Brinson Family Medicine

Ashton C. Brinson, MD
695 Douglas Avenue
Altamonte Springs, FL 32714

Patient Registration Form

Reason for today's visit: _____ **Describe Pain Level:** (lowest) 1 2 3 4 5 6 7 8 9 10 (highest)
If this is an injury, is it work related? YES NO (circle one) **Auto Accident?** YES NO (circle one)

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Male: _____ Female: _____ Date of Birth: _____ SSN: _____ Marital Status: _____
Race: _____ Ethnicity: _____ Preferred Language: _____

CONTACT INFORMATION

Please enter the information below and indicate your preferred means of contact and message permission. Please leave a detailed message including patient information at ____ home ____ mobile ____ work ____ none.
Home Phone: _____ Mobile Phone: _____ Work Phone: _____
Email: _____ Emergency Contact: _____
Relation to Patient: _____ Emergency Contact Phone: _____

INSURANCE AND RESPONSIBLE PARTY INFORMATION *(if different from above)*

We will obtain your insurance information from your insurance card. Please provide us with this additional information.

Primary Insurance Information

Insurance Company Name: _____ ID #: _____ Group #: _____
Insurance Subscriber's Name: _____ Subscriber's Date of Birth: _____
Patient's Relationship to Subscriber: _____ Subscriber's SSN: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Secondary Insurance Information

Insurance Company Name: _____ ID #: _____ Group #: _____
Insurance Subscriber's Name: _____ Subscriber's Date of Birth: _____
Patient's Relationship to Subscriber: _____ Subscriber's SSN: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Mobile Phone: _____ Work Phone: _____

REFERRAL INFORMATION

How did you hear about us? Advertising: ___ Physical Referral: _____ Word of Mouth: . Google: _____ Insurance Company: ____
Hospital: _____ Family/Friend is a patient here: _____ Other: _____

FINANCIAL RESPONSIBILITY

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that certain insurance claims may be filed as a courtesy, however, if for any reason the claim is denied, I am responsible for payment. Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and other pay a percentage of the charge. I understand my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance or third-party payer within a period not to exceed 60 days.
THERE WILL BE A $25.00 NO SHOW FEE BILLED TO THE PATIENTS ACCOUNT FOR ANY FAILURE TO NO SHOW FOR THEIR SCHEDULED APPOINTMENT. WE REQUIRE A 24 HOURS NOTICE. THIS FEE WILL BE COLLECTED BEFORE THE PATIENT CAN BE SEEN, ALONG WITH ANY ADDITIONAL CO-PAY OR PAYMENT DUE FOR THE CURRENT VISIT. There is a $25 fee for all Forms & Prior-Autho.

_____ _____
Patient/Guardian Signature **Date**

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Acknowledgement of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third party payers (insurance).
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Brinson Family Medicine has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I further understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not legally required to agree to my requested restrictions, but if you are in agreement then you are bound to abide by such restrictions.

Consent for Treatment

I _____, hereby consent for treatment at this facility for either myself or my minor child (or another person for whom I have medical power of attorney) listed below.

I understand that all treatments or even lack of treatment carries certain risks and benefits. I understand that the doctor at Brinson Family Medicine will help me to understand the benefits and common risks of any recommended treatment. It is my responsibility to request further information if there is anything about the risks and benefits that I do not understand. I agree to read any written material provided by the Doctor and/or the pharmacist regarding any medication that I may have now or have had in the past and will notify the Doctor promptly of any changes in my medical condition.

I understand minor procedures involving injections, scraping, cutting, and sewing may lead to some side effects such as pain bruising, bleeding, scarring or infection in spite of our best efforts to prevent those effects. Although these risks of any minor procedures in the office may be reviewed prior to such procedure, this constitutes my acknowledgement of the inherent risks of any such procedure.

Signature of Patient (Parent, Guardian or Spouse): _____ **Date:** _____

Individuals we may discuss your health records and care with:

Physicians: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Office Use Only

I attempted to obtain the patient's (healthcare surrogate) signature in acknowledgement of Notice of Privacy Practices, but was unsuccessful in doing such as documented below:

Date: _____ Initials: _____ Reason: _____

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Patient Name: _____ **Date:** _____

MEDICAL HISTORY (please check) ☐ No medical history

__Environmental Allergies __COPD __Heart Attack __Osteoporosis
__Anemia __Coronary Artery Disease __Hepatitis __Stomach Ulcers
__Angina __Crohn's Disease __High Cholesterol __Stroke/CVA/TIA
__Anxiety __Enlarged Prostate __Hypertension __Seizures
__Asthma __Depression __Irritable Bowel Disease __Tuberculosis
__Atrial Fibrillation __Diabetes __Kidney Disease __Thyroid Disease
__Blood Clots __Gallbladder Disease __Liver Disease __Other: _____
__Cancer: _____ __GERD/Acid Reflux __Migraine Headaches

SURGICAL HISTORY (please check) ☐ No surgical history

__Angioplasty __CABG (Heart Bypass) __Inguinal Hernia Repair __Pacemaker
__Appendectomy __Carpel Tunnel Release __Hip Replacement __Small Bowel Resection
__Arthroscopic Knee __Gallbladder __Knee Replacement __Surgical Fracture Repair
__Back Surgery __Gastric Bypass __Liver Biopsy __Tonsillectomy
__Other: _____

SOCIAL HISTORY (please circle)

Smoker? Current Smoker Previous Smoker Never Smoked Occasionally
Drinker? Yes No Occasionally **Drugs?** Yes No Occasionally

MALES ONLY (please check) ☐ No surgical history

__Prostate Biopsy __TURP (Prostate Resection) __Vasectomy __Other: _____

FEMALES ONLY (please check)

Last menstrual period: _____ /_____ /_____
__Tubal Ligation
__Breast Augmentation
__Breast Reduction
__Other: _____

Nursing? Y N
__No periods yet
__D & C
__Breast Biopsy
__Cesarean Section

Pregnant? Y N
__No longer having periods
__Hysterectomy
__Mastectomy
__Uterine Fibroid Removal

FAMILY MEDICAL HISTORY (please check) ☐ No family history

__Heart Attacks __Stroke/CVA/TIA __Diabetes __High Cholesterol
__Cancer: _____ __Asthma __Hypertension __Other: _____

MEDICATIONS

☐ I do not take any medications

ALLERGIES

☐ No known drug allergies

Name of medication and dosage	How often taken	Name of medication allergic to	Reaction caused by medication

Pharmacy: _____ **Phone:** _____ **Address:** _____

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Patient Health Questionnaire (PHQ-9)

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Circle the number that indicates your answer.

Problem	Not at All	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could notices. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3
ADD COLUMNS				
TOTAL [ ]				

Scoring: Sum the values for the nine items. Range 0-27.

Depression Severity:

0-4 None
5-9 Mild
10-14 Moderate
15-19 Moderately Severe
20-27 Severe

10.	If you checked off *any problems*, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Source: Spitzer, R., et.al. Utility of a new procedure for diagnosing mental disorders in primary care. The PRIME MD 1000 study. Journal of the American Medical Association. 1994; 272: 1749-1756.