NFMC
North Florida Medical Centers, Inc.

Patient Registration Information

Patient Last Name:_____ Patient First Name:_____ MI:_____

Previous Name: (*if applicable*)_____

Mailing Address: _____City:_____ State:_____ Zip:_____

Home Phone:_____ Cell No:_____ Work Phone:_____ Ext:_____

Email:_____ Date of Birth:_____

Sex: __ Male __ Female __ Unknown __ Transgender Social Security Number: _____

Responsible Party (Guarantor) Name: _____ Relation: _____
Last Name *First Name*

Emergency contact: _____ Relation: _____
Last Name *First Name*

Address: _____ Phone: _____

Marital Status: __ Divorced __ Married __ Partner __ Single __ Unknown __ Widowed __ Legally Separated

Primary Language:_____ Is a Translator Needed: __ Yes __ No

Race: __ American Indian or Alaska Native __ Asian __ Native Hawaiian or Other Pacific Islander __ Black or African American
__ White __ Hispanic __ Other Race __ Other Pacific Islander __ Unreported/Refused to Report

Ethnicity: __ Hispanic or Latino __ Not Hispanic or Latino __ Refused to Report

Release of Information (*HIPAA form provided and signed*): ___ Yes ___ No

Advance Directive: __ (DNR) Do Not Resuscitate __ N/A

Employment: __ Full-time __ Part-time __ Not employed __ Self-employed __ Retired __ Active military duty __ Unknown

Student Status: __ Full-time __ Not a student __ Part-time

INSURANCE

Primary Insurance: _____ Policy Number: _____

Insured's Name: _____ Patient Relationship to Insured: _____

Secondary Insurance: _____ Policy Number: _____

Insured's Name: _____ Patient Relationship to Insured: _____

Patient's Alternate Name, if applicable (Last, First, MI):_____

Insured's Alternate Name, if applicable (Last, First, MI):_____

Patient Last Name: _____ ***Patient First Name:*** _____ ***Birth Date:*** _____

PHARMACY *(Please include pharmacies you use and indicate which is your Primary pharmacy)*

Pharmacy Name and Address: _____ Primary? __ Yes __ No

Pharmacy Name and Address: _____ Primary? __ Yes __ No

ADDITIONAL INFORMATION

Address: _____ City: _____ State: _____ Zip: _____
(If different than mailing address)

Employer Name: _____ Employer Address: _____

Sexual Orientation: __ Straight __ Lesbian or Gay __ Bisexual __ Something else __ Don't know __ Choose not to disclose

Gender Identity: __ Male __ Female __ Transgender Male/Female-to-Male __ Transgender Female/Male-to-Female __ Other __ Choose not to disclose

How did you hear about us? __ Billboard __ Community event __ Confinement facility __ Doctors office __ Drive by __ Employer __ Family __ Friend __ Health Dept. __ Health Fair __ Hospital __ Insurance/Social Services __ Internet __ Newspaper __ Nursing home __ Outreach ___Phonebook __ Postcard __ Realty company __ School __ Other (specify) _____

Veteran: __ Yes __ No Seasonal farm work: __ Yes __ No Migrant farm work: __ Yes __ No

Homeless: __ Yes __ No If Yes, Homeless Status: __ Unknown __ Street __ Doubling Up __ Transitional Housing __ Homeless Shelter __ Other

Public Housing: __ Yes __ No Limited English in speaking, writing or understanding: __ Yes __ No

ADDITIONAL CONTACTS

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Consent and Financial Responsibility Agreement

I/We hereby grant North Florida Medical Center's Inc. (NFMC) permission to treat myself and/or my child/ward for any illness or injury that I/we may encounter. I/We hereby authorize NFMC to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/we agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We authorize payment of medical benefits to NFMC and agree that should I receive any payments directly from any insurance companies for services billed on my behalf by the center, that I will turn those payments over to NMFC immediately. I further understand that should my account have to be referred to a collection agency that I am responsible for all fees and costs incurred therein. I/We hereby authorize NFMC to act on my behalf in accessing my medical records when and if needed.

_____ _____

Patient's Lifetime Signature or Parent/Legal Guardian **Patient's Name (Print) and Date**

North Florida Medical Centers, Inc.

Patient Medical, Family, Social History

Please fill out the following sections as completely and accurately as possible so that we may provide you the best quality of care

This information is collected to identify conditions that may affect your health, functioning, and/or quality of life, and so that we may connect you to resources which may provide support.

Today's Date: _____ ***Name:*** _____ ***Date of Birth:*** _____

Current Medications: _____

_____

_____

PAST MEDICAL HISTORY- PMHx (*Do you have/had any of the following?*):

- □ AIDS/HIV or exposure to
- □ Alcohol abuse
- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Bipolar
- □ Bleeding problems
- □ Bronchial
- □ Cancer bladder
- □ Cancer breast
- □ Cancer cervical
- □ Cancer colon
- □ Cancer esophageal
- □ Cancer kidney (renal)
- □ Cancer laryngeal
- □ Cancer lung
- □ Cancer prostate
- □ Cancer rectal
- □ Cancer skin
- □ Cancer testicular
- □ Cancer thyroid
- □ Chest pain
- □ Congenital abnormalities
- □ Congestive heart failure
- □ COPD
- □ Dementia
- □ Depression
- □ Diabetes mellitus
- □ Heart (cardiac) disease
- □ Hepatitis (A) (B) (C) carrier or exposure
- □ Hyperlipidemia
- □ Hypertension (HBP)
- □ Immune Disorders
- □ Kidney disease (renal)
- □ Liver/stomach/bowel problems
- □ Migraine headaches
- □ Obsessive Compulsive
- □ Parkinson's disease
- □ Pulmonary embolism
- □ Reflux/GERD
- □ Schizophrenia
- □ Seizures/convulsions
- □ Sexually transmitted disease
- □ Sinusitis
- □ Skin problems
- □ Thrombophlebitis
- □ Thyroid disease
- □ TIA or Stroke
- □ Tuberculosis (TB)

Other:

_____

_____

Drug Allergies/Reactions: _____

_____

SURGICAL HISTORY

- □ Abdominal
- □ Angioplasty
- □ Aortic aneurysm repair
- □ Appendectomy
- □ Arthroscopy knee
- □ Back surgery
- □ Bladder
- □ Breast biopsy
- □ Cardiothoracic
- □ Carpal tunnel
- □ Cataract/lens implant
- □ Cholecystectomy
- □ Colectomy
- □ Colostomy, partial
- □ Coronary artery bypass graft
- □ Delivery by C-section
- □ Ears, nose, throat
- □ Gastric, other
- □ Gastroplasty, bariatric
- □ Hernia
- □ Hip replacement
- □ Hysterectomy
- □ Intestinal bypass
- □ Joint replacement
- □ Kidney
- □ Laminectomy/ discectomy
- □ Lithotripsy
- □ Mastectomy
- □ Neurosurgery
- □ Oophorectomy
- □ Open lysis adhesions
- □ Orthopedic
- □ Prostate
- □ Skin/dermal
- □ Small bowel resection
- □ Thyroid
- □ Tonsillectomy
- □ Tubal ligation
- □ TURP
- □ Ulcer

□ Prior surgery **Other** - Explain:

_____

_____

_____

Previous Hospitalizations and Dates: _____

_____

Today's Date: _____ *Name:* _____ *Date of Birth:* _____

FAMILY HISTORY *Please check (√) all that apply*

Status: A=Alive, D=Deceased, U=Unknown

Relatives - Family Members	Status	Birth Year	Age (yrs)	Diabetes	Hyper tension	Heart Disease	Mental Illness	Cancer	Unknown	Notes
Daughter(s)										
Father										
Friend(s)										
Son(s)										
Spouse										
Mother										
Paternal Grand Father										
Paternal Grand Mother										
Maternal Grand Father										
Maternal Grand Mother										
Paternal uncle										
Paternal aunt										
Maternal uncle										
Maternal aunt										
Siblings										
Children										

Number of Siblings = Brothers _____ Sisters _____ ☐ Healthy Notes: _____

Number of Children = Sons _____ Daughters _____ ☐ Healthy Notes: _____

SOCIAL HISTORY

Family characteristics: # of Adults in the household _____ # of Children in the household _____

Communication needs: Hearing? ☐ Yes ☐ No Vision? ☐ Yes ☐ No Cognition (understanding)? ☐ Yes ☐ No

Social life: Do you consider yourself a social person? ☐ Yes ☐ No

Most recent Hospital/ER visit date? _____ Follow-up date? _____ Discharged? ☐ Yes ☐ No

Tobacco Use: ☐ Smoker ☐ Former smoker ☐ Nonsmoker How many/how often? _____

☐ chews tobacco ☐ pipe smoker ☐ snuff user Are you another tobacco user? ☐ Yes ☐ No _____

Sexual History: Had sex in the past 12 months (vaginal, oral, or anal)? ☐ Yes ☐ No

Have you had any sexually transmitted disease (STD)? ☐ Yes ☐ No Last menstrual period (LMP) _____

Unable to document LMP: ☐ depo provera ☐ hysterectomy ☐ Mirena birth control ☐ postmenopausal ☐ uterine ablation

Are you having any sexual problems? ☐ Yes ☐ No How many sexual partners have you had? _____

Today's Date: _____ *Name:* _____ *Date of Birth:* _____

Any sexual abuse: □ none □ has safety plan □ history in the past □ ongoing in relationship

Use condoms: □ Yes □ No Use other birth control method: _____

Drugs/Alcohol: Have you used drugs other than those for medical reasons in the past 12 months? □ Yes □ No

If "Yes" which drug(s) _____

Did you have a drink containing alcohol in the past year? □ Yes □ No If "Yes" how often: □ never □ monthly or less

□ 2-4 times a month □ 2-3 times a week □ 4 or more a week

Caffeine intake: □ none 1–2 cups per day □ 2-3 cups per day □ 3-4 cups per day □ more than 4 cups per day

Other caffeine: □ chocolate □ soda □ pills □ other How much/how often? _____

Miscellaneous: Children: □ none □ aware of safety issues □ no behavioral concerns □ no school issues □ in daycare

Community involvements: □ none □ religious group □ community organizations □ sports or recreation activities

Domestic Violence: □ none □ history in the past □ has restraining order □ feels unsafe at home □ has safety plan

Exercise: □ Yes □ No How often? □ weekly □ daily □ occasionally What type of exercise _____

Home smoke detectors? □ none □ smoke detectors □ radon detectors □ carbon monoxide detector

Housing: □ homeless □ shelter □ renting □ owns a home □ living with relatives

Legal problems: □ none □ on probation □ on parole □ awaiting trial

Living with: □ alone □ spouse □ significant other □ family □ friends

Marital status: □ never married □ single □ married □ separated □ divorced □ widowed

□ in relationship with male partner □ in relationship with female partner

Natural support system: □ none □ relies on family □ relies on friends □ relies on government assistance

Occupation employment status: □ retired □ self-employed □ unemployed □ works at home □ works part-time

□ work full-time Occupation: _____

Occupational exposure: □ none □ toxic chemicals □ noise □ infectious agents □ repetitive physical stress

Others at home: □ parents □ siblings □ foster children

Pets: □ none □ cats □ dogs □ birds □ reptiles □ exotic animals _____

Travel outside of the United States: □ none in last six (6) months □ South America □ Europe □ Asia □ Africa

Today's Date: _____ *Name:* _____ *Date of Birth:* _____

Verbal abuse: □ none □ occasional □ frequent □ seeking counseling □ has safety plan

Household:

Number of adults in household ____ Number of children in household ____ Religion _____

Education: □ some high school □ finished high school □ some college □ finished college □ professional school

Family yearly income: _____

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 _____

A2663B 10-04-2005

UNIVERSAL PATIENT AUTHORIZATION FORM FOR LIMITED DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE ENTIRE FORM, ALL THREE PAGES, BEFORE SIGNING BELOW

Individual (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow limited access to and use of your health information by certain persons for certain purposes. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure (including paper, oral and electronic interchange):

OF WHAT: (initial one)

_____ **ALL MY HEALTH INFORMATION including information about sensitive conditions (if any). Health information includes, but is not limited to, all records and other information regarding my health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain information about my health. This includes my specific permission to release any and all of the following information:**

a. Drug, alcohol, or substance abuse
b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
c. Sickle cell anemia
d. Birth control and family planning
e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
f. Genetic (inherited) diseases or tests
g. Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.

_____ ONLY THE INFORMATION INDICATED BELOW (initial next to all that you want disclosed):

_____ History and Physical _____ Operation Reports _____ Discharge Summary _____ Radiology Reports & Images
_____ Pathology Reports _____ EKG Reports _____ Progress Notes _____ Consultation Reports
_____ Lab Results _____ Physician's Orders _____ Drug, Alcohol or Substance Abuse Records
_____ Family Planning Records _____ Prenatal Records
_____ Mental Health Records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
_____ Diagnostic Test Reports (specify type of test): _____
_____ Other (please specify): _____

Note: Information created before or after the date of this form may be disclosed, unless you specify a date range of records here:
From (mm/dd/yyyy): _____ To (mm/dd/yyyy) : _____.

FROM WHOM: (choose one)

☐ **All information sources,** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

☐ **Only the following specific sources of my health information:**

Person/Organization Name: _____ Phone: ( ) _____
Address: _____ Fax: ( ) _____
Person/Organization Name: _____ Phone: ( ) _____
Address: _____ Fax: ( ) _____
Person/Organization Name: _____ Phone: ( ) _____
Address: _____ Fax: ( ) _____
Person/Organization Name: _____ Phone: ( ) _____
Address: _____ Fax: ( ) _____
Person/Organization Name: _____ Phone: ( ) _____
Address: _____ Fax: ( ) _____
Person/Organization Name: _____ Phone: ( ) _____
Address: _____ Fax: ( ) _____

TO WHOM: (check one)

☐ Specific person(s) or organization(s) permitted to receive my information:

Person/Organization Name: WAKULLA MEDICAL CENTER Phone: (850) 984-4735
Address: 1328 Coastal Highway, Panacea, FL 32346 Fax: (850) 984-4742
Person/Organization Name: _____ Phone: ( )
Address: _____ Fax: ( )
Person/Organization Name: _____ Phone: ( )
Address: _____ Fax: ( )
Person/Organization Name: _____ Phone: ( )
Address: _____ Fax: ( )
Person/Organization Name: _____ Phone: ( )
Address: _____ Fax: ( )
Person/Organization Name: _____ Phone: ( )
Address: _____ Fax: ( )

PURPOSE: (check all that apply)

☐ My medical treatment and related services and products
☐ To evaluate and improve patient safety and the quality of medical care provided to all patients
☐ Payment (as defined in HIPAA at 45 CFR 164.501)
☐ Eligibility for certain health care services (e.g., hospice)(please specify: _____)
☐ Eligibility for clinical trials (if limited, please specify here: _____)
☐ Scientific research with proper Institutional Review Board approval or waiver
☐ Personal Health Record for my use
☐ Personal use
☐ Other, please specify: _____

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until (check one):

☐ The day I withdraw my permission or the date of my death
☐ A specific date (mm/dd/yyyy): _____
☐ A specific event. Please specify: _____

REVOKING YOUR PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization to whom I originally gave this form.

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed.**

X _____ _____

Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

☐ Parent of minor
☐ Guardian
☐ Other personal representative (explain: _____)

This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Further Explanation of Form Florida AHCA FC4200-005
"Universal Patient Authorization Form for Limited Disclosure of Health Information"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

Definitions: In this form, the term "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501).

Note on Mental Health Records: If you are requesting a copy of your mental health records with this form, Florida allows such access, unless such access is determined by your physician to be harmful to you. For more information, see Florida Statute 394.4615(10).

"To Whom":

- If you specified a healthcare provider in the "TO WHOM" section above, this permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified.
- If you specified an organization other than a healthcare provider in the "TO WHOM" section above, this permission would also include that organization's staff or agents and subcontractors who carry out activities and purpose(s) permitted by this form for that organization that you specified.

Revocation: You have the right to revoke this authorization and withdraw your permission at any time regarding future uses by giving written notice. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

Re-disclosure of Information: Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want all of your health information shared with your healthcare provider for treating you, you need to use Form Florida AHCA FC4200-004 (Universal Patient Authorization Form For Full Disclosure of Health Information For Treatment & Quality of Care), instead of this form. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.