FM Medical Inc.
3560 A1A South
St Augustine, Fl 32080
Patient Registration

Last Name			Primary Care Physician/Referring Physician
First Name		MI	Email Address
Previous Name	Date of Birth (mm/dd/yyyy)		Social Security Number
Address			Gender □ Male □ Female
City			Marital Status □ Single □ Divorced □ Married □ Widowed
State	Zip	County	Race : □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Other Pacific □ Black or African American □ White □ Hispanic □ Other □ Refuse to report
Home Phone	Cell Phone		Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Refuse to report
Work Phone	Ext.		Preferred Pharmacy

Responsible Party or Guarantor (If under 18 years of age)

Last Name		Relation		
First Name	MI	Address		
Home Phone	Cell Phone	City	State	Zip

Patient Employer Information

□ Employed □ Retired □ Full-time Student □ Part-time Student □ Disabled □ Unemployed

Employer Name		Occupation		
Address	City	State	Zip	Work Phone

Insurance Information

Primary Insurance Company Name	Subscriber's Name	Subscriber's Date of Birth
Subscriber's Social Security/ID Number	Subscriber's Address	Subscriber's Home Phone
Secondary Insurance Company Name	Subscriber's Name	Subscriber's Date of Birth

In Case of Emergency

Name of local friend or relative	Relationship:	Home # Cell #

Patient Request for Confidential Communications

Patient Name: ____

Patient Date of Birth: _____________________________________ Patient SSN: _______________________

This is a request for confidential communications of my protected health information (PHI). When the doctor, nurse or other members of your office want to contact me please use the following guidelines. I understand that you will do your best to adhere to the following requests.

Please check all that apply to this request:

_____ When contacting me by phone it is ok to leave messages and discuss my health information with:

Name:_________________________________Relationship________________

Name: _________________________________Relationship ________________

May we speak with the above named person(s) regarding your billing/payment information? ____________________

Advanced Directive Planning

Do you have an Advanced Directive? ☐ Living Will ☐ Power of Attorney ☐ DNR ☐ I do not have an Advanced Directive

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by this office and its associated physicians, clinicians and other personnel. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantee has been made as to the result of treatments or examinations.

Assignment of Benefits and Patient Responsibility

I certify that the information on these forms is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay bills at time of service unless other arrangements are made. I authorize my insurance claim to be paid directly to the clinic. I further understand that my health care insurance carrier or payor of my health benefits may pay less than the actual bill for services, and all second opinion and pre-admission review requirements are ultimately my responsibility.

Signature of Patient (or patient's personal representative):____

Relationship of representative to patient: ____

Date: ______________________________

FM Medical

Scott Michaels M.D.

ST AUGUSTINE
3560 A1A South
Saint Augustine, FL 32080
Ph: 904-5842273
Fax: 904-429-9783

Notice of Privacy Practices Acknowledgment Form HIPAA

I acknowledge that I have received a copy of the **FM Medical** Notice of Privacy Practices and have had an opportunity to review it. I have also been given an opportunity to request restriction on the use and disclosure of my protected health information, as well as to request confidential treatment of communications relating to my health information.

1. ____

Patient acknowledgement (Signature) Date

Consent for Purposes of Treatment, Payment and Health Care Operations

I understand that, as a condition to my receiving treatment from **FM Medical**. The **FM Medical** may use or disclose my personally identified health information for treatment obtained for payment for the treatment provided and as otherwise necessary for the operations of **FM Medical**.or FM Medical Urgent Care. Use disclosures are more fully explained in the Notice of Privacy Practices that has been provided to and reviewed by me.

While I am here, I permit the employees, the doctor and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition, his or her recommended treatment and any associated risk involved. I also understand that he or she will explain to me other ways this condition could be treated. I further understand that this care may include diagnostic testing, examinations, and medical and/or surgical treatment, and that no guarantees have been made to me about the outcome of this care.

"Personally identifiable health information" refers to health and demographic information collected about me by my physician (or other health care provider, public health authority, health plan, employer, life insurer, school or university, or health care clearinghouse) that relates to my past, present or future physical or mental health or condition or payment for provision of health care. The information identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand the privacy practices described in the Notice of Privacy Practices may change over time and that I have a right to obtain any revised Privacy Notice by contacting **FM Medical** to make such a request. I may receive a revised Notice of Privacy Practices by calling the office and requesting a revised copy by mail or by asking for one at my next visit.

I also understand that I have the right to request **FM Medical** trestrict how my health information is used or disclosed. **FM Medical** does not have to agree to my request for the restriction, but if **FM Medical** does agree, **FM Medical** is bound to abide by the restriction as agreed. Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that **FM Medical** has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment could be withdrawn if I withdraw my consent.

2.____

Signature Date

Financial Policy

I have read and understand the Financial Policy and agree to all provisions outlined.

Signature of Patient (or patient's personal representative):____ Date:_________

FM Medical

Scott Michaels M.D.

ST AUGUSTINE
3560 A1A South
Saint Augustine, FL 32080
Ph: 904-584-2273
Fax: 904-823-9394
FMMedical.org

Medical Records Release

To ensure that your medical records are held in the utmost confidentiality, please be as explicit as possible as to where you want them sent.

Name ____

Address ____

Street City State ZIP

Home phone ________________________ **Work phone** ______________________

Date of birth ________________________

Please transfer my medical records* as follows:

From: ________________________ To: ________________________

________________________ ________________________

________________________ ________________________

________________________ ________________________

***Records to be released**:

__ Annual exam and Pap smear / Prostate
__ Labs/X-Ray
__ Birth control
__ Abortion care
__ All medical records
__ Other ___________________________________

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

Please initial below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked.

_____ Drug and/or alcohol abuse, diagnosis or treatment
_____ HIV/AIDS testing and/or treatment
_____ Psychiatric care and/or mental illness
_____ Confirmed sexually transmitted infection test results and/or treatment

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

____

ST AUGUSTINE
165 Southpark Blvd
Saint Augustine, FL 32086
Ph: 904-823-8833
Fax: 904-823-9394
FMMedical.org

FM Medical

Scott Michaels M.D.

PAST MEDICAL HISTORY: Please check if you have ever had any of the following:

- Diabetes
- Obesity
- Overweight
- High Blood Pressure
- Heart Disease
- High Cholesterol
- Hyperlipidemia
- Coronary Artery Disease
- Hepatitis A
- Tuberculosis
- Blood Disorder
- Thalassemia
- Sickle Cell
- Turners Syndrome
- Klinefelter's Syndrome
- G6PD
- Congenital Heart Defect
- Anemia
- Gastroparesis

- Rheumatoid Arthritis
- Lupus
- Scleroderma
- Reflux Disease
- Peptic Ulcers
- Crohn’s Disease
- Ulcerative Colitis
- Kidney Stones
- Kidney Disease
- Lung Cancer
- Stomach Cancer
- Colon Cancer
- Breast Cancer
- Skin Cancer
- Leukemia
- Other Cancer
- Raynaud’s
- Sleep Apnea
- Thyroid Disease
- Diverticulitis
- Appendicitis
- Gallbladder disease

- COPD
- Emphysema
- Asthma
- Pleurisy
- Pulmonary Fibrosis
- Empyema
- Rib Fractures
- Hemorrhoids
- HIV
- AIDS
- Hepatitis B or C
- Preeclampsia
- Gestational Diabetes
- Migraine Headache
- Measles
- Mumps
- Rubella
- Varicella Shingles
- Chicken Pox
- Cushing's disease
- Crohn’s disease
- Diabetes Insipidus

- PMS
- Urinary Tract infections
- Fibroids
- Endometriosis
- Back Pain
- Cystic Fibrosis
- SLE Lupus
- Scleroderma
- Psoriasis
- Eczema
- Bells’ Palsy
- Stroke
- TIA
- Normal Pressure Hydrocephalus
- Seizure Disorder
- Myasthenia Gravis
- Cerebral Palsy
- Temporal /Giant Cell Arteritis
- Polio
- Vitamin D Deficiency

- Depression
- Anxiety
- Schizophrenia
- Bed Wetting
- Night Terrors
- Narcolepsy
- Alcoholism
- Drug Addiction
- Personality Disorder
- PAD
- ADD
- ADHD
- Parkinson’s Disease
- ALS
- Alzheimer’s disease
- Essential Tremor
- Brain Injury

SURGICAL HISTORY: List all operations below

Procedures/Operations	Year

MEDICATIONS:

START date	Medication	Dose	Times taken per day	Quantity	STOP DATE

ALLERGIES: List all allergies and any reactions that you have had

Allergy	**Reaction Hives, Anaphylaxis:, Vomiting, etc.**

FAMILY HISTORY: List chronic health diseases in your family i.e., heart disease, diabetes etc.…

MOM	DAD	SIBLINGS	MATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	1st Cousin

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SOCIAL HISTORY:

SMOKER yes or no	Number Packs per day	How many years
ALCOHOL INTAKE yes or no	Number Drinks per Day	How many years
NON PRESCRIPTION DRUGS		
OCCUPATION		

FAMILY HISTORY: List chronic health diseases in your family i.e., heart disease, diabetes etc.…

MOM	DAD	SIBLINGS	MATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	1st Cousin

SHOW US WHERE IT HURTS

Case# _____________ Name: ____________________________ Date: __________

Please mark the area(s) of injury or discomfort as shown in the example below.

Mark all areas with the appropriate symbols and indicate the degree of pain using a

scale from 1 (discomfort) to 10 (extreme pain).

Description:	Numbness	Pins & Needles	Burning	Aching	Stabbing	Dull
Symbol:	NNN	PPP	BBB	AAA	SSS	DDD