



...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. Dr. Story is credentialed at Fawcett Memorial Hospital and handles his own hospital admissions.

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	OTHER PROVIDERS/ SPECIALISTS		LIST OF PREFERENCES
Type of Operation	Date	Provider Name	Specialty Type
_____	_____	_____	Hospital _____
_____	_____	_____	Pharmacy _____
_____	_____	_____	Laboratory _____
_____	_____	<input type="checkbox"/> No Other Providers	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: _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Coronary Atherosclerosis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> GERD |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> GOUT |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Blood Abnormality | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Blood Deficiency | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Colitis/IBS | <input type="checkbox"/> Heart Arrhythmia | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Ulcers |
| | | <input type="checkbox"/> Implantable Device |
| | | <input type="checkbox"/> Pacemaker Status |
| | | <input type="checkbox"/> ID# _____ |
| | | <input type="checkbox"/> Unsteady Balance |
| | | <input type="checkbox"/> Urinary Incontinence |
| | | <input type="checkbox"/> Seizures |
| | | <input type="checkbox"/> Stroke |
| | | <input type="checkbox"/> Other: _____ |
| | | <input type="checkbox"/> NO MEDICAL HISTORY |

FAMILY HISTORY

- | | Mother | Father | Sibling | Other |
|---------------------|--------------------------|--------------------------|--------------------------|--|
| Heart Condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack/Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ (Please specify) _____ |
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Colon Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ (Please specify type of Cancer) _____ |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung Conditions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Issues | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

IMMUNIZATIONS:

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

MMR: _____ EXAMS:

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

REVIEW OF NEW OR EXISTING SYMPTOMS

NO CURRENT COMPLAINTS

- | | | | |
|--|--|--|--|
| Eyes: | GI: | Nose & Throat: | Muscle/Bones/Joints: |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Nausea/ Vomiting | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Sore/Achy Muscles |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Stomach Pain | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Worsening Sight | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Sinus Issues | <input type="checkbox"/> Painful Joints |
| | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Foot Pain |
| | <input type="checkbox"/> Constipation | | <input type="checkbox"/> GOUT |
| Ears & Hearing: | Urinary: | Respiratory: | <input type="checkbox"/> Leg Pain |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Burning | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Cough | Neurological: |
| <input type="checkbox"/> Wax Buildup | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Confusion |
| | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Dizziness |
| Head & Neck: | <input type="checkbox"/> Hesitancy | Cardiac: | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Headaches | | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Dizziness | Oral: | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Lightheaded | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Tremors/Shaking |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Poor Balance |
| | | | <input type="checkbox"/> Poor Coordination |
| | | | Skin: |
| | | | <input type="checkbox"/> Rash/Hives |
| | | | <input type="checkbox"/> Itching |
| | | | <input type="checkbox"/> Bruising |
| | | | <input type="checkbox"/> Abnormal Growth |
| | | | General Mood: |
| | | | <input type="checkbox"/> Anxiety |
| | | | <input type="checkbox"/> Depression |
| | | | <input type="checkbox"/> Stressors |
| | | | <input type="checkbox"/> 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 (HIPAA 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: _____

CARD ON FILE: 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 in person with the card holder who must be present.

I acknowledge and authorize Story Family Medicine to process the credit card as "Card on File". The patient may also revoke this form by submitting a written request to the medical practice.

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	941.875.9059
Name of Healthcare Provider	tele
17912 Toledo Blade Blvd Suite A Port Charlotte, FL 33948	941.206.2066
Address	fax

DELIVERY OPTIONS: Self Pick up Fax Mail to: _____
 To be picked up by, I hereby authorize: _____ (Photo ID required)

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ to _____
 (If left blank, information from the past (2) years will be disclosed) (month/year) (month/year)

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

For Office Use Only: Yes No Completed by: _____ Date Released: ___/___/___
 Signature/ID verified _____ Name/Title _____
 _____ # of Pages
 _____ # of CD(s)

SEND CORESPONDENCE 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/>