Story Family Medicine

...your health is *Our Story*

NEW PATIENT APPOINTMENTS

About Our Doctor and his Practice:

As a Medical Practice, we strive to bring back the personal experience of having an *Old-Fashioned* Family Physician. Dr. Story takes his own office phone calls directly, after hours and on the weekends in case of an emergency. Our office keeps appointments available for urgent visits & same day appointments

A few reminders regarding your upcoming New Patient Appointment:

- Please arrive 10-15 minutes before your appointment time for paperwork. If your paperwork cannot be completed by your appointment time, your appointment will have to be re-scheduled. If you need to cancel or reschedule your appointment, please do so within 24 hours,if possible.
- Complete all sections of Paperwork
- Please provide us with a current Government-Issued Photo ID and Health Insurance Card. This is required and must be present.

Thank you for your interest in Story Family Medicine

Our Practice Location: 17912 Toledo Blade Blvd Suite A Port Charlotte FL 33948 Main Telephone: 941-875-9059 Facsimile: 941-206-2066

STORY FAMILY MEDICINE
NEW PATIENT REGISTRATION FORM

Today's Date: _____

Name: _____ Date of Birth: __/__/____ Height: ____
Last First M
Status: ☐ Married ☐ Single ☐ Widowed ☐ Child ☐ Other **Gender** ☐ Female ☐ Male ☐ Other: _____
Social Security# _____ **Religion:** _____ **Ethnicity:** _____
Phone (Home) _____ **Cell:** _____ **Email Address**: _____
Address: _____ Is this a seasonal residence? ☐ yes ☐ no
City, State and Zip Code Are you a Full-Time Resident of Florida? ☐ yes ☐ no
Occupation Status: ☐ Working ☐ Retired ☐ Unemployed ☐ On Medical Leave ☐ Disabled ☐ Other ☐ Declined to Specify

In Case of an Emergency

Name: _____ **Relation** ☐ Spouse Mother ☐ Father ☐ Grandparent ☐ Friend ☐ Other: _____
Phone: _____ Is it okay to contact this person in case of an emergency? ☐ Yes ☐ No

Advanced Care Directives, Medical Wishes or Other Preferences

*Do you have a living will? ☐ Yes ☐ No ☐ n/a
*Are you an organ donor? ☐ Yes ☐ No ☐ n/a
*Do you have a DNR? ☐ Yes ☐ No ☐ n/a
*Do you have a Power of Attorney? ☐ Yes ☐ No

If you have a Power of Attorney or a Health Care Surrogate, please list them below.
Name: _____ Relationship _____ Phone Number _____
Are we able to disclose Medical Information with them? ☐ YES ☐ No

Health Insurance Information

Do you have Health Insurance? ☐ Yes ☐ No (Relationship to Insured) ☐ Self ☐ Dependant
Primary Insurance _____ Policy# _____
Plan Type ☐ HMO ☐ PPO ☐ Medicare ☐ Federal ☐ Veteran ☐ Disability ☐ Other _____
Secondary Plan: _____ Policy# _____ Is this a Medicare Plan? ☐ Yes ☐ No
Do you have Medicaid? ☐ Yes ☐ No (Please Advise: We are Out-of Network with Medicaid)

Health and Social History

Have you ever smoked/used tobacco products? ☐ Yes ☐ No (If Former smoker, when did you Quit?) _____
Do you currently smoke? ☐ Yes ☐ No (If you currently smoke, how many a day or week?) _____
Do you drink alcohol? ☐ Yes ☐ No (If yes, how often): _____ Currently use recreational drugs? ☐ Yes ☐ No
Do exercise regularly? ☐ Yes ☐ No (If yes, how often): _____ What type of exercise? _____
Nutritional Diets: ☐ Diabetic Diet ☐ Low Sodium ☐ Low Fat ☐ Low Cholesterol ☐ Other: _____
Do you have drug, environment or food allergies? ☐ Yes ☐ No (If yes, please list type and reactions)
_____

Major Medical Events and History

Complications to Medical Treatments ☐ Yes ☐ No _____
Hospital Admissions or Emergency Care? ☐ Yes ☐ No _____

PAST SURGERIES/OPERATIONS

Type of Operation	Date
_____	_____
_____	_____
_____	_____
_____	_____

OTHER PROVIDERS/ SPECIALISTS

Provider Name	Specialty Type
_____	
_____	
_____	

☐ No Other Providers

LIST OF PREFERENCES

Hospital _____
Pharmacy _____
Laboratory _____
Imaging _____

Do you have any health concerns that need further clarification? ☐ Yes ☐ No (If yes, please explain)
_____
How did you hear about Dr. Story? _____

Current Medical Conditions

Patient Name: _____

- ☐ Anemia
- ☐ Anxiety
- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Asthma
- ☐ Blood Clots
- ☐ Blood Abnormality
- ☐ Blood Deficiency
- ☐ Cancer: _____
- ☐ Chronic Back Pain
- ☐ Congestive Heart Failure
- ☐ Colitis/IBS
- ☐ COPD
- ☐ CoronaryAtherosclerosis
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Erectile Dysfunction
- ☐ Headaches
- ☐ Hypertension
- ☐ Hypothyroid
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Arrhythmia
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ GERD
- ☐ GOUT
- ☐ Glaucoma
- ☐ Gallbladder Disease
- ☐ Hepatitis
- ☐ Lung Disease
- ☐ Muscle Weakness
- ☐ Respiratory Problems
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Ulcers
- ☐ Implantable Device
- ☐ Pacemaker Status
- ☐ ID# _____
- ☐ Unsteady Balance
- ☐ Urinary Incontinence
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____

☐ **NO MEDICAL HISTORY**

FAMILY HISTORY

	Mother	Father	Sibling	Other	
Heart Condition	☐	☐	☐	☐	_____ (Please specify) _____
Heart Attack/Stroke	☐	☐	☐	☐	_____
Alcoholism	☐	☐	☐	☐	_____
Breast Cancer	☐	☐	☐	☐	_____
Colon Cancer	☐	☐	☐	☐	_____
Other Cancer	☐	☐	☐	☐	_____ (Please specify type of Cancer) _____
Depression	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	_____
Lung Conditions	☐	☐	☐	☐	_____
Thyroid Issues	☐	☐	☐	☐	_____

☐ **No Family History**

☐ **Unknown Family History**

LIST OF MEDICATIONS

☐ **NO CURRENT MEDICATIONS**

_____	mg	x daily	_____	mg	x daily
_____	mg	x daily	_____	mg	x daily
_____	mg	x daily	_____	mg	x daily
_____	mg	x daily	_____	mg	x daily

PROCEDURES & TESTING

☐ **NO TESTING COMPLETED**

DIAGNOSTIC TESTS:

- Colonoscopy: _____
- Bone Density: _____
- Mammogram: _____
- Chest Xray: _____
- EKG: _____
- Echo: _____
- Stress Test: _____
- Other: _____

IMMUNIZATIONS:

- Flu Vaccine: _____
- Co-vid 19: _____
- Pneumonia 23: _____
- Prevnar 13 : _____
- TDap/Tetanus: _____
- Shingles Vaccine: _____
- MMR: _____
- Other: _____

EXAMS:

- Last Labs: _____
- Health Physical: _____
- Breast Exam: _____
- Prostate Exam: _____
- Pap Smear: _____
- Eye Exam: _____
- Foot Exam: _____
- Other: _____

REVIEW OF NEW OR EXISTING SYMPTOMS

☐ **NO CURRENT COMPLAINTS**

Eyes:
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Worsening Sight

Ears & Hearing:
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Wax Buildup

Head & Neck:
- ☐ Headaches
- ☐ Dizziness
- ☐ Lightheaded
- ☐ Memory Loss

GI:
- ☐ Difficulty Swallowing
- ☐ Nausea/ Vomiting
- ☐ Stomach Pain
- ☐ Loss of Appetite
- ☐ Diarrhea
- ☐ Constipation

Urinary:
- ☐ Burning
- ☐ Frequent Urination
- ☐ Difficulty Urinating
- ☐ Incontinence
- ☐ Hesitancy

Oral:
- ☐ Dry Mouth
- ☐ Loss of Taste

Nose & Throat:
- ☐ Sneezing
- ☐ Nose Bleeds
- ☐ Runny Nose
- ☐ Sinus Issues
- ☐ Sore Throat

Respiratory:
- ☐ Asthma
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiac:
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Palpitations
- ☐ Irregular Heartbeat

Muscle/Bones/Joints:
- ☐ Back Pain
- ☐ Sore/Achy Muscles
- ☐ Swollen Joints
- ☐ Painful Joints
- ☐ Foot Pain
- ☐ GOUT
- ☐ Leg Pain

Neurological:
- ☐ Confusion
- ☐ Dizziness
- ☐ Seizures
- ☐ Numbness
- ☐ Tingling
- ☐ Tremors/Shaking
- ☐ Poor Balance
- ☐ Poor Coordination

Skin:
- ☐ Rash/Hives
- ☐ Itching
- ☐ Bruising
- ☐ Abnormal Growth

General Mood:
- ☐ Anxiety
- ☐ Depression
- ☐ Stressors
- ☐ Mood Changes

CANCELLATION AND NO-SHOW POLICY

Office Visits are reserved by appointment only. We understand that situations may arise that cause schedule conflicts or delays. If you cannot keep your appointment, please notify us within 24 hours or a charge of $30.00 may result and billed to your account.

I acknowledge and understand the Story Family Medicine (Cancellation and No-Show Policy). PATIENT INITIALS:

HIPAA-CONSENT TO TREAT AND DISCLOSURE OF HEALTH INFORMATION

TO PROVIDE TREATMENT: We will use your HPI within the office to provide you medical care. This may include administrative, clinical and office procedures designed to optimize scheduling/coordination of care between the physician and/or other clinical, lab, imaging centers, pharmacies and/or other health care providers involved with your care.

TO OBTAIN PAYMENT: We will use your HPI with an invoice, used to collect payment for the treatment you receive here. HPI will be used on your insurance forms sent by mail or electronically.

IN PATIENT NOTIFICATIONS: Phone calls to remind you of an upcoming appointment or other situations may be necessary. We also may use other electronic methods to contact you such as email, text message, phone, online medical record accounts, postcards, letters, statements, etc. These methods of communications help optimize our office workflow.

ABUSE OF NEGLECT: We may notify government or other agencies if we believe a patient is a victim of abuse, neglect, or domestic violence. We will make their disclosure only when we are compelled by our ethic judgement, specially required, authorized by law or with patient's agreement and request.

PUBLIC HEALTH/NATIONAL SECURITY: We may be required to disclose to federal/ military officials or other authorities, if HPI is necessary to complete an investigation related to public health or national security. HPI is important to the government if they believe that public safety could benefit from, control or prevent an epidemic.

FOR LAW ENFORCEMENT: As permitted/required by State/Federal Law, disclosure of HPI may be necessary under certain circumstances, if warranted. Whether being a victim of a crime or reporting a crime. We will revoke access, at any time to also protect the patient, unless there is a warrant in place or consent given from the patient directly.

TELEMEDICINE SERVICES: This may be offered as an alternative service which involve the use of audio, live video (like Skype, Zoom, Etc, for the purpose of providing medical care. A potential risk of telemedicine is that your specific concerns may still necessitate a face-to-face session as part of your medical treatment. Virtual communications involving medical documentation will be necessary to provide proper documentation.

I understand the (HIPPA Consent to Treat/Disclosure of Health Information) PATIENT INITIALS: _____

MEDICAL HEALTH BENEFITS AND PATIENT RESPONSIBLY/ FINANCIAL POLICY

IF YOU HAVE HEALTH INSURANCE- As a condition of receiving medical services, a financial arrangement must be made. If you have Health Insurance, you are responsible with becoming familiar of the coverage and benefits your insurance plan offers. These benefits are an agreement *between (you and your insurance company)*. To file claims properly, you must present us a with the most current insurance cards. Services rendered, will be charged directly to your account for any balance owed/ pending the response with the insurance regarding reimbursement/benefit. Any balances transferred to the patient's responsibility must be paid within a timely manner. There is a $25.00 fee for returned checks. Any fees due at the time of service include: Co-pays, deductibles, non-covered services.

IF YOU DO NOT HAVE HEALTH INSURANCE- For self-pay patients, we offer discounted rates, though require payment in full at the time of your office visit. *We accept Cash, Visa, Mastercard, American Express, Discover and Care Credit.*

I understand the (Medical Health Benefit/Patient Responsibility/ Financial Policy). PATIENT INITIALS: _____

CREDIT CARD AUTHORIZATION FORM (OPTIONAL)

As the account holder of the credit card provided at the time of service, I hereby authorize Story Family Medicine to process the transaction as a form of payment towards my account. Story Family Medicine will not except any form of payments or transactions that are not directly made by the "patient.

I acknowledge and authorize Story Family Medicine to process & authorize my credit card. The patient may also revoke this form by submitting a written request to the medical practice at any time.

Patient Name: _____ Signature: _____ Today's Date: _____

NARCOTIC PRESCRIBING AND MEDICATION ADHERENCE POLICY

Scheduling an appointment, does not guarantee that you will be prescribed narcotics or other medications. Some medications may provide therapeutic relief, though have more risks than benefits. The patient must disclose all medications that they are using as well as any illicit drugs. If deemed medically necessary, blood work and/or a urine drug test might be required before prescribing medication. Medical Records from the former prescriber will be required.

To the best of my knowledge, the answers and information provided are true and correct. I acknowledge and understand the (Narcotic Prescribing/Medication Adherence Policy), I agree to the terms stated above. PATIENT INITIALS: _____

MEDICAL RECORD RELEASE

URGENT REQUEST ☐ YES ☐ NO

Date Needed by: _____

Fax Records to: 941.206.2066

1) PATIENT INFORMATION:

Name _____ Address _____ City _____ State _____ Zipcode _____

_____/_____/_____ Date of Birth _____ Daytime Phone _____ Previous Names _____

2) AUTHORIZES

Name of Healthcare Provider/Agency or Facility _____ tele# _____

Address _____ fax # _____

3) TO DISCLOSE TO:

Dr. Curtis Story MD of Story Family Medicine — Name of Healthcare Provider

941.875.9059 — tele

17912 Toledo Blade Blvd Suite A Port Charlotte, FL33948 — Address

941.206.2066 — fax

DELIVERY OPTIONS: ☐ Self Pick up ☐ Fax ☐ Mail to: _____

To be picked up by, I hereby authorize: _____ above) _____ (Photo ID required)

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ (month/year) to _____ (month/year)

(If left blank, information from the past (2) years will be disclosed)

5) INFORMATION TO BE DISCLOSED:

☐ All medical records related to (specify condition, treatment, etc.): _____

☐ All billing records related to (specify condition, treatment, etc.): _____

☐ Radiology films/images (specify test): _____

☐ Specific records/information as follows: _____

_____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):

☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health / Developmental Disabilities

6) EXPIRATION: This Authorization is good until the following date/event: _____

7) PURPOSE (Check all that apply - (Copy fees may apply) ☐ Further Medical Care ☐ Legal Investigation /Action ☐ Insurance Eligibility/Benefits ☐ Personal (at my request) ☐ Other: _____

8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law. If you have issues receiving your records or information or need assistance in filing a civil rights or health information privacy complaint, please email OCR at OCRMail@hhs.gov or call 1-800-368-1019 for more information.

9) SIGNATURE OF PATIENT / LEGAL REP: _____ **DATE:** _____

If signed by a person other than the patient, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent* ☐ legal guardian ☐ next of kin / executor of deceased ☐ activated POA for Health Care

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For Office Use Only: ☐ Yes ☐ No Completed by: _____ Date Released: __/__/_____

Signature/ID verified *Name /Title*

___#of ☐ Pages

___#of ☐ CD(s)

SEND COORESPONDENSE TO:

17912 Toledo Blade Blvd Suite A Port Charlotte, Florida 33948

telephone: 941.875.9059 facsimile 941.206.2066

visit our website at https://www.storyfamilymedicine.com/