

Patient Registration Form

Janis Black, D.O.

| PATIENT INFORMATION (Person seeing the Doctor today) | | | |
|---|---|--|---|
| Last Name | First Name | Middle Initial | Family Health Center at Port St. John 3740 Curtis Blvd, Suite 108 Cocoa, FL 32927 |
| Home Address (Street, Apt #) | | City | State Zip |
| Mailing Address (if different from home) | | City | State Zip |
| Home Phone Number | Cell Phone Number | | Social Security Number |
| Date of Birth | Gender (M-F) | Emergency Contact (Name of Person to call) | Emergency Phone Number |
| Patient Employer (Company Name) | Work Address (Complete: street, city, state, zip) | | Work Phone Number |
| Referring Doctor (Doctor who referred you to us. If not referred, please write "none" or your Primary Care Physician) | | | Patient Marital Status |
| BILLING INFORMATION (Person responsible for bill; balance bill; not covered by insurance; also called "Guarantor") | | | |
| Name of Person responsible for bill | Home Address (Complete: street, city, state, zip) | | Home Phone Number |
| INSURANCE INFORMATION (Person whose insurance is used for to pay for, to pay for, or to pay for self; also called "Subscriber") | | | |
| Name of First (Primary) Insurance Company | Address of First (Primary) Insurance Company (back of Ins card) | | Insurance Company Phone Number |
| Group Number | Policy Number or Insured Person ID Number | | Relationship to Patient |
| Subscriber Name (Policy holder of Insurance) | Subscriber's Home Address (Complete: street, city, state, zip) | | Subscriber's Home Phone Number |
| Subscriber Date of Birth | Gender (M-F) | Social Security Number | Name of Company where Subscriber works |
| Name of Second Insurance Company | Address of Second Insurance Company | | Insurance Company Phone Number |
| Group Number | Policy Number or Insured Person ID Number | | Relationship to Patient |
| Subscriber Name (Policy holder of Insurance) | Subscriber Home Address (Complete: street, city, state, zip) | | Subscriber Home Phone Number |
| Subscriber Date of Birth | Gender (M-F) | Social Security Number | Name of Company where Subscriber works |

*** Please note: We do not file liability insurance; visits related to accidental injuries must be paid in full. You will be given a receipt to file the liability claims with the insurance for reimbursement.

*** List any person with legal Power of Attorney for you. A copy of the Power of Attorney must be provided for your chart.

(Name of Person with Power of Attorney)

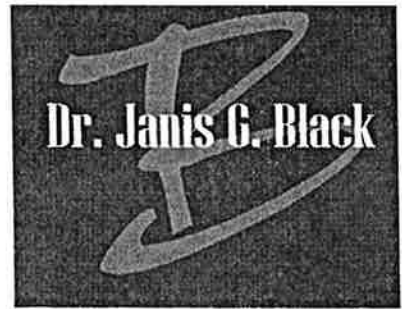
**** I authorize Family Health Center at Port St John to access and view my prescription history from external sources. Signature _____

AUTHORIZATION: I certify that the information given by me in applying for payment under my insurance contract (including Title XVIII of the Social Security Act) is correct. I authorize release to my insurance carrier, employer, and referring physician any information needed including diagnosis and records of any treatment or examination rendered to me to process this claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable or authorize Family Health Center at Port St John to submit a claim to my insurance, including Medicare, for payment on my account. I understand that I will receive monthly statements reflecting my balance and that the FINAL PAYMENT of these accounts remains my responsibility.

(Patient / Legal Guardian's Signature)

(Date)

Family Health Center at Port St John
Dr. Janis G. Black
Taniqua Andrews, APRN
Sarah Crandall, APRN
3740 Curtis Blvd Suite 108
Port St John, FL 32937



Patient Information Form

Please fill out form completely (check no or does not apply), please do not leave questions blank, unless indicated. The more information you provide enables the physician to provide better care.

Name: _____ Today's Date: _____ Age: _____ Marital Status: _____
Email Address: _____ May we email you with Appt reminders? _____
Occupation: _____ Retired? _____
Birth date: _____ Birthplace: _____ Lived outside of US?: _____
Ethnicity: _____ Preferred Language: _____
Who referred you to see the doctor today? _____
What is the reason for today's visit? _____

Past Medical History

Allergies Do you have any food or drug allergies? If so, please list below and describe.

Have you had any reactions to IVP dye used for X-ray studies? ___yes ___no

Medications For any additional medications please continue on back of form.

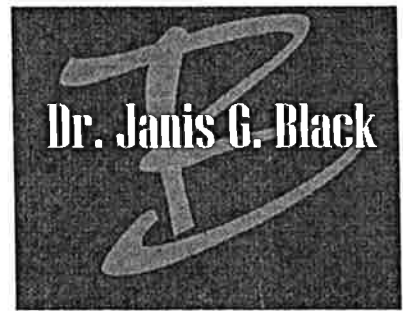
| Name of Medication | Dose | Instructions | Prescribing Physician |
|--------------------|------|--------------|-----------------------|
|--------------------|------|--------------|-----------------------|

| | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Herbs, supplements, vitamins:

Patient Name: _____ Date: _____

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Surgeries:

| Year | Surgery | Hospital | Doctor |
|------|---------|----------|--------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever been advised to have a surgical operation that was not done? Yes No
 If yes, explain. _____

Have you ever had radiation or chemotherapy? Yes No If yes, please explain.

Start Date End Date

| Month | Year | Month | Year | Area Treated | Hospital | Doctor |
|-------|------|-------|------|--------------|----------|--------|
| | | | | | | |
| | | | | | | |

Blood Transfusions Yes No When _____

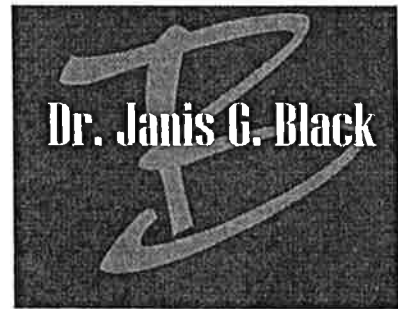
Illnesses (rheumatic fever, polio, TB, hepatitis, meningitis, malaria) _____

Do you see a Specialist (Cardiologist, OBGYN, Pulmonologist, Urologist, etc.)

| Specialty | Doctor's name | Phone/fax | City, State | Last visit |
|-----------|---------------|-----------|-------------|------------|
| | | | | |
| | | | | |
| | | | | |

Patient Name: _____ Date: _____

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Family History

| Relation | Age | High Blood Pressure High Cholesterol Heart Disease/Stroke Heart Attack | Diabetes | Cancer (What kind and age at Diagnosis) | Lung Disease COPD Emphysema | Seizures Neurological Disorders | Mental Illness Suicide Depression Alcoholism | Rheum. Arthriti Lupus | Other Medical Concern | Age at Death |
|----------------------|-----|---|----------|--|-----------------------------------|---------------------------------------|---|-----------------------------|-----------------------------|-----------------|
| <u>M</u> Grandfather | | | | | | | | | | |
| <u>M</u> Grandmother | | | | | | | | | | |
| <u>P</u> Grandfather | | | | | | | | | | |
| <u>P</u> Grandmother | | | | | | | | | | |
| Father | | | | | | | | | | |
| Mother | | | | | | | | | | |
| Brothers | | | | | | | | | | |
| Sisters | | | | | | | | | | |
| Children | | | | | | | | | | |
| Other relatives | | | | | | | | | | |

Personal History

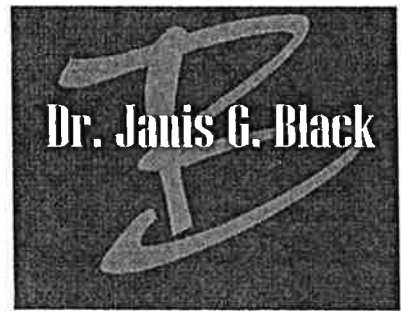
Do you use any medical devices? Check all that apply. glasses hearing aids
 walker wheelchair oxygen Cpap Other _____
 What medical equipment company do you use? _____

Smoking:

Do you currently smoke cigarettes? Yes No
 If yes, are you interested in quitting? Yes No. If not, did you previously? Yes No
 If you stopped, when was it? _____ How many years have you smoked? _____

Patient Name: _____ Date: _____

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During the entire time, what is the average number of packs per day smoked? _____

Do you smoke a pipe or cigars? ___Yes ___No. If yes, how long? _____

Do you or did you use snuff/chewing tobacco? ___Never ___Past ___Current-How Long _____

Alcohol:

Do you drink any alcoholic beverages? ___Current ___Former What kind? _____

How much? ___1-2 ___2-3 ___4+ How often? _____ Daily, Weekly, Weekends, Rarely.

Has it ever interfered with your personal or professional life? ___Yes ___No If yes, explain

Have you ever been treated for this? _____

Drug Use:

Have you ever used illegal/recreational drugs? ___Current ___Past ___Never

If yes, what kind? _____ how often? _____

Have you ever had formal treatment for this? _____

Have you ever been addicted to or abused prescription medication? _____

Women only:

Last Menstrual Period : _____ Might you be pregnant? Yes ___ No ___ Unsure ___

Contraceptive Method None ___ Pills ___ Condoms ___ Surgical ___ Menopause ___ Other ___

Number of times pregnant: _____ # of Deliveries: _____ # of Children _____

Last Pap Smear: _____ Performed By Dr: _____ Results: _____

Prior abnormal Pap? _____ When? _____ Last Mammo? : _____

Action taken for abnormal pap? Repeat exam ___ Cryotherapy ___ Cone ___ LEEP ___ Other ___

Testing:

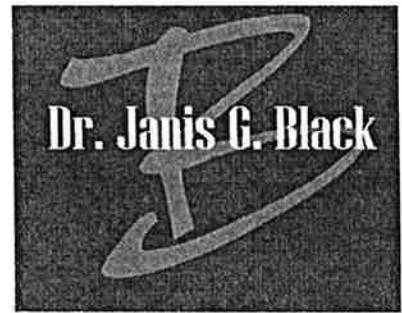
Colonoscopy or Other Bowel or Digestive Studies? (Why, When, Results, When to Repeat?) _____

Stress Test/Cardiac Cath/EKG/Heart Studies? (Why, When, Results, Actions Taken/Advised?) _____

Have you ever had a DEXA scan (Bone Density Scan) done? _____

Patient Name: _____ Date: _____

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Vaccines:

Flu Vaccine? _____ Pneumonia Vaccine? _____

Shingles Vaccine? _____ Tetanus Vaccine? _____

Have you completed your Hepatitis B series? _____

Patient Portal

Have you been given information about our patient portal? ____Yes ____No

Would you like more information about our Patient Portal where you can login and access your lab results, appointment times, and visit summaries? ____Yes ____No

Our office would be happy to provide you with more information about our new Patient Portal and provide you will your login information, please ask our staff.

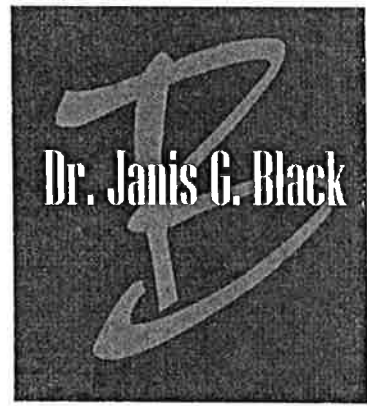
What Three things would you like to discuss with your care provider today?

1. _____
2. _____
3. _____

Thank you for completing this information it will enable us to give you the best possible care.

Patient Name: _____ Date: _____

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(321)633-5500 Fax (321)633-5566



Acknowledgement of receipt of HIPAA notice of privacy practices.

I have received a copy of Dr. Janis Black's HIPAA Notice of Privacy Practices. The notice describes how medical/protected health information may be used and disclosed. I understand that I should read it carefully, I am aware that the notice may be changed at any time. I may obtain a revised copy of the notice by requesting one from Dr. Black or her staff.

Initial below:

_____ I am accepting a copy at this time.

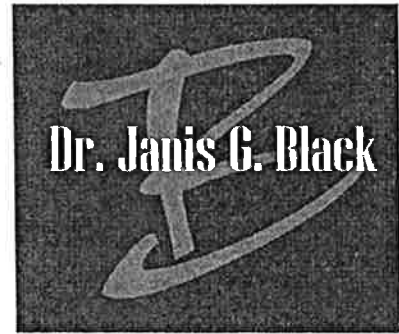
_____ I am refusing a copy, but am aware that I can request a copy at any time.

If you have any questions regarding our HIPAA Policy please feel free to ask our staff.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Advance Directives

(For compliance with the patient self determination)

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Have you executed an Advance Directive? _____ Yes _____ No

If yes, is this directive in the form of:

(Circle your answer)

- Living Will
- Durable Power of Attorney
- Healthcare Surrogate

If you executed Advance Directives in any of these forms, have you provided this office with a copy for your medical records? _____ Yes _____ No

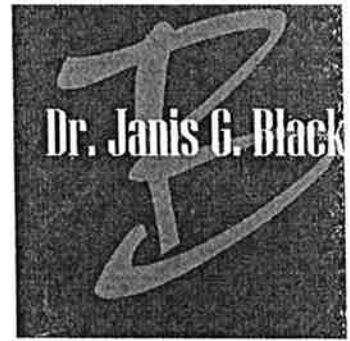
If you would like more information regarding Advance Directives, please speak to our staff.

Patient Name: _____ Date: _____

Patient Signature: _____

Witness Signature: _____ Date: _____

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Authorization to release health information

Patient name: _____ Date of Birth: _____

Address: _____ Phone: _____

I Authorize: _____

Address: _____ Phone: _____

To release the following health records:

_____ Complete health record _____ Consultation reports _____ EKG/Cardiac Testing
_____ History and Physical _____ Progress Notes _____ Labs/X-ray Reports
_____ Medication list _____ Immunizations _____ Other

In compliance with Florida Statutes which require special permission to release otherwise privileged information, please release records pertaining to: **(PATIENT MUST INITIAL)**

_____ HIV/AIDS results _____ Substance abuse/treatments _____ Developmental disabilities

Purpose of need for disclosure:

_____ Further Medical Care _____ Payment of Claim _____ Legal _____ School
_____ Application for Insurance _____ Disability Claim _____ Personal _____ Other

Please release this information to:

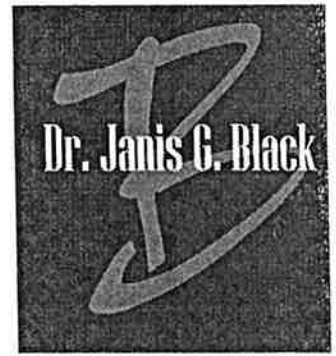
**Family Health Center at Port St. John
3740 Curtis Blvd. Suite 108
Port St. John, Florida 32927
Phone: (321) 633-5500 Fax: (321) 633-5566**

I am aware that the release of information carries the potential for an authorized re-disclosure and the information may not be protected under federal confidentiality laws. I may contact the number above with any questions or concerns regarding my health information.

I understand that this authorization expires in 90 days and that I may revoke it at any time.

Patient Name _____ Date _____
Witness Name _____ Date _____

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No Show, Late Cancellation, and Unconfirmed Appointment Notice

Due to the high demand for appointments and the number of no shows and late cancellations, The Family Health Center at Port St. John has had to institute a policy regarding these broken appointments.

No shows and Late Cancellations waste the doctors' limited appointment availability. They adversely affect the care provided to our patients by wasting appointment times that would otherwise be used by sick patients or patients who are requesting to be seen sooner.

If you are unable to make your appointment, you will need to cancel by calling the office at least 24 hours in advance of your scheduled appointment time so that the time-slot can be used for another patient. Failing to do so may result in a fee being billed to your account in the amount of **\$50.00. This fee is subject to change. This fee is not covered by insurance and the patient is responsible for paying this before their next appointment.** You may cancel your appointments by calling our office at 321-633-5500. If it is after business hours you must leave a detailed message about your cancellation.

Our office makes two attempts to confirm your appointment by calling 48 hours prior and again 24 hours prior. You are responsible for verbally confirming your appointment with our office. If you are unable to call until after hours, please leave a detailed message confirming your appointment. Failing to do so may require us to reschedule your appointment to a later date.

Consecutive no shows or late cancellations will result in discharge from the practice, as we are unable to properly provide the quality of care that is necessary when appointments are not kept.

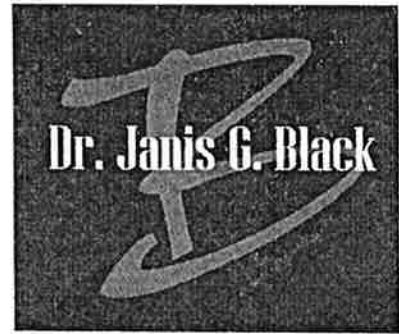
Your signature below indicates that you understand the policy, and agree to be responsible for no show appointments, late cancellations, and unconfirmed appointments.

Patient Name _____ Date _____

Patient Signature _____

Witness Signature _____

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Authorization to disclose health information

Patient Name: _____ DOB: _____

Address: _____ Date: _____

I authorize the Family Health Center at Port St John to share my personal health information, such as test results, medications, appointment times, and other details in relation to my care with the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that certain information relating to my health such as HIV/AIDS status, behavioral health services and psychiatric care, and drug and alcohol treatments will not be disclosed without my written permission.

I also understand that I have the right to revoke this authorization at any time. Unless revoked, this authorization will not expire. If I have any questions about the disclosure of my health information, I can contact Dr Black's office at (321) 633-5500.

Patient signature: _____ Date: _____

Witness Signature: _____ Date: _____