# PATIENT REGISTRATION FORM

Patient Name

First Middle Last

Date of Birth / /

|  |  |
| --- | --- |
| **Self**Mailing Address Street Address City State Zip Home Phone Cell Phone Email Address SSN Ok to Leave Message? Home Cell Both | **Primary Insurance**Insurance Name Mailing Address City State Zip Phone Number Subscriber ID Group ID Co-Pay Deductible Subscriber Name Date of Birth SSN  |
| **Guarantor (Responsible Party)** | Relation to Patient  |
| Name Relation Address City State Zip Home Phone Cell Phone Date of Birth SSN  | **Secondary Insurance**Insurance Name Mailing Address City State Zip Phone Number Subscriber ID Group ID Co-Pay Deductible Subscriber Name Date of Birth SSN Relation to Patient  |
| **Employer**Company Name Phone Number Ok to Leave Message? Yes No |
| **Primary Care Physician** | **Emergency Contact** |
| Name Office Phone Fax  | Name Relation Home Phone Cell Phone  |
| **Referring Physician** | **Pharmacy** |
| Name Office Phone Fax  | Pharmacy Name Phone Number  |

# MEDICATION AND ALLERGIES LIST

Patient Name

First Middle Last

Date of Birth / /

# Please list all medications that you are currently taking and allergies you may have.

**Name of Medication: (i.e. Advil) Strength/Type (i.e. 800mg tablet) How taken: (i.e. orally) How often: ( i.e. 3 x day )**

**MEDICATIONS (include over the counter/dose) Please provide list if available.**

# ALLERGIES (medications or food)

Patient Name

# PATIENT INTAKE FORM

First Middle Last

Date of Birth / /

Weight

Height

Is this weight typical for you? Yes

No

Reason for Visit

Is Visit Accident Related? Yes

No

Work Related? Yes

No

Date of Accident/Onset When and how did this problem start?

# SOCIAL HISTORY

**Tobacco Use:**

Are you a current tobacco user? O Yes O No Are you a former tobacco user? O Yes O No

If yes, how often: O Every day O Some days but not everyday

If yes, how many days? O 5 or less O 6-10 O 11-20 O 21-30 O greater than 30 What kind of tobacco? O Cigarettes O Cigars O Chewing Tobacco

**Alcohol Intake:**

Do you drink alcohol?O yes O no

Did you drink any within the past year? O yes O no

If yes, how often? O less than monthly O 2 to 4 times a month O 2 to 3 times a week O > 4x weekly

**Illegal/Illicit Substances:**

Do you use illegal/illicit substances? O yes O no

If yes, what types(s)? O Marijuana O Narcotics O Cocaine O Other

**Marital Status:**

Are you: O Single O Married O Divorced O Widowed O Partnered

Patient Name

# SURGICAL HISTORY

First Middle Last

Date of Birth / /

# Please list all previous surgeries including approximate month and year.

**Please List any Family Medical History**

Patient Name

# PAST MEDICAL HISTORY

First Middle Last

Date of Birth / /

Anxiety Anemia Arthritis

**Please completely BUBBLE IN your answers in the circles provided.**

O Yes O Yes O Yes

Atrial fibrillation Bipolar disorder Blood Clots Cardiac arrhythmia

Congestive heart failure Coronary artery disease

Cancer (Location)

O Yes O Yes O Yes O Yes O Yes O Yes O Yes

Chronic obstructive pulmonary disease (COPD) O Yes

Dementia Depression Diabetes, type I Diabetes, type II

Diabetes, gestational (during pregnancy) Esophageal reflux

Headaches

Myocardial infarction (heart attack) Hyperlipidemia (high cholesterol) Hypertension (high blood pressure) Kidney stones

Migraine headaches Osteoporosis Prostate cancer

Peripheral vascular disease

O Yes O Yes O Yes O Yes O Yes O Yes O Yes O Yes O Yes O Yes O Yes O Yes O Yes O Yes O Yes

Stroke (CVA cerebrovascular accident) O Yes

# FINANCIAL CONSENT

**Patient Name: DOB: Date:**

I hereby authorize said assignee to release all information necessary to secure payment. I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services or authorize such physician to submit a claim to the above insurance company for payment to me.

I understand that I am financially responsible for all charges whether or not paid by my insurance, including any deductible and co-pays, and that payments are due at the time services are rendered.

I understand and agree that in the event that I fail to make payments for services rendered to me, my name and account may be turned over to an attorney or a collection agency, and I agree to pay collection agency’s fees for collection, court costs, and/or reasonable attorney’s fees that may be incurred in the collection of any outstanding balance. I authorize the physician to release any information necessary to allow payment of any claim or any information acquired in the course of my examination or treatment to my referring physician. I understand and agree if I do not keep my appointment or fail to give a 48-hour notice of appointment change I will be charged a

$25 charge. This charge is not covered by insurance.

# Patient Signature: Date:

**PRIVACY CONSENT**

I have been provided with a copy of the practice’s Notice of Privacy Practices.

# Patient Signature:

**Date:**

**CONSENT FOR TREATMENT**

I hereby voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedures I understand that I am under the care of supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of the physician(s).

# Patient Signature: Date:

**CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY**

I hereby voluntarily consent to the rendering of care, to view my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

# PRESCRIPTION DRUG POLICY

**Patient Name: DOB: Date:**

The law requires responsible usage of prescription drugs by physicians and patients. If you accept a prescription from Dr. Mixa, you are also accepting the responsibly to use the drug for yourself and only in the prescribed manner. Our responsibility is to prescribe medications in an appropriate dosage and amounts, with clear instructions. We will also inform you of the reasons we are prescribing the drug, the expected benefits from its use, and the major precautions and side effects. We will answer any questions you may have about the prescription drug you are being given.

Prescription drugs have potential for abuse and are regulated closely by the state and federal agencies. Certain more closely controlled drugs (narcotic pain medications and tranquilizers) require even more responsibility on your part. We accept NO excuse for their loss or theft and will not order replacements. We will not prescribe them if you are using them other than exactly as prescribed or receiving them from another source. We expect you to notify our office if you change drug stores, so that the order at the first store may be canceled.

Many prescription drugs are appropriate for short-term use only. If and when we feel it is not in your best interest to continue on a medication, we will tell you. If we cannot agree about your continued use of a substance, then we will require additional consultation with other specialists to help decide on the correct course of action.

Our office also requires a 24-48 hour call-in policy for the refill of your prescription. When your medications are getting low and you feel you need a refill, please call our office with the name of your pharmacy and the pharmacy phone number 24-48 hours prior so that we will have sufficient time to confirm your medication and then to call your prescription into your pharmacy.

Failure to follow these policies will force our office to terminate our professional relationship and may require us to file a report with the Department of Professional Regulation (DPR) or call the local police.

If you are in agreement with all the information that has been provided above, please sign your acceptance to abide by these policies.

# I agree to the following guidelines:

1. I will take any medications only as prescribed and I will not change the amount or the frequency without authorization from my physician.
2. I understand that due to the high potential for abuse and these medications, the following rules apply: I will NOT be allowed to obtain early refills or receive replacement of lost or stolen medication. Refills will be provided during regular office hours.
3. If another provider prescribes additional medications, I will notify my primary care physician as soon as possible.
4. I will submit to random urine or blood tests if requested by my physician to assess my compliance.
5. If I do not follow these guidelines, I understand that my treatment may be terminated.

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

**Patient Name: DOB: Date:**

I hereby authorize my medical records to:

**Thomas Mixa M.D., P.A.**

**1609 Pasadena Ave S. Suite 1 A**

**South Pasadena, Fl. 33707**

, Medical Records Department, to release

This request and authorization applies to:

* Healthcare information relating to the following treatment, condition, or dates:
* All Healthcare Information
* Other:

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes simples, human papilloma virus, wart, genital wart, condyloma, Chlamydia, nonspecific urethritis, syphilis VDRL, Chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

* Yes  No I authorize the release of STD results, HIV/AIDS, testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above. I understand that the person listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
* Yes  No I authorize the release of any records regarding drug alcohol, or mental health treatment to the person(s) listed above.