurance Company:_							Policy#:					
Name of Insured:							DOB of Ins	sure	ed:			
Insured's Employer:												
Polices: I understand that I at a Verification of bender All patient balances or Patient balances over Past due accounts we I give permission for I understand and accept	efits is not a s are due wi er 60 days v vill be sent t or Michael I	guarante thin 30 da will be cha to a collect Hsu to req	ee of pays of arges etion a	payment f patient collect agency record	nt, but nt respection fe y.	only an onsibilitie up to	n estimate. ity. 40%.					

Date

Michael C. Hsu, M.D.

201 Health Park Blvd. Suite #107 St Augustine, FL 32086

Phone: (904) 824-4277; Fax (904) 824-4490

MEDICAL HISTORY

Date of Birth: Today's Date: Medical and Family History Please check Self Relative Relationship	Name:			Referri	ng Phy	siciai	n:	•		
Medical and Family History Please check Self Relative Relationship Review of Systems Circle if applies Vision Changes Chest Pain Shortness of breath Constipation Diarthea Blood in Stools Sleep Apnea Mild Moderate Severe Blood in Urine Muscle Weakness Skin Rashes Seizures Skin Rashes Statistic easily Pevers Fatigue Arthritis Hepatitis High Cholesterol Liver Disease Arthritis Weight Gain Weight Gain Weight Cash Weight Gain Weight Loss Wear Byeglasses Wear Contacts Wear Contacts Wear Deatures F P T B Henria Inguinal Umbilical Ventral HIV / AIDS Irr heart beat For how long? Drug Allergies: YES or NO If yes, please list medications and reactions:	Date of Birth:	Referring Physician: Primary Care Physician:								
Review of Systems Circle if applies		Cardiologist:								
Circle if applies	Medical and Family History									
Self Relative Relationship Cost Pain Pa	Ple	ase check								
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HIV / AIDS Irr heart beat Past Surgeries/Year Performed: Current Medications: Drug Allergies: YES or NO If yes, please list medications and reactions:	Tumors			Wear Hearin	ng Aids	L	R	***********		
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YES or NO If yes, please list medications and reactions:			Down to A II	•					•	
If yes, please list medications and reactions:			Drug Alle	ergies:						
If yes, please list medications and reactions:	YES or	NO								
	If yes, please list me		ctions:							
				iture:						

MICHAEL C. HSU, M.D. MEDICAL HISTORY CONTINUED

Patient Name:							
Have you ever been diagnot If yes, explain (include yea	osed with any r it occurred	(<u>HEAR'</u> ()	T or KI	DNEY :	problems:	Yes	No
Have you ever had a blood	transfusion	? Yes	No		Voor		
Have you ever had a colon	oscopy?	Yes	No	Most	Year:		
Have you ever had an upp	er endoscopy	? Yes	No	Most	recent:		
Have you had an EKG in t If yes, where?	he past 6 mo	nths?	Yes	No		1.5	
Have you had a fall with in	jury, or 2 or	more fa	alls with	in the	past year?	Yes	No
Have you had the flu vacci	ne within the	e last 12	months	? Yes	No Where:	200	110
						38000 100000	
	S	oriol III	stower		Most Recent:		
	50	ocial H	istory:				
Occupation:							
	Yes No				Date of inj	ury:	
If yes, approximatel	ly number of	drinks	per wee	k?			
Do you drink:	beer wine	e liquo	r		e all that apply	y)	
Are you currently:	married	single	e	divor	ced widow	wed .	
Do you smoke cigarettes? If yes, how many pe How many years? If you have quit, wh	r day?						,
Do you chew tobacco?	Yes No						
If so, how many yea	rs?						
						*	
	И	omen (Only:				
	e incini		0.11071				
Are you pregnant? Date of last period?	Yes No						
Date of last PAP smear? Last Mammogram?		_					
Have you ever had a breast	lump?	– Vac	No	T of	Dial4 XX	0	
Have you been diagnosed w	ith Breast C	ancer?	Yes	No	Right Whe		
Have you had a Breast Biop	osy? Yes	No			Left/Right When?	м пеп :_	
				_	-		
Signature:							

Michael C. Hsu, M.D., LLC

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Michael C. Hsu, M.D., LLC to furnish all necessary information they may have regarding my condition under their observation or treatment, including the history obtained, x-ray, laboratory, and physical findings, diagnosis and prognosis to my insurance company and/or physicians.

ASSIGNMENT OF BENEFITS & PAYMENT RESPONSIBILITY

I hereby assign all medical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to Michael C. Hsu, M.D., LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Michael C Hsu M.D. Notice of Privacy Practices.

ELIGIBILITY WAIVER

I understand that my eligibility for coverage may not be able to be confirmed at this time. I wish to receive medical service form Michael C. Hsu M.D., LLC. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

RELEASE OF RECORDS

Please complete this section with the names of any person, other than yourself, that you would like to have access to your medical information. If there are no names listed we will only be able to speak with you regarding your healthcare. Please consider if you want family members or friends to have any access to your information.

I authorize the release of my medical information to the following people:

Name:	relationship
Name:	realtionship
I have read and agreed to all statements, terms and condition	ons above.
Signature of Patient or Legal Guardian	
Print NameDat	e

Michael C. Hsu, M.D. 201 Health Park Blvd. Suite 107 St. Augustine, FL 32086 (904) 824-4277 (904) 824-4490

Authorization for the Release of Medical Information

Date:	
Patient name:	
Date of Birth: SS#: Phone #:	
Patient Address:	
I authorize to release medical information from my medical records to:	
Name of Physician/Hospital or other entity:	
Address:	
Phone:Fax:	
SPECIFIC DOCUMENTS TO BE RELEASED:	
Specific dates of service or all:	_
Expiration date of this request:	
PURPOSE FOR INFORMATION:	
() Continued Medical Care () Insurance () Personal	
NOTE TO REQUESTING PARTY This request is authorized to include any federal and/or state protection under 394.459(9) Psychiatric Information, 397.050/396. 112 Drug and Alcohol Abus HIV and AIDS related conditions and /or 397.50(3) records of a minor client.	r Florida Statues e Information, 381.609
NOTE TO REQUESTING PARTY: Florida statue has established guidelines copying of some records. Your signature on this form indicates your knowled	ge of this statement.
I hereby release Michael C. Hsu, M.D. and his employees, agents, officer any and all liability, responsibility, claim, and damages which may result from information authorized by the consent for release of information.	s and affiliates from the release of
Signed:D (if not patient, state relationship	ate:
Form of ID verifiedD	ate:
Witness:D	ate:
WD. I	

"Release of medical information"

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:		DATE:		***************************************		
Over the last 2 weeks, how often have you been						
bothered by any of the following problems?						
(use "√" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day		
1. Little interest or pleasure in doing things	0	1	2	3 .		
2. Feeling down, depressed, or hopeless	0	1	2	3		
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3		
4. Feeling tired or having little energy	0	1	2	3		
5. Poor appetite or overeating	0	1	2	3		
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3		
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3		
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3		
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3		
	add columns		+	H		
(Healthcare professional: For interpretation of TOTA please refer to accompanying scoring cara).	AL, TOTAL:		4 7 2 2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4			
10. If you checked off any problems, how difficult		Not diffi	cult at all			
have these problems made it for you to do			Somewhat difficult			
your work, take care of things at home, or get		Very difficult				
along with other people?						
		Extreme	ely difficult			

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