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: _____ Social Security Number: _____

Sex: __Male __Female __Unknown **S.O./G.I. Birth Sex**: __Male __Female __Unknown

Sexual Orientation: __Lesbian, gay or homosexual __Straight or heterosexual __Bisexual __Do not know __Choose not to disclose __Something else, please describe _____

Gender Identity: __Male __Female __Female-to-Male (FTM)/Transgender Male/Trans Man
__Male-to-Female (MTF)/Transgender Female/Trans Women __Genderqueer, neither exclusively male nor female
__Choose not to disclose __Transgender __Additional gender category or other, please specify _____

Responsible Party Name:_____ Date of Birth:_____ Relation:_____
(Guarantor) Last Name First Name (Guarantor)

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 __Other Race __Other Pacific Islander __Declined to Specify

Ethnicity: __Hispanic or Latino __Not Hispanic or Latino __Declined to Specify

Release of Information: *(HIPAA form provided and signed)* __Yes __No RX History Consent: __Yes __No

Advance Directive: __N/A (not applicable) __No __Yes

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: _____

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 NFMC 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 Dental Centers

Patient Name: _____ Date of Birth: _____ Date: _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY

PleaseCircle

Do you have a specific dental problem? Describe _____	YES	NO
Do you have dental examinations on a routine basis? Last Visit? _____	YES	NO
Would you describe your present dental health as good? Comments_____	YES	NO
Do you think you have active decay or gum disease? _____	YES	NO
Do your gums ever bleed? When? _____	YES	NO
Do you brush and floss daily? _____	YES	NO
Do you feel nervous about having dental treatment? _____	YES	NO
Have you ever had a bad experience in a dental office? Describe _____	YES	NO
Do you want to keep your remaining teeth? _____	YES	NO
Do you like the appearance of your teeth when you smile? _____	YES	NO

If NO, why not? _____

Name of previous dentist (optional) _____

MEDICAL HISTORY

Are you taking any medications or substance? If YES, what? _____	**YES**	**NO**
Medical Doctor's name: _____	YES	NO
Are you under a doctor's care? Why? _____	YES	NO
Have you been hospitalized during the past two years? Why? _____	YES	NO
Are you on any anticoagulant therapy including Aspirin? _____	YES	NO
Are you pregnant? (Women) _____	YES	NO

****If you are pregnant please bring a dental clearance from your OB to your dental appointment****

Do you use tobacco?_____	YES	NO
Do you have a history of tobacco use?_____	YES	NO
Do you drink alcoholic beverages?_____	YES	NO

Please **Circle** if you have any of the following:

Aids (HIV Postiive)	Chronic Fatigue	Heart Murmur	Kidney or Liver Disease
Anemia	Diabetes	(Mitral Valve Prolapse)	Night Sweats
Asthma	Epilepsy	(Barlows Syndrome)	Rheumatic Fever
Blood Transfusion	Glaucoma	Hepatitis	Sinus Trouble
Cancer	Heart Trouble	High Blood Pressure	Tuberculosis
Veneral Disease	Stomach Problems	Fainting/ Dizzy spells	Joint Replacement

Have you ever had any other serious illness not circled above?_____ YES NO

If YES, please describe in detail _____

ALLERGIES

Do you have any allergies? (For example: penicillin or latex)_____ YES NO

If YES, please list:_____

Do you wish to talk to the Dentist privately about any problems?_____ YES NO

MEDICAL UPDATES:

I have read my Medical History dated _____ and confirm that it adequately states past and present conditions.

_____ _____

Patient signature (Parent/Guardian) Date Dentist signature Date

Dental History Rev 06/10/15, 12/21/16, 08/31/20