

Florida Coast Surgical

Darren L. Peterson, MD, FACS

PATIENT REGISTRATION FORM

Name: _____ Date: _____
 DOB: _____ SSN#: _____ Male: ___ Female: ___
 Mailing Address: _____
 City: _____ State: _____ Zip: _____ Telephone #: _____
 Alternate Phone #: _____ E-Mail address: _____
 Marital Status: _____ Spouse's Name: _____ Spouse's Occupation: _____

Responsible Party—ONLY IF NOT THE PATIENT

Name: _____ DOB: _____ SSN#: _____
 Mailing Address: _____
 City: _____ State: _____ Zip: _____ Telephone #: _____
 Relationship to Patient: _____

Employment Information

Employer: _____ Office Telephone #: _____
 Occupation: _____

Primary Insurance

Name: _____ ID#: _____ Group#: _____

Secondary Insurance (If applicable)

Name: _____ ID#: _____ Group#: _____

Emergency Notification/Next of Kin

Name: _____ Relationship to Patient: _____
 Telephone #: _____

Dr. Peterson and/of staff may discuss my medical condition with the following:

Name: _____ Relationship to Patient: _____
 Name: _____ Relationship to Patient: _____

Release of Information/Assignment of Benefits

I authorize the release of any medical information necessary to process my insurance claim. I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I understand and agree that regardless of my insurance status I am responsible for any balance of my account.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES.

We accept VISA and MasterCard for your convenience. Planned method of payment:

- Cash VISA MasterCard

 Patient Signature or Responsible Party

 Date



FLORIDA COAST SURGICAL

DARREN L. PETERSON, MD, FACS

Florida Hospital
 Memorial System
 61 Memorial Medical
 Parkway, Ste. 2815

Phone: (386) 586-1850
 Fax: (386) 586-1851
 www.floridacoastsurgeons.com



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PERSONAL INFORMATION & MEDICAL HISTORY-PAGE 1

Date: _____

Patient's Name: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Reason for visit:

Primary Care Physician:

Consult Requested By:

Medical Problems:

Treating Physician

Previous Surgical Procedures:

Surgeon:

Month/Year

Current Medications: (Dose and Frequency) - Continue on back as necessary

Treating Physician

List All Medication Allergies:

Social History:

Tobacco:	Packs per Day:	How long?	Quit/When?
Alcohol:	# Drinks per Day/Week		
Married / Single	Occupation:		



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FAMILY, SOCIAL, & SYSTEMS HISTORY—PAGE 2

Date: _____

Patient's Name: _____

Family Medical History: (Note Mother, Father, Brother, or Sister next to each):

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Renal Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> Ulcerative Colitis / Crohn's Disease
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Uterine Cancer	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Other _____

Female Patients Only:

Last Menstrual Cycle: _____ Age cycles started: _____	Are you taking any hormonal therapies? (i.e. Estrogen, Tamoxifen, Arimidex) NO YES
Do you think/know you are pregnant? NO YES	Post Menopausal? NO YES If YES, at what age? _____
Age at your first pregnancy: _____	Previous breast biopsy? NO YES Diagnosis: _____
Number of pregnancies: _____ Number of children: _____	Have you had a hysterectomy? NO YES — Total / Partial

Medical Problems: (Check all that apply):

General Symptoms:

<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Easily fatigued	<input type="checkbox"/> Skin changes	<input type="checkbox"/> Recent weight loss — lbs/mo _____
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Head and Neck:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Neck masses	<input type="checkbox"/> Facial drooping	<input type="checkbox"/> Previous head injury	<input type="checkbox"/> Sleep apnea
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Eyes and Ears:

<input type="checkbox"/> Blurring	<input type="checkbox"/> Double vision	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Temporary blindness
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Endocrine

<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Infertility	<input type="checkbox"/> Irregular menses	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Thyroid enlargement/pain
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Breasts:

<input type="checkbox"/> Pain	<input type="checkbox"/> Tenderness	<input type="checkbox"/> Lumps	<input type="checkbox"/> Nipple discharge	<input type="checkbox"/> Yearly mammograms	<input type="checkbox"/> Frequency of self breast exams _____
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Lungs:

<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Lung blood clots	<input type="checkbox"/> Use of home O ₂ _____ L/min
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Cardiovascular:

<input type="checkbox"/> Chest pain	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Previous heart attack	<input type="checkbox"/> Claudication (pain in calves with walking)
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Gastrointestinal:

<input type="checkbox"/> Reflux (heart burn)	<input type="checkbox"/> Bleeding ulcers	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Constipation/Diarrhea	<input type="checkbox"/> Changes in stool (clay, tarry, mucus, blood)
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Genitourinary:

<input type="checkbox"/> Pain with urination	<input type="checkbox"/> Groin Hernias	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Flank or pubic pain
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Hematologic/Lymphatic:

<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Previous transfusions	<input type="checkbox"/> Enlarged/tender lymph node
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Musculoskeletal/Neurologic:

<input type="checkbox"/> Joint pain	<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Seizures	<input type="checkbox"/> Tremors	<input type="checkbox"/> Weakness or paralysis	<input type="checkbox"/> Syncope (fainting spells)
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Psychiatric:

<input type="checkbox"/> Depression	<input type="checkbox"/> Mood changes	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Sleep disturbances	<input type="checkbox"/> Suicidal thoughts	<input type="checkbox"/> Bipolar disorder
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PATIENT PRIVACY PRACTICES

By signing this Written Acknowledgement of Receipt of Notice of patient Privacy Practices ("Acknowledgement"), I hereby expressly acknowledge my receipt of Notice of Patient Privacy Practices.

Patient or Legal Representative Signature

Printed Patient or Legal Representative Name (or label)

Date

Acknowledgement NOT obtained because:

_____ Patient or legal representative declined Notice of Patient Privacy Practices

_____ Other (briefly describe): _____

Employee Signature

Employee Printed Name

Date



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PATIENT CONSENT & AUTHORIZATIONS

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you. I further agree to hold Dr. Peterson harmless for any adverse outcome that occurs as a result of information which I have knowingly withheld from this form. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examination in the office. I understand that I am responsible for the outcomes of care of treatment if I do not follow the care, service or treatment plan.

CONSENT FOR TREATMENT: I, the undersigned patient, parent or legal guardian, do hereby present myself (or the patient) for care or treatment at the office of Darren L. Peterson, M.D., and voluntarily consent to the rendering of such care or treatment, including performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of my physician and it is the responsibility of the practice and its staff to carry out the instructions of such physician. I understand that the physician furnishing services to me is an employee of the hospital, however, other services such as radiology, laboratory, and pathology may be provided by independent practitioners. All physicians expect payment in full upon receipt of a bill and I will assist in billing appropriate insurance companies if insurance or other benefits are involved.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to Darren L. Peterson, M.D., the physician accepting this assignment, of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Darren L. Peterson, M.D. for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

RELEASE OF MEDICAL INFORMATION: I, the undersigned patient, parent, or legal guardian, do hereby authorize Darren L. Peterson, M.D., the practice's officers and his employees, to release to any third party payor (such as an insurance company or government agency; Example: Blue Cross/Blue Shield of Florida or Medicare) any medical, psychiatric, alcohol, drug abuse, and/or HIV (AIDS or AIDS related complex) treatment information and records, in accordance with the policy of Darren L. Peterson, M.D. and any applicable State or Federal Statutes, concerning diagnosis and treatment for the above admission when requested by such third party payor for its use in connection with determining a claim for payment for such care, treatment and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. I do hereby release Darren L. Peterson, M.D. from all liability that may arise from the release of the information requested.

FLORIDA LAW: Section 817.234 Florida Statutes, stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

FOR MEDICARE AND MEDICAID PATIENTS ONLY – CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII or /or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary-carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to Darren L. Peterson, M.D. I understand that I am responsible for any health insurance deductibles and coinsurance.

MEDICARE BENEFICIARY NOTICE OF NON-COVERED SERVICES: Medicare does not cover some inpatient, outpatient, and emergency services. Items not covered include, but are not limited to, medications typically self-administered, annual testing and physicals.

ACKNOWLEDGEMENT OF RECEIPT OF AN IMPORTANT MESSAGE FROM MEDICARE (FOR MEDICARE PATIENTS ONLY): My signature only acknowledges my receipt of this message from Darren L. Peterson, M.D. as dated below and does not waive any of my right to request a review or make me liable for any payment.



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I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH MAY BE ON FILE AT THE OFFICE OF DARREN L. PETERSON, M.D.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually hereby obligates himself/herself to pay the account of Darren L. Peterson, M.D. in accordance with the regular rates and terms of the physicians. The undersigned will pay all costs and expenses including reasonable collection fees (which may include agency, attorney, interest or court fees) incurred or paid by the hospital or Darren L. Peterson, M.D. in the collection of this obligation by suit or otherwise. Furthermore, I hereby authorize and appoint the administrator of Florida Hospital Memorial System and/or Darren L. Peterson, M.D. and/or his successor/designee as my attorney-in-fact to take measures in my behalf as may be necessary to collect such claims or insurance proceeds and to endorse any checks made payable to me for such claims or insurance proceeds by signing my name as attorney-in-fact for me to any such checks and/or insurance claim forms.

Patient's signature

Patient's representative/policy holder or spouse
Indicate relationship _____

Witness

Date

Patient unable to sign due to: