Orange Park MEDICAL CENTER | First Coast Neurology

Thank you for choosing our Services. We are committed to providing you with the best possible medical care. Please arrive at least 30 minutes early to allow time for registration. If unable to keep your appointment, kindly give 24 hour notice for any reschedule or cancellation. Please bring this completed form along with your Photo ID and current Insurance card (s).

Patient Name:	DOB:

Patient Pharmacy Information

Pharmacy Name:	
Pharmacy Address :	
Pharmacy Phone:	
Pharmacy Fax:	

Patient Physicians

Physicians Name		Phone Number /Fax Number
	PCP	
	Specialist	

Patient Name_____ **Date**_____

We are committed to providing the safest environment for our patients. Together we can prevent the spread of germs.

Please complete the questionnaire below. If you answer yes to any of the questions, please be considerate of others and act appropriately such as covering your mouth or nose when you cough, washing your hands, and covering any open wounds.

To help protect your health and the health of all our patients, we will gladly give you tissue, masks, hand sanitizer, and Band-Aids.

1. Have you had flu or flu like symptoms (fever, sore throat, cough or runny nose) in the past week? YES NO
2. In the past three weeks, have you:

   Traveled outside the U.S.? YES NO

   - If yes, has it been to one of these West African countries: Guinea, Liberia, Sierra Leone; or Mali; or other: _____
   - If not a West African country or Mali, please list where:_____

   Or, had close contact with someone who has traveled outside the U.S? YES NO

   - If yes, was it a West African country: Guinea, Liberia, Sierra Leone; or Mali; or other:_____
   - If not a West African country or Mali, please list where:_____
3. Do you have history of Tuberculosis or been exposed to Tuberculosis? YES NO
   - If yes, in the last four weeks have you had any of the following symptoms? YES NO
     - night sweats
     - bloody cough
     - unexplained weight loss
4. Are you currently experiencing earache, sinus or eye infection? YES NO
5. Have you had a "new onset" of multiple episodes of diarrhea in the last week or currently experiencing diarrhea **not** related to a chronic condition (i.e. irritable bowel, ulcerative colitis or Crohn's Disease)? YES NO
   - If yes, how many episodes per day: _____
6. Have you been told that you have a drug resistant staph infection (ex. MRSA)? YES NO
   - If yes, do you currently have any open sores or wounds on your mouth or skin?
7. Do you have any "new" skin rashes / irritations? YES NO

Thank you for your help and support in caring for our patients and community.

Thank you for trusting us with your healthcare!

To be filled out by the office staff

Reviewed by:_____

Action taken:

- ☐ No action taken
- ☐ Isolate
- ☐ Cough/ hand washing etiquette provided
- ☐ Mask provided
- ☐ PM/ Lead clinical provided

Thank you for trusting us with your healthcare!

Orange Park Medical Center | First Coast Neurology

Date: _____

Patient Name: _____ Date of Birth: _____

As part of the quality measures mandated by Centers for Medicare/Medicaid, as a medical provider engaged in your care, we are asked to ask you the following during each visit. As always, the content of this document is your personal and private healthcare information, and is protected under HIPAA. First Coast Neurology is committed to your privacy.

Please answer the following:

1. **Influenza Immunization:**
   - Have you received your 2013/2014 flu vaccine yet? **YES / NO**
     - If so, when and where? _____
   - If flu vaccine NOT yet received this season, are you interested in receiving one? **YES / NO**
   - If not interested, do you wish to DECLINE a flu vaccine for this season? **YES / NO**

2. **Pneumococcal Vaccination:**
   - Have you ever received a pneumococcal vaccine? **YES / NO**
     - If so, when and where? _____
   - If pneumococcal vaccine NOT yet received, are you interested in receiving one? **YES / NO**

3. **Tobacco Use:**
   - Are you a tobacco user? **YES / NO**
   - If so, PAST tobacco user? Not since: (year) _____
   - If so, CURRENT tobacco user?
     - About how long have you used tobacco? _____ year(s) _____ months
     - What kind of tobacco products do you use?
       - Cigarettes? **YES / NO**
       - Smokeless Tobacco (Snuff or Chew)? **YES / NO**
       - Other? **YES / NO** Please describe: _____
       - How many cigarettes do you usually smoke per day? (1 pack = 20 cigarettes) ____ cigarettes
       - Interested in Smoking Cessation Counseling? **YES / NO**

4. **Alcohol Use:**
   - Do you consume alcohol? **YES / NO**
     - If so, number of drinks per occasion? _____
     - If so, number of drinks per week? _____

5. **Use of Aspirin or Another Antithrombotic:**
   - Are you taking Aspirin, Clopidogrel, Dipyridamole or another Anithrombotic (blood thinner)? **YES / NO**
     - If so, what medication and how often? _____

Do I have a Sleep Disorder ?

- ☐ I've been told that I snore.
- ☐ I stop Breathing when I am asleep, although I many not remember
- ☐ I feel Sleepy or tired during the day even though I slept all night.
- ☐ I have high blood pressure.
- ☐ I have been told that I am restless Sleeper.
- ☐ I perspire at night during sleep.
- ☐ I frequently have head aches during the morning when I wake.
- ☐ I wake up and cannot return to sleep.
- ☐ I find it very difficult to lose weight.
- ☐ I seem to be losing my sexual drive/desire.
- ☐ I have awakened chocking or gasping.
- ☐ I am up to the bathroom several times a night.
- ☐ I have been diagnosed with CHF, COPD, CAD, other heart or lung disease.

Personal History

Do you have or have you ever had any of the following conditions:

YES	NO		YES	NO	
		AIDS/HIV			Heart Murmur
		Alcohol/Drug problem			Hemorrhoids
		Anemia/low blood count			Hepatitis
		Arthritis			Hernia
		Asthma			High Blood Pressure
		Blood Clots			High Cholesterol
		Cancer (Type_____			Concussion/Head Injury
		Cataracts			Kidney/Bladder problems
		Circulation problems			Liver Disease/hepatitis
		COPD/Emphysema			Mental Trouble/Depression/Anxiety
		Diabetes			Pneumonia
		Easy Bleeding			Rheumatic fever
		Eating Disorder			Seizures/fits/Epilepsy
		Eczema			Serious injury/Serious Accident
		Genital Herpes			Sickle cell anemia
		Genital infections			Skin disorder
		Genital Warts/HPV			Stroke
		Glaucoma			Thyroid problem
		Gout			Transfusion
		Hay Fever/pollen allergy			Tuberculosis (TB)
		Headaches			Ulcers
		Hearing Loss			Heart attack./Heart disease

SURGERY / HOSPITALIZATION / ACCIDENT / INJURY HISTORY

Please list any surgeries / hospitalization / accidents / injuries and the year.	YEAR

PERSONAL HABITS

Do you drink alcohol regularly?	Yes	No	If yes, what amount? _____
Do you drink>4 cups of caffeinated beverages per day?	Yes	No	If yes, what amount? _____
Do you smoke?	Yes	No	If yes, how many packs? _____
			If yes, how many years? _____
Are you a former smoker?	Yes	No	If yes, how many packs? _____
			If yes, how many years? _____
Have you ever used street drugs?	Yes	No	If yes, what type? _____
Are you currently using street drugs?	Yes	No	If yes, what type? _____

FAMILY HISTORY

Relative	Age	If deceased,age of death	Medical Problems / Cause of Death
Mother			
Father			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			
Siblings			
Spouse			
Children			

MEDICATIONS

Please list the medications, with dosages and frenquencies, that you currently use. Please include over the counter and herbal medications

Medication	Dosage	Frequency

ALLERGIES

Please list any drug allergies and the type of reactions you experience with each drug

DRUG	REACTION

REVIEW OF SYMPTOMS

Please check any of the following symptoms that apply to you

Past	Present	Symptom	Past	Present	Symptom
☐	☐	Weight change(unexpected)	☐	☐	Anxiety
☐	☐	Fever	☐	☐	Depression
☐	☐	Chills	☐	☐	Stress
☐	☐	Fatigue	☐	☐	Trouble swallowing
☐	☐	Dizziness	☐	☐	Heartburn
☐	☐	Night Sweats	☐	☐	Constipation
☐	☐	Trouble Sleeping	☐	☐	Diarrhea
☐	☐	Appetite change	☐	☐	Blood in stools
☐	☐	Headache	☐	☐	Black, tarry stool
☐	☐	Visual change	☐	☐	Pencil-thin stool
☐	☐	Hearing Loss	☐	☐	Hemorrhoids
☐	☐	Ear ache	☐	☐	Jaundice
☐	☐	Ear discharge	☐	☐	Nausea / Vomiting
☐	☐	Ringing in Ears	☐	☐	Vomiting of blood
☐	☐	Nosebleeds	☐	☐	Stomach pain which:
☐	☐	Sinus problems	☐	☐	occurs after a meal
☐	☐	Bleeding gums	☐	☐	occurs with eating greasy, fried foods
☐	☐	Hoarseness	☐	☐	awakens you at night
☐	☐	Sore throat	☐	☐	is relieved by antacids
☐	☐	Shortness of Breath	☐	☐	Seasonal / environmental allergies
☐	☐	when doing usual work	☐	☐	Red, itchy eyes
☐	☐	when climbing one flight of stairs	☐	☐	Easy bruising
☐	☐	which awakens you at night	☐	☐	Rash
☐	☐	Cough	☐	☐	Change in moles
☐	☐	Coughing up blood	☐	☐	Itchy skin
☐	☐	Wheezing	☐	☐	Burning when urinating
☐	☐	Chest pain or tightness	☐	☐	Blood in urine
☐	☐	when walking fast or up hill	☐	☐	Frequency urination
☐	☐	after a heavy meal	☐	☐	Trouble starting urination
☐	☐	when upset or excited	☐	☐	Trouble holding urine
☐	☐	that radiates down your arm	☐	☐	Frequent nighttime urination
☐	☐	Irregular heartbeat	☐	☐	Muscle pain
☐	☐	Swelling of ankles	☐	☐	Joint pain
☐	☐	Numbness	☐	☐	Seizures
☐	☐	Weakness	☐	☐	Fainting

IMMUNIZATIONS

Date of last tetanus booster: _____ Date of last pneumonia vaccine: _____

Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) ____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP_____ Pharmacy_____Pharmacy Phone_____

Home Phone _____ Cell No. _____ Work Phone _____Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address:_____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number ___-___-___ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

City, State _____ ZIP_____

Home Phone _____ Work Phone _____ Ext. _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____/DD _____/YYYY _____

Social Security Number ___-___-___ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer_____ Employer Phone Number_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____ (_____)_____

Name of Insured_____ Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ Date of Birth MM _____/DD _____/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____ (_____)_____

Name of Insured_____ Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ Date of Birth MM _____/DD _____/YYYY _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

Section A: This section must be completed for all Authorizations			
Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN (optional):**
Provider's Name:	**Recipient's Name:**		
Provider's Address:	**Address 1:**		
	Address 2:	**Recipient's Phone:**	
	City:	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ Paper Copy ☐ Electronic Media, if available (*e.g.*, USB drive, CD/DVD) ☐ Encrypted Email ☐ Unencrypted Email

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	*Date(s):*	*Description:*	*Date(s):*	*Description:*	*Date(s):*
☐ All PHI in medical record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test		☐ Transfer forms		☐ Other:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may he found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

Consent for Treatment and Payment Agreement

I hereby authorize First Coast Neurology to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to First Coast Neurology of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to First Coast Neurology all insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Patient Initial: _____

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to First Coast Neurology. **Patient Initial: _____**

I request this authorization also apply to all other insurance. **Patient Initial: _____**

I acknowledge that I have been given First Coast Neurology's Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Facility Privacy Official.
Patient Initial: _____

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

Patient Signature_____**Date**_____

Orange Park Medical Center | First Coast Neurosurgery

Narcotics Prescribing Policy

The prescribing of narcotics for pain is a challenge under the best of circumstances. Due to legal requirements, substance abuse and addiction, it is necessary for our Practice to have stringent controls and rigid rules in place. Our medical practice provides narcotics when deemed appropriate, all while following State and Federal guidelines. Our mission is to maintain the health and welfare of our patients while obeying the laws under which we operate. It is imperative that you, the patient, understand and agree to the following policy:

1- Refills of prescriptions for narcotics are only handled during scheduled office visits. **We will not** call in narcotic prescriptions during non-office hours.

2- We will only write prescriptions for narcotics if you have had surgery performed by one of our Physicians.

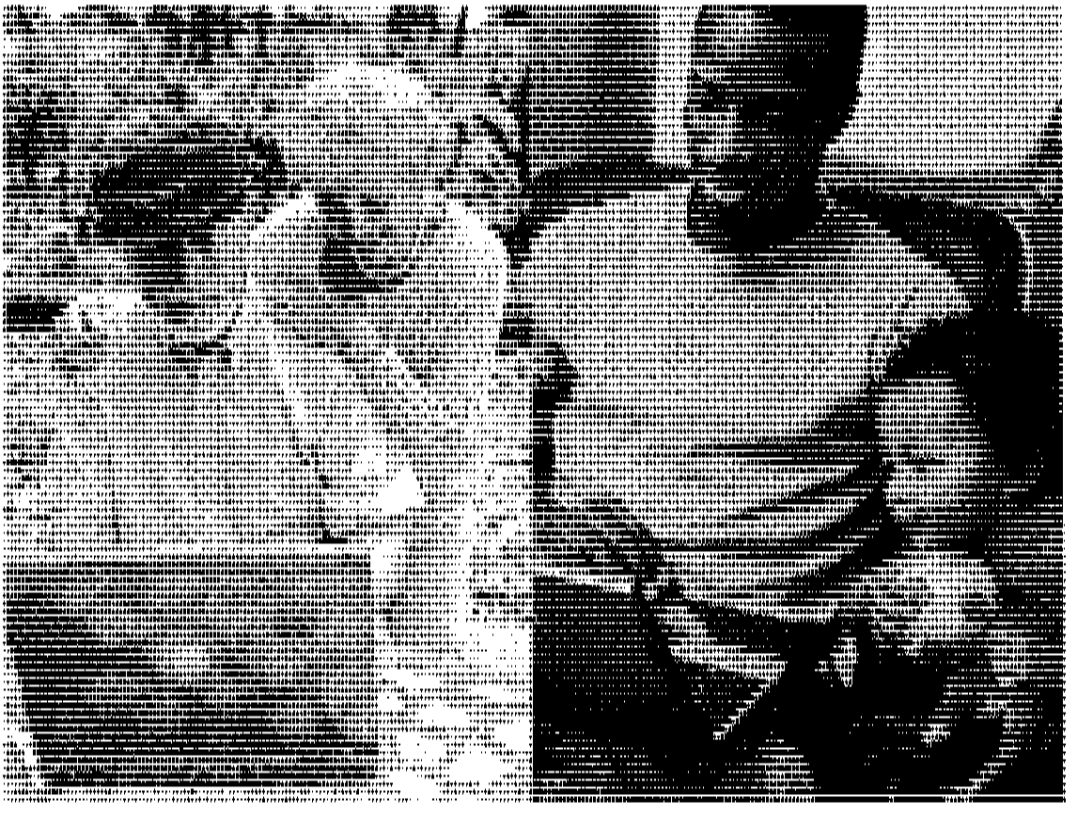
3- The Physician will only prescribe narcotics during the 90 post operative period.

4- It will ultimately be up to the discretion of the Physician as to the type, dose and amount of medication prescribed.

Your signature below confirms that you, the patient, understand and agree to our narcotics prescribing policy

Signature: _____

Date: _____



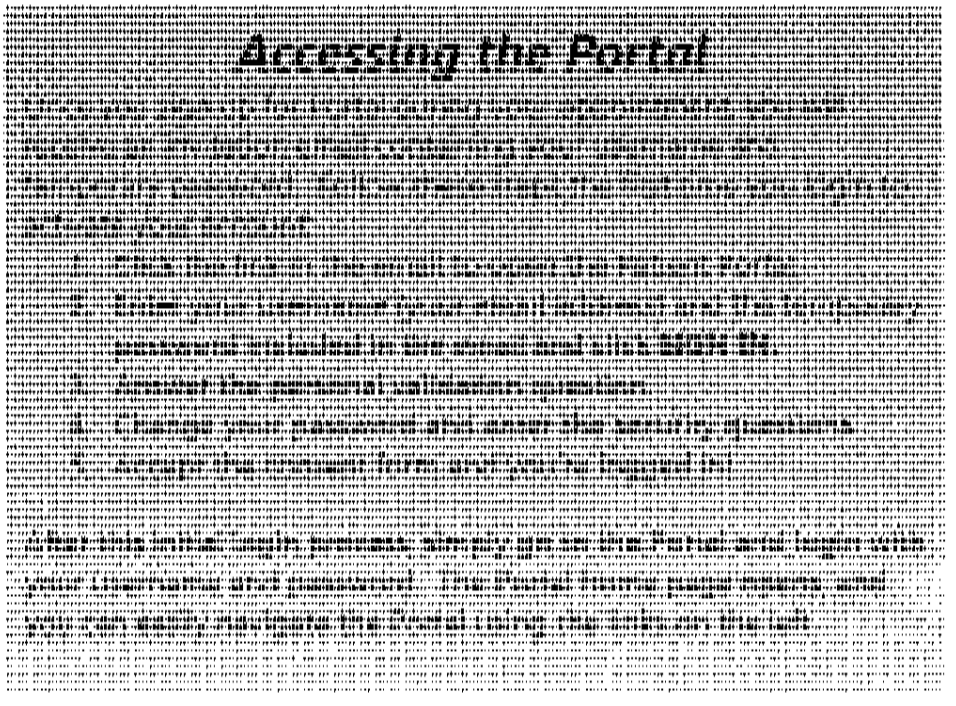
Know your health... know yourself.

We are pleased to offer our patients convenient, secure access to their medical information online. Visit our website and click **Patient Portal.**

The Patient Portal is here!

With the Patient Portal, you can:

- Schedule and keep Track of your appointments.
- Access and view lab results.
- Request medication refills.
- View your personal health record.
- Send and receive messages from clinic staff.



http://orangeparkphysicians.com

Orange Park Medical Center | First Coast Neurology

Orange Park Medical Center | First Coast Neurosurgery

Orange Park Medical Center | First Coast General and Acute Care Surgery

The Patient Portal is not intended to be used in a medical emergency. If you have a true medical emergency, dial 911.