SOUTH BEACH MEDICAL ASSOCIATES

NEW PATIENT REGISTRATION

Date of Visit: _____/_____/_____ **Office Use Only** Account#:_____
Last Name: _____ **Middle Initial**_____ **First Name** _____
Social Security #:_____-____-_____ **Birth Date:** ____/____/____ **Age:** ___**Gender:**☐Male ☐Female
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Life Partner
Race: □ Caucasian □ African American □American Indian or Alaskan □Asian □ Other
Ethnicity: □ Hispanice □ Not Hispanice or Latino □ Other
Employer/School: _____**Occupation:** _____ Year Retired: _____
Do you have Insurance: Yes/ No **Name of insurance**_____

Is your visit today work related: Please Circle (Yes/No)
Is your visit today for routine physicals: Please Circle (Yes/No)
Reason for Visit (Main Compaint):_____
Who referred you to our practice? _____

CONTACT INFORMATION

Mailing Address: _____**CITY:**_____ **State:** ___**Zip Code:** _____

Primary Contact phone: _____ Secondary Contact Phone: _____

E-Mail:_____
Preferred Method of Contact: ☐ E-Mail ☐ Mail ☐ Mobile ☐ Phone
May we send you emails? (i.e., appointment reminders, service offerings) Yes__ NO__
May we send you texts reminders? Yes___ NO__
May we leave voicemails at the above phone numbers? Yes___NO___

EMERGENCY CONTACT INFORMATION

Name _____Relationship: _____
Phone#:_____
Address:_____
Name:_____Relationship:_____
Phone#:_____

DO YOU HAVE AN ADVANCE DIRECTIVE? ____YES ____NO

DO YOU HAVE POA? If yes, who is? NAME _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Patient Name: _____Todays' Date:_____
Policyholder name: _____Policyholder DOB: _____/_____/_____
Relationship to patient: ☐ Self ☐ Spouse ☐Child ☐ Other
Insurance Company:_____Policy #: _____
Group#:_____ Insurance Phone#:_____

Claims Address:_____

SECONDARY INSURANCE INFORMATION

Insurance Company:_____Policy #: _____
Group#:_____Insurance Phone#:_____

Claims Address:_____

Un-Insured/SELF-PAY. Please circle Yes/No

I authorize the release of my medical information necessary for treatment or to process claims. I also authorize for the release of my medical records to any physician, hospital or ancillary care center participating in my care and treatment. Only medically necessary information will be released when requested. I understand that this information will be faxed or mailed to the party requesting the information.
I hereby assign all medical benefits to include major medical benefits to which I am entitled to _____.

This assignment will remain effect until revoked by me in writing. I further agree to be solely responsible for any balances that my insurance does not pay. I understand that I am responsible for any collection and/or legal fees incurred as a result of non-payment on my account.

If we **do** participate with your insurance plan, we will ask you to pay any co-payment, deductible or co-Insurance amount at the time of service and we will submit a claim to your insurance company.

If we **do not** participate with your insurance plan, we will ask you to pay in full at the time of service and as courtesy submit a claim to your insurance company.

If you **do not present any insurance cards we will presume you do not have any insurance coverage and payment in full will be due at the time of service.**

A PHOTOCOPY OF THESE AUTHORIZATIONS ARE TO BE CONSIDERED LEGALLY VALID AS ARE THE ORIGINALS.

By my signature below, I affirm the above information.

Patient's Signature: _____ **Date:** _____

HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Patient's Full Name: _____ Account#_____

DOB: _____ Height: _____ Weight:_____

Chief Complaint:_____

When Symptoms Started:_____

PAST MEDICAL HISTORY (please check) ☐ **NONE**

☐Acid Reflux-GERD	☐Dementia	☐Neck pain/disorder
☐Addiction	☐Depression MDD or dysthymia	☐Neuropathy
☐Alzheimer's Disease	☐Diabetes DM-I/ DM-II	☐Obesity/over weight
☐Acne	☐Dialysis	☐OCD
☐Amputation	☐Diverticulosis or diverticulitis	☐Osteoarthritis
☐Angina	☐Dizziness	☐Pacemaker
☐Anxiety/Panic attack/PTSD	☐Down Syndrome	☐Pancreatitis
☐Arrhythmia-palpitations	☐Edema	☐Paralysis
☐Atrial Fibrillation-Flutter	☐Encephalitis	☐Parkinson's
☐Attention Deficit Disorder-ADHD	☐Endometriosis-Fibroids	☐Peripheral Vascular Disease (PVD)
☐Asthma or/and Allergy	☐Erectile dysfunction-impotence	☐PDD (Autism-Rett)
☐Back/degenerative disease	☐Esophagus or dysphagia	☐Phlebitis
☐Bipolar Disorder	☐Gout	☐Pneumonia
☐Bleeding Disorders	☐Glaucoma	☐Pressure Ulcer
☐Blood Clot	☐Headaches-Migraines or cluster	☐Prior Anesthesia Complications
☐Blood Transfusion or post Reaction	☐Heart Disease	☐Prostatic enlargement BPH
☐Bulimia nervosa	☐Hematuria	☐Rectal Bleeding
☐Bowel disease-IBS	☐Hepatitis	☐Rheumatoid Arthritis
☐Bursitis	☐Hernia	☐Seizure -epilepsy
☐Cancer Type:_____ Current Treatment: _____ Past Treatment: _____	☐High Blood Pressure-HTN or low BP	☐Shortness of Breath
☐Cataract	☐History of VRE	☐Sleep Apnea
☐Cerebral Palsy	☐HIV/AIDS	☐Stroke/TIA
☐Chest Pain-CAD	☐IBS	☐STD
☐Cholesterol/Lipid	☐Incontinence	☐Stroke or CVA
☐Chronic Obstructive Pulmonary Disease (COPD)	☐Kidney Disease	☐Sickle Cell Disease
☐Congenial Anomaly	☐Kidney Infections	☐Thyroid Disease
☐Congestive Heart Failure-CHF	☐Kidney Stones	☐Tuberculosis
☐Constipation	☐Liver Disease	☐Ulcers
☐Coronary Artery Bypass Graft (CABG)	☐Lupus	☐Urinary Frequency
☐Coronary Artery Disease (CAD)	☐Lyme Disease	☐Urinary Tract Infection (UTI)
☐Cohn's Disease/Ulcerative Colitis	☐Lymphedema	☐Urinary Retention
☐Defibrillator	☐Mental Illness-personality disorder	☐Valve Replacement
	☐Memory impairment	☐Vertigo/syncope
	☐MRSA	☐Weakness
	☐Myocardial Infarction (MI)	

Others medical history: (Not listed above):

MEDICATIONS

Please List ALL prescribed and non-prescribed Medications, OTC, vitamins, minerals, probiotics, etc

No	Name of medication	Dose	How many? How many times per day?
	Example: Tylenol	500mg	1 pill 3X per day
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

If more please use space below

_____

_____

_____

_____

Preferred Pharmacy name and address: _____

Phone Number: _____

PLEASE LIST ALLERGIES TO MEDICATION ☐ **NONE**

MEDICATION_____ REACTION:_____ MEDICATION_____ REACTION_____

MEDICATION_____ REACTION:_____ MEDICATION _____REACTION_____

SURGICAL HISTORY

_____

_____

FAMILY HISTORY

_____

_____

SOCIAL HISTORY
Tobacco smoking status
□ Current smoker □ Former smoker □ Never smoked
☐Light-1-9cigs/day ☐Moderate-10-19-cigs/day ☐Heavy-20-39cigs/day ☐VeryHeavy-40+cigs/day Do you use: ☐Cigarettes ☐Chewing Tobacco
Alcohol □ None □ Occasional □ Moderate □ Heavy □ Past Abuse
Drug Use □ None □ Yes List _____
Exercise □ None □ Yes How often_____
Caffeine □ None □ Yes How many drinks per day_____

PREVENTIVE and SCREENINGS
When were you last vaccinated for:
Tetanus _____ Influenza (flu) _____
Pneumonia _____ Shingles_____
Colonoscopy:_____ For smokers, have you ever had chest CT scan. Please circle: Y/N Any bloody cough? Y/N Abdominal Aortic Aneurysm Screening? Please circle Y/N

For Female Patients:

Currently pregnant or planning to be pregnant? Y/N Date of last menstrual period: ___/___/____

List Number: Pregnancies: ____ Live birth: _____ Miscarriage: ____

Last PAP (Pap Smear) _____ Mammogram _____ DEXA Scan: _____

What are you currently using for Birth Control? _____

I confirm that the information provided is true and will be used as part of my treatment plan

Patient Name: _____Patient Signature_____

Todays' Date: _____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
PERMISSION TO SHARE HEALTH INFORMATION

Patient Name: _____ DOB _____

Notice of Privacy Practices

I acknowledge that I have received a copy of South Beach Medical Associates "Notice of Privacy Practices" and it has been clearly available at the front desk and online for review, and is available to me if I request a copy in the future.

Medical Information Release Form (HIPAA Release Form) Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information to my insurance as listed previously.

This information may be also released to:

[ ] Spouse_____ Phone: _____

[ ] Child (ren)_____ Phone:_____

[ ] Other_____Phone:_____

[ ] Information is not to be released to anyone.

[ ] *I UNDERSTAND THAT THIS RELEASE WILL REMAIN IN EFFECT UNTIL OTHERWISE STATED BY ME IN WRITING.*

By my signature below, I affirm the above information.

Signature: _____ Date: _____

Assignment of Benefits Form

Financial Responsibility:

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to South Beach Medical Associates for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by Insurance.

Authorization to Release Information:

I hereby authorize South Beach Medical associates to:

1. Release any information necessary to insurance carriers regarding my illness and treatments.
2. Process insurance claims generated in the course of examination and treatment.
3. Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing. I have requested medical services from South Beach Medical Associates on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable at the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature_____ Date _____

Consent for Evaluation and Treatment Consent

CONSENT FOR PURPOSES OF TREATMENT, AND HEALTHCARE OPERATIONS

TO THE PATIENT:

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient/Guardian: _____Date: _____

Printed Name of Witness: _____Employee Job Title: _____
Signature of Witness: _____ Date: _____

Patient Policy Acknowledgment & Financial Responsibility

To establish care with South Beach Medical (SBM), I acknowledge and agree to the following: I acknowledge that I have **received, reviewed, or had the opportunity to review** the policies of SBM, including but not limited to:

- Financial Policy
- Cancellation / No-Show Policy
- Patient Conduct / Dismissal Policy
- Forms & Administrative Charges Policy
- Medication Refill Policy (pharmacy requests only; allow 48–72 business hours)
- Office Visit Requirements / Laboratory & Results Communication Policy
- Controlled Substance Agreement (if applicable) and Unvaccinated children Policy (if applicable)

I understand that these policies are **provided in the office for patient review (including laminated or in-office materials)** and are also available on the practice website and it is my responsibility to review them.

Financial Responsibility

I understand and agree that:

- I am **personally and fully responsible** for payment of all services rendered, regardless of insurance coverage.
- Any charges **not covered, denied, or partially paid by my insurance** are my responsibility.
- **Co-payments, deductibles, coinsurance, self-pay fees, no-show fees, and late cancellation fees are my responsibility and are due at check in or otherwise applicable under office policy.**
- If my insurance info is incorrect, inactive, or not provided, I accept **full financial responsibility** for all charges.
- Balances not paid within **30 days** of the statement date are considered past due and **a $25 late fee** will be applied after 30 days, along with a finance charge of **1.5% per month (18% annually)** on outstanding balances as permitted by law.
- Unpaid balances will be referred to a collection agency, and I agree to be responsible for applicable collection costs and related expenses. Failure to make payment will result in additional fees, and/or dismissal from the practice.

Initials: _____

Appointment & Administrative Policies

I understand and agree that:

- Failure to provide appropriate notice for cancellations will result in **no-show and or late cancellation fees of $100**.
- Administrative requests (forms, letters, records, etc.) have **additional charges**, as outlined in the Forms Charge Policy.

Initials: _____

Clinical & Communication Policies

I understand and agree that:

• **Medication refills** require appropriate follow-up and adherence to office visit frequency determined by the physician

• Controlled substances require regular in-person evaluation and cannot be managed without appropriate follow-up

• If I receive medications or care from another physician (including online or telemedicine providers), I authorize coordination of care and understand that communication with that provider may be required

• Laboratory results, imaging, and diagnostic studies may require **an office visit follow up** for review and management

• Medical advice, new diagnoses, or treatment changes are not provided by phone, email, or message without appropriate evaluation, except in urgent situations at the physician's discretion **Initials: _____**

Acknowledgment & Agreement

By signing below, I confirm that:

- I have **read, understand, and agree** to the above terms
- I have been given the opportunity to ask questions
- I understand that it is my responsibility to review these policies prior to signing
- I agree to comply with all policies as a condition of receiving care

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian Name (if applicable): _____

Parent/Legal Guardian Signature: _____ Date: _____