MEDICAL CONCIERGE CARE

PATIENT REGISTRATION FORM

Date:_____

S.S#_____-_____-_____

Patient name:_____ Date of Birth_____

Mailing Address:_____ City_____ State_____Zip_____
Is this the address you would like to receive all our billing statement/correspondence to? Yes, if no, please list the alternative address here_____

Correspondences from our office should be sent in a sealed enveloped marked "CONFIDENTAL"?
_____ YES _____NO

Phone number:_____ Cell number: _____Other _____
Please circle the one you wish to receive calls about your appointment, lab, x-ray results or other healthcare information.

Can confidential messages be left on your home answering machine or voice mail? ____ Yes ___ No ____ Other option: Please list_____

Sex: M_____ F_____ Marital Status: S____, M____, D____, W____, Other_____

Occupation:_____ Employer:_____

Business address & Phone:_____

Whom may we thank for referring you today?_____

Emergency contact name:_____Phone:_____

Authorization to release information

In an attempt to preserve the confidential nature of the doctor/patient relationship, it is requested that you complete the information listed below regarding appointments and other administrative matters.

Please list all the people whom we may inform about your general medical condition and diagnosis:_____

Please list all the persons that we may inform about your condition in an emergency situation only:_____

I, the undersigned certify that I or my dependent have insurance with_____ and assign directly to Dr. _____, all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorized the use of the signature on ALL insurance submissions.

_____ _____ _____
Responsible Party Signature | Relationship to patient | Date

Policy

It is the policy of Medical Concierge Care to release information to your immediate family and or leave messages with them or on your answering machine regarding: appointments, lab/tests results, billing, or any other information we feel is necessary to provide quality care for you, unless otherwise stated by you in writing.

HIPAA

I have read, The Health Insurance Portability & Accountability Act of 1996 (HIPAA), and understand my rights. (Should you desire a copy of this form, please advise the front desk)

Spouse/Parent/Guardian Information

Name:_____Relationship to Patient:_____

Address: _____City: _____State:_____ Zip:_____

H. Phone:_____Cell:_____SS#:_____

Employer: _____ Phone: _____

Place of Employment:_____ Spouse's name:_____

Do you have a Living Will or Advanced Directive? Yes or No

Are you currently receiving care from any other doctors, or other health care professionals? If yes, we would like to know whom so that we can coordinate your care:

Provider's Name:	Condition they are treating you for:
_____	_____
_____	_____
_____	_____
_____	_____

When was your last physical? _____When was your last blood/lab test?_____

Dates of most recent immunizations

Tetanus _____ Influenza_____Pneumonia_____Hepatitis B_____

Other: _____

Personal History

Are you currently married or living with a significant other? _____Who lives with you at home?_____

Are you employed? _____

If yes, what kind of work do you do?_____

If no, is this by choice?___ Disability?____ Other reasons?_____

Do you exercise more than 2 X per week? _____Do you often feel sad or depressed? _____

Do you feel there is something seriously wrong with your body? _____

Are you having money problems which limit your access to food, shelter or medical care? _____

In the last year, have there been any major changes in your life like marriage, divorce, death of a family member or close friend, illness or injury, or change in job situation? _____

Do you have some form of church or spiritual support? _____

_____ _____

Patient or Responsible Party Signature Date

785 Highway 466, Lady Lake, Florida, 32159
Email: mail@mccvillages.com
Office: 352-775-6428 ** Fax: 352-633-1614
Web: www.mccvillages.com

Health History (Confidential)

Patient Name: _____ Todays Date: _____

Age: _____ Birth Date: _____ Sex: _____ Date of last physical examination: _____

What is the reason for your visit? _____

_____

Symptoms: X- all symptoms that you are currently having or have had in the past year

GENERAL		GASTROINTESTINAL		EYE, EAR, NOSE, THROAT		MEN ONLY	
Chills		Appetite poor		Bleeding gums		Breast lump	
Depression		Bloating		Blurred vision		Erection difficulties	
Dizziness		Bowel changes		Crossed eyes		Lump in testicles	
Fainting		Constipation		Difficulty swallowing		Penis discharge	
Fever		Diarrhea		Double vision		Sore on penis	
Forgetfulness		Excessive hunger		Earache		Other	
Headache		Excessive thirst		Ear discharge			
Loss of Sleep		Gas		Hay fever		**WOMEN ONLY**	
Loss of Weight		Hemorrhoids		Hoarseness		Abnormal pap smear	
Nervousness		Indigestion		Loss of hearing		Bleeding between menstruation	
Numbness		Nausea		Nosebleeds		Breast lump	
Sweats		Rectal Bleeding		Persistent cough		Extreme menstrual pain	
		Stomach pain		Ringing in ears		Hot flashes	
MUSCLE, JOINT, BONE		Vomiting		Sinus problems		Nipple discharge	
Pain, weakness, numbness in		Vomiting blood		Vision-Flashes		Painful intercourse	
Arms / Hips				Vision-Halos		Vaginal discharge	
Back / Legs		**CARDIOVASCULAR**				Other	
Feet / Neck		Chest pain		**SKIN**		Date of last menstrual period? _____	
Hands / Shoulder		High blood pressure		Bruise easily		Date of last pap smear? _____	
GENITO-URINARY		Irregular heart beat		Hives		Have you had a mammogram? Yes / No	
Blood in urine		Low blood pressure		Itching		Are you pregnant? Yes / No	
Frequent urination		Poor circulation		Changes in moles		Number of children: _____	
Lack of bladder control		Rapid heart beat		Rash			
Painful urination		Swelling of ankles		Scars			
		Varicose veins		Sore that won't heal			

Conditions: X- all symptoms that you are currently having or have had in the past year

AIDS		Chemical Dependency		High Cholesterol		Prostate problem	
Alcoholism		Chicken Pox		HIV Positive		Psychiatric care	
Anemia		Diabetes		Kidney Disease		Rheumatic fever	
Anorexia		Emphysema		Liver Disease		Scarlet fever	
Appendicitis		Epilepsy		Measles		Stroke	
Arthritis		Glaucoma		Migraine headaches		Suicide attempt	
Asthma		Goiter		Miscarriage		Thyroid problems	
Bleeding disorders		Gonorrhea		Mononucleosis		Tonsillitis	
Breast lump		Gout		Multiple Sclerosis		Tuberculosis	
Bronchitis		Heart Disease		Mumps		Typhoid fever	
Bulimia		Hepatitis		Pacemaker		Ulcers	
Cancer		Hernia		Pneumonia		Vaginal infections	
Cataracts		Herpes		Polio		Venereal disease	

List Medications you are currently taking:
(*use extra sheet of paper if necessary*)

_____

_____

_____

_____

_____

_____

_____

All known Allergies:

_____

_____

_____

_____

_____

_____

Pharmacy: _____

Phone #: _____

FAMILY HISTORY-FILL IN HEALTH INFORMATION ABOUT YOUR FAMILY

RELATIONSHIP	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				
Brothers				
Sisters				

	Check (x) if your blood relatives had any of the following disease	
	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

YEAR	HOSPITAL	REASON FOR HOSPITALIZATION	OUTCOME

PREGNANCY HISTORY

BIRTH YR	SEX OF BIRTH	COMPLICATION IF ANY

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES___ NO___ Dates:_____

Serious Illness/Injuries	Date	Outcome

Health Habits: X all that apply

	Caffeine
	Tobacco
	Drugs
	Other

Occupational Concerns: X if your work exposes you to the following

	Stress
	Hazardous Substances
	Heavy Lifting
	Other
	Your Occupatioin:_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omission that I may have made in the completion of this form:

_____ _____

Patient or Responsible party signature Date