Joseph C. & Ann S.
Day Medical Center

900 SE Salerno Rd, Stuart, FL 34997
Telephone: (772) 223-7864 Fax: (772) 781-2963

Please return this packet at least one (3) day prior to scheduled appointment.

Patient Registration Form

Please bring the following items to your first appointment: picture ID, insurance card, all medication bottles (including over-the counter medications) and any Advance Directives.

Date: _____

Name _____**Birth Date** _____ **Sex: MALE** ☐ **FEMALE** ☐

Address _____**City** _____**State** _____**Zip** _____

Alternate Address _____**City** _____**State**____ **Zip** ____

Home Phone _____ **Cell Phone** _____ **Social Security No.** ____-___-____

Email Address _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Other**

Living Situation: ☐ **Alone** ☐ **Spouse** ☐ **Children** ☐ **Caregiver** ☐ **Other**

Social Supports: _____

Person to contact in case of emergency:

Name _____**Phone** _____**Relationship**_____

Insurance Information (YOU MUST Bring Picture ID and Insurance Card to appointment)

Primary Insurance: Name_____

Member ID # _____ Group # _____

Insured Birth date _____Relationship to you: **SELF** ☐ **SPOUSE** ☐ **OTHER** ☐

Secondary Insurance: Name_____

Member ID # _____ Group # _____

Insured Birth date _____Relationship to you: **SELF** ☐ **SPOUSE** ☐ **OTHER** ☐

Name of Previous Primary Care Dr _____

Phone (____) _____Fax (____) _____

List any other physician/specialist currently treating you: _____

_____

Advance Directives: Do you have any of the following? (If YES, please bring a copy to your appointment.)

1. Living Will: YES ☐ NO ☐
2. Healthcare Surrogate: YES ☐ NO ☐
3. Power of Attorney: YES ☐ NO ☐
4. Advanced Directive: YES ☐ NO ☐
5. Do Not Resuscitate: YES ☐ NO ☐

How did you hear about this practice? (Please check one)

☐ Friend/Family Member
☐ Kane Center
☐ Internet (Website/Search Engine)
☐ Newspaper (Name:_____)
☐ Flyer/Brochure at: _____
☐ Health Fair or other Event
☐ Hospital/ER
☐ Insurance Company
☐ Other Physician/Provider (Name: _____)
☐ Other: _____

Joseph C. & Ann S.
Day Medical Center
900 SE Salerno Rd, Stuart, FL 34997
Telephone: (772) 223-7864 Fax: (772) 781-2963

Medication List

Please list all medications and over the counter medications you are currently taking.

Please BRING your medication bottles to EVERY appointment.

Name of Medication	Strength	How many times a day
Example: Aspirin	***81mg***	***One a day***

PHARMACY:

LOCAL**:** _____ PHONE#:_____

MAIL ORDER: _____ PHONE #: _____

Joseph C. & Ann S.
Day Medical Center
900 SE Salerno Rd, Stuart, FL 34997
Telephone: (772) 223-7864 Fax: (772) 781-2963

Medical History: (Please circle)

Abnormal Mammogram	*Depression*	*Hepatitis*	*Postmenopausal bleeding*	*Blood Clots*
Abnormal Pap Smears	*Diabetes*	*High blood pressure*	*Seizures*	*Vision Problems*
Addiction Problems	*Elevated PSA*	*High Cholesterol*	*Shingles*	*Weight issues*
Arthritis	*Head Injury*	*Memory trouble/loss*	*Stomach Ulcers*	*Cancer*
Bleeding Problems	*Heart Problems*	*Mental Illness*	*Trouble walking*	*Kidney Problems*
Stroke	*Heart Attack*			

OTHER: _____

Allergies: _____

_____

Surgery & Procedure History (Include the year):

_____

_____

_____

Describe any hospitalizations or recent illnesses:

_____

_____

Family History: Who in your family has/had any disease or illness? (Example: Diabetes, High blood pressure, Cancer, Heart Disease, Thyroid Disease, and Mental Illness)

Family Member	Medical Problem	Living or Deceased	Age at death
Mother		Living ☐ Deceased ☐	
Father		Living ☐ Deceased ☐	
Siblings		Living ☐ Deceased ☐	
Other:			

Social History:

1. How is your Diet? Poor ☐ Average ☐ Good ☐ Excellent ☐
2. Do you currently smoke? Yes ☐ No ☐ If yes, start date _____ How much per day_____
   If former smoker, when did you quit? _____How many years did you smoke? _____
   How much did you smoke? _____Is there any tobacco exposure at home? Yes ☐ No ☐
3. Do you drink? Yes ☐ No ☐ Beer_____Wine_____Liquor_____
   How often? _____ How much? _____
4. Do you exercise? Yes ☐ No ☐
   If yes, what exercise do you do? _____
   How often? _____For how long? _____

Joseph C. & Ann S.
Day Medical Center
900 SE Salerno Rd, Stuart, FL 34997
Telephone: (772) 223-7864 Fax: (772) 781-2963

Preventative Screening: (Please date the last time you had one of the following)

Influenza Shot_____
Pneumovax Shot _____
Prevnar 13 _____
Shingles Shot _____
Tetanus Shot _____

DEXA _____
Colonoscopy _____
Mammogram _____
Pap smear _____

Dermatology exam _____
Eye Exam _____
Dental Exam _____

Women

Date of last mammogram _____ Date of last PAP _____
Date of last period _____ Are you sexually active currently? _____
Any GYN problems to discuss? _____

Men

Last PSA _____ Rectal Exam _____ Are you sexually active currently? _____

What do you want to discuss with your healthcare provider at today's visit?

_____
_____
_____
_____
_____
_____

Joseph C. & Ann S.
Day Medical Center
900 SE Salerno Rd, Stuart, FL 34997
Telephone: (772) 223-7864 Fax: (772) 781-2963

Insurance Benefits and Information Release

SIGNATURE REQUIRED ON THIS FORM

I understand that the physician services of the Day Medical Center are to be billed by the Council on Aging of Martin County, Inc. Medical information regarding my visit at the Day Medical Center will be available to the Day Medical Center staff.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any service rendered that are not paid for directly by me.

_____
Patient's Name (PRINT)

_____
Patient's Name (SIGNATURE)

_____
DATE

Joseph C. & Ann S.
Day Medical Center
900 SE Salerno Rd, Stuart, FL 34997
Telephone: (772) 223-7864 Fax: (772) 781-2963

Permission for Verbal Communication (HIPPA Form)

THIS IS A REQUIRED FORM – PLEASE FILL OUT AND SIGN

_____ _____ _____

Print name of Patient **Date of Birth** **Last 4 digits of Social Security Number**

In an attempt to preserve the confidential nature of the doctor-patient relationship, please select the different locations/persons with whom or where we may leave messages regarding appointments or other administrative matters.

I wish to be contacted in the following manner:

Primary choice telephone number: _____Home☐ Work☐ Cell☐
Secondary choice telephone number: _____Home☐ Work☐ Cell☐

Please indicate if you authorize us to leave a message or fax information: (check all that apply)

This includes name of physician, date and time of appointment and any instructions.

☐Home answering machine ☐Work telephone number/answering machine/voicemail
☐Cell phone voicemail ☐Fax information to: _____ (Fax Number)

I permit Day Medical Center, their physicians, nurses, and other personnel to discuss my health information including billing and payment information, test results or lab results in person or by telephone, with the following family members or friends involved in my medical care.

This may include information related to psychiatric care, drug and alcohol use, HIV testing and/or AIDS.
Limit discussions to the following medical condition(s) or services(s): _____

Name	Phone	Relationship
1._____	_____	Home Work Cell _____
2._____	_____	Home Work Cell _____
3._____	_____	Home Work Cell _____
4._____	_____	Home Work Cell _____

_____None, I do not wish my information discussed with anyone other than myself.

Release of information under this document is limited to verbal discussions as indicated above and/or limited paper records or business office documents as necessary for my immediate assistance.

This authorization expires in one year unless revoked. If at any time I do not want verbal discussions to be permitted between my health care providers or facility and any of the individuals name above (provided that the information has not yet been released) I must notify my Health Care Provider or contact the Day Medical Center.

_____ _____

Patient or Authorized Signature **Date**

_____

Relationship to Patient (Explain and/or attach Legal Documentation)

Joseph C. & Ann S.
Day Medical Center
900 SE Salerno Rd, Stuart, FL 34997
Telephone: (772) 223-7864 Fax: (772) 781-2963

Note: Medical records exceeding 25 pages cannot be received via fax. Mail to Day Medical Center. CDs cannot be accepted. Thank you.

Authorization for Release of Medical Records

1. **I Authorize:**

_____
Name of sending person/organization

_____
Street Address

_____
City State Zip Code

2. **To Release to:**

DAY MEDICAL CENTER
Name of receiving person/organization

900 SE SALERNO ROAD
Street Address

STUART, FL 34997
City State Zip Code

3. **INFORMATION TO BE RELEASED:** (Check all applicable)

☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-Ray Reports
☐ Electrocardiogram (ECG) ☐ Allergy Records ☐ Other _____

SPECIAL AUTHORIZATION: Check applicable box (es) and sign immediately below.
By signing below, I am authorizing the office to release any and all information regarding:
☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: _____ Date: _____

4. Records from the time period:___/___/___ through ____/____/____

5. Purpose of Disclosure: (Check applicable purpose)

☐ Continue Medical Care ☐ Payment of Insurance Claim ☐ Legal
☐ Personal ☐ Other: _____

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee will be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Date of Birth: _____ Home Phone: _____

Joseph C. & Ann S.
Day Medical Center
900 SE Salerno Rd, Stuart, FL 34997
Telephone: (772) 223-7864 Fax: (772) 781-2963

THE REMAINING FORMS ARE REQUIRED BY MEDICARE TO BE COMPLETED.

Medicare Questionnaire

Name: _____

We are required by Medicare to ask these questions each visit per Federal requirements in Section 1862(b) of the Social Security Act (42 USC Section 1395y(b)(5). Applicable regulations are found at 42 CFR Part 411 1990. Your cooperation in completing this form will be appreciated. Medicare's telephone number is (866) 454-9007.

1. Are you entitled to Medicare based on age, disability, ESRD (End Stage Renal Disease)? YES NO
2. What is your date of retirement: _____/_____/_____
3. Name of HMO, if you are a member: _____
4. Are you receiving Black Lung (BL) benefits? YES NO
5. Are you **employed** and covered by group health? YES NO
6. Are you covered under a working spouse's group plan? YES NO
   Does employer have more than 28 employees? YES NO
   ****If you and your spouse are employed and covered by GHP, and the employer has more than 28 employees, the GHP is primary.**
7. Is injury /illness due to a work-related accident/condition? YES NO
   ****W/Comp is primary payer for claims related to work.**
8. Is injury/illness the result of an auto-related condition? YES NO
9. Is injury/illness related to a liability claim? YES NO
   ****Liability insurance is primary payer for claims related to accident.**
10. Was the injury/illness due to a non-work related accident? YES NO
11. What type of accident caused the illness/injury? _____
12. Are you receiving ESRD (End Stage Renal Disease) benefits? YES NO
13. Have you received a kidney transplant? YES NO
    Date of kidney transplant? ____/____/____
14. Are you receiving maintenance dialysis treatments? YES NO
    When did dialysis begin? ____/____/____
15. If you participated in self dialysis, what was the date: _____
    Are you within the 38 month coordination period? YES NO
16. Has VA authorized/agreed to pay for care at this facility? YES NO
17. Are services to be paid for by a Research Grant? YES NO
18. Are you currently a resident of a nursing home/facility: YES NO
    Name of facility: _____
19. Are you currently under the care of Hospice? YES NO
20. Who furnished this Medicare Questionnaire information? _____

Name:_____ Date:_____ Date of Birth:_____

A Checklist for Your Medicare Wellness Annual Visit

Joseph C. & Ann S. Day Medical Center

Please complete this checklist before seeing your doctor or nurse. Your answers will help you receive the best health care possible.

1. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

2. During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors or groups?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

3. During the past 4 weeks, how much bodily pain have you generally had?
   - ☐ No pain
   - ☐ Very mild pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe pain

4. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.
   - ☐ Yes, as much as I wanted
   - ☐ Yes, quite a bit
   - ☐ Yes, some
   - ☐ Yes, a little
   - ☐ No, not at all

5 During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
- ☐ Very heavy
- ☐ Heavy
- ☐ Moderate
- ☐ Light
- ☐ Very light

	Yes	No
6. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?	☐	☐
7. Can you shop for groceries or clothes without help?	☐	☐
8. Can you prepare your own meals?	☐	☐
9. Can you do your own housework without help?	☐	☐
10. Can you handle your own money without help?	☐	☐
11. Do you need help eating, bathing, dressing, or getting around your home?	☐	☐

12. During the past 4 weeks, how would you rate your health in general?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

13. How have things been going for you during the past 4 weeks?
   - ☐ Very well - could hardly be better
   - ☐ Pretty good
   - ☐ Good and bad parts about equal
   - ☐ Pretty bad
   - ☐ Very bad - could hardly be worse

14. Are you having difficulties driving your car?

- ☐ Yes, often
- ☐ Sometimes
- ☐ No
- ☐ Not applicable, I do not use a car

15. Do you always fasten your seat belt when you are in a car?

☐ Yes, usually ☐ Yes, sometimes ☐ No

16. How often during the past 4 weeks have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up	☐	☐	☐	☐	☐
Sexual problems	☐	☐	☐	☐	☐
Trouble eating well	☐	☐	☐	☐	☐
Teeth or dentures	☐	☐	☐	☐	☐
Problems using the telephone	☐	☐	☐	☐	☐
Tired or fatigued	☐	☐	☐	☐	☐

17. Have you fallen 2 or more times in the past year?

☐ Yes ☐ No

18. Are you afraid of falling?

☐ Yes ☐ No

19. Are you a smoker?

- ☐ No
- ☐ Yes, and I might quit
- ☐ Yes, but I'm not ready to quit

20. During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have?

- ☐ 10 or more per week
- ☐ 6-9 per week
- ☐ 2-5 per week
- ☐ 1 drink or less per week
- ☐ No alcohol at all

21. Do you exercise for about 20 minutes 3 or more days a week?

- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ No, I usually do not exercise this much.

22. Have you been given any information to help you with the following:

- Hazards in your house that might hurt you?
  ☐ Yes ☐ No
- Keeping track of your medications?
  ☐ Yes ☐ No

23. How often do you have trouble taking medicines the way you have been told to take them?

- ☐ I do not have to take medicine
- ☐ I always take them as prescribed
- ☐ Sometimes I take them as prescribed
- ☐ I seldom take them as prescribed

24. How confident are you that you can control and manage most of your health problems?

- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ I do not have any health problems.

How old are you? ☐ 65-69 ☐ 70-79 ☐ 80 or older

Are you male or female? ☐ Male ☐ Female

What is your race? (check one or more than one)

- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaskan Native
- ☐ Hispanic or Latino origin or descent
- ☐ Other