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

New Patient Registration Information

Patient Information

Patient's Full Name				Home Phone
Address				Cell Phone
City		State		Zip Code
Social Security Number	Sex (Circle One) M F	Date of Birth	Age	Race
Employer's Name and Address				
***Email Address**				May we leave a message
Work Phone No. ( )	Occupation		How Long Employed?	
Marital Status (Circle One) Single Married Widowed Divorced	Spouse's Name		Work No. ( )	
In Case of Emergency Notify	Relationship		Phone No. ( )	

Referring Physician's?Person's Name?Address		List Date Seen	Phone No. ( )
What are you seeing Dr. Michael Hsu for?			
Pharmacy Name	**Pharmacy phone #**	**Pharmacy Location**	

Insurance Company:_____ Policy#:_____

Name of Insured:_____ DOB of Insured:_____

Insured's Employer:_____

Polices:

- I understand that I am responsible for any co-payment or deductible required by my insurance company.
- Verification of benefits is not a guarantee of payment, but only an estimate.
- All patient balances are due within 30 days of patient responsibility.
- Patient balances over 60 days will be charges collection fee up to 40%.
- Past due accounts will be sent to a collection agency.
- I give permission for Michael Hsu to request records and release records to any of my current treating physician's.

I understand and accept the above office policies:

_____ _____

Patient Signature Date

Michael C. Hsu, M.D.
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Phone: (904) 824-4277; Fax (904) 824-4490

MEDICAL HISTORY

Name: _____ **Referring Physician:** _____
Date of Birth: _____ **Primary Care Physician:** _____
Today's Date: _____ **Cardiologist:** _____

Medical and Family History

Please check

	Self	Relative	Relationship
Heart Attack (YR)			
COPD			
Emphysema			
Diabetes			
Anemia			
High BP			
Low BP			
Asthma			
Stroke			
Seizures			
Reflux/GERD			
Arthritis			
Hepatitis			
High Cholesterol			
Liver Disease			
Kidney Disease			
Thyroid Disease			
Migraines			
Cancer			
Tumors			
Radiation			
HIV / AIDS			
Irr heart beat	For how long?		

Review of Systems

Circle if applies

Vision Changes	
Chest Pain	
Shortness of breath	
Constipation	
Diarrhea	
Blood in Stools	
Sleep Apnea	**Mild Moderate Severe**
Blood in Urine	
Muscle Weakness	
Skin Rashes	
Fainting Spells	
Dizziness	
Bruise easily	
Fevers	
Fatigue	
Arthritis	
Weight Gain	
Weight Loss	
Wear Eyeglasses	
Wear Contacts	
Wear Hearing Aids	L R
Wear Dentures	F P T B
Hernia	Inguinal Umbilical Ventral

Past Surgeries/Year Performed:

_____ / _____ _____ / _____
_____ / _____ _____ / _____
_____ / _____ _____ / _____

Current Medications:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Drug Allergies:

YES **or** **NO**
If yes, please list medications and reactions: _____

Patient signature: _____

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

Patient Name: _____

Have you ever been diagnosed with any ***HEART or KIDNEY*** problems: Yes No
If yes, explain (include year it occurred) _____

Have you ever had a blood transfusion? Yes No Year: _____
Have you ever had a colonoscopy? Yes No Most recent: _____
Have you ever had an upper endoscopy? Yes No Most recent: _____
Have you had an EKG in the past 6 months? Yes No
If yes, where? _____
Have you had a fall with injury, or 2 or more falls within the past year? Yes No
Have you had the flu vaccine within the last 12 months? Yes No Where: _____

Most Recent: _____

Social History:

Occupation: _____

Is the reason you are here work-related? Yes No Date of injury: _____
Do you drink alcohol? Yes No
If yes, approximately number of drinks per week? _____
Do you drink: beer wine liquor (circle all that apply)

Are you currently: married single divorced widowed

Do you smoke cigarettes? Yes No
If yes, how many per day? _____
How many years? _____
If you have quit, when? _____
Do you chew tobacco? Yes No
If so, how many years? _____

Women Only:

Are you pregnant? Yes No
Date of last period? _____
Date of last PAP smear? _____
Last Mammogram? _____
Have you ever had a breast lump? Yes No Left Right When? _____
Have you been diagnosed with Breast Cancer? Yes No Left/Right When? _____
Have you had a Breast Biopsy? Yes No Left/Right When? _____

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 conditions above.

Signature of Patient or Legal Guardian_____

Print Name_____ Date_____

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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 Florida Statues 394.459(9) Psychiatric Information, 397.050/396. 112 Drug and Alcohol Abuse Information, 381.609 HIV and AIDS related conditions and /or 397.50(3) records of a minor client.

NOTE TO REQUESTING PARTY: Florida statue has established guidelines and cost rates for the copying of some records. Your signature on this form indicates your knowledge of this statement.

I hereby release Michael C. Hsu, M.D. and his employees, agents, officers and affiliates from any and all liability, responsibility, claim, and damages which may result from the release of information authorized by the consent for release of information.

Signed: _____ Date: _____
(if not patient, state relationship

Form of ID verified _____ Date: _____

Witness: _____ Date: _____

"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
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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