

Annual Update Patient Registration

Please have all INSURANCE CARDS and DRIVER'S LICENSE or PHOTO ID ready to copy.
(PLEASE PRINT)

Today's Date: _____ Account #: _____

LAST NAME		FIRST		MI	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED
SOCIAL SECURITY NO.		DATE OF BIRTH / /		RACE		<input type="checkbox"/> EMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/> STUDENT
LOCAL ADDRESS			CITY		STATE	ZIP CODE
HOME PHONE		WORK PHONE		CELLULAR PHONE		
EMAIL ADDRESS			LANGUAGE PREFERENCE <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER _____ <input type="checkbox"/> HEARING IMPAIRED <input type="checkbox"/> VISION IMPAIRED			
PERMANENT ADDRESS			CITY		STATE	ZIP CODE
PREFERRED PHARMACY				PREFERRED PHARMACY PHONE		

IN CASE OF EMERGENCY, CONTACT:

LAST NAME		FIRST	
ADDRESS		CITY	STATE ZIP CODE
HOME PHONE	WORK PHONE	CELL PHONE	RELATIONSHIP

INSURANCE INFORMATION PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY		INSURED'S DOB
INSURANCE/CARD HOLDER'S NAME		RELATIONSHIP
ID #	GROUP #	PHONE

History of Sexually Transmitted Diseases? _____

Do you practice safe sex? _____

Diet/Exercise:

Type of Diet: _____

Do you exercise? (Circle one)

No Minimal Moderate

Have you ever had a blood transfusion?

Yes No

If yes, please give approximate dates:

Other:

Spiritual or Cultural Preferences? _____

Healthcare Proxy _____

Durable Power of Attorney for Healthcare _____

Advance Directive Yes No

Name: _____

Relationship: _____

Patient unable/unwilling to discuss advanced directive

Primary Care Giver _____

Health Habits: Check which substances you use and describe how much you use.

Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> 1 or 2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5 or more
Tobacco	<input type="checkbox"/> None	<input type="checkbox"/> 1 pack/wk	<input type="checkbox"/> 1 pk/day	<input type="checkbox"/> 2 pks/day
When did you stop smoking?		How long did you smoke?		
Drugs	<input type="checkbox"/> None	<input type="checkbox"/> Prescription	<input type="checkbox"/> Recreational	
Alcohol	<input type="checkbox"/> None	<input type="checkbox"/> Social	<input type="checkbox"/> 1-2 day	<input type="checkbox"/> 3 or more/day

Fall Risk:

Have you fallen any time during the past year? Yes No

How many falls? _____ When? _____

Injury? _____

Occupational: Check if your work exposes you to the following

Stress
Heavy Lifting
Repetitive Motion
Have you ever been exposed to chemicals or radiation? <input type="checkbox"/> Yes <input type="checkbox"/> No

Occupation: _____

Contact Phone # of Primary Care Giver _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Please Read and Sign Back

Date Scanned: _____ Initials: _____ Account Number: _____

1. **CONSENT FOR TREATMENT.** I understand that medical treatment of an immediate nature may be necessary for the patient and that such medical care, treatment, and procedures will be performed by licensed physicians and/or employees of S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER during posted operating hours. I understand that medical treatment only is being provided and I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results, that may be obtained. I understand and recognize that GULF COAST MEDICAL CENTER is a teaching facility.
Do you have an Advance Directive? Yes No Would you like information pertaining to Advance Directives? Yes No
2. **FINANCIAL RESPONSIBILITY.** For and in consideration of the care and treatment provided to the patient, I promise to pay S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER all charges for services rendered to or on behalf of the patient. Any services that are not covered by insurance are the patients' responsibility and will be due and payable at the time services are rendered unless other arrangements are made in advance. Patient is also responsible for the costs of collection of any amounts due S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER, to include reasonable attorney's fees and court costs.
3. **RELEASE OF MEDICAL INFORMATION.** I hereby authorize S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER to release any medical information, in connection with these services, requested with regard to processing my claim or to my personal physician, insurance carrier, and/or attorney of record with appropriate release.
4. **DIAGNOSTIC TESTING.** Please be aware of YOUR insurance policy exclusions with regard to diagnostic testing. Although GULF COAST MEDICAL CENTER strives to provide our patients with any type of diagnostic testing he/she may need, certain insurance companies have specific facilities you must go to for certain tests, i.e., laboratory, X-ray procedures. It is your responsibility to verify that procedures performed at GULF COAST MEDICAL CENTER are covered by your insurance policy. The patient is ultimately held responsible for any balance due to the reason stated above.
5. **MEDICARE/MEDIGAP, BLUE CROSS/BLUE SHIELD OR OTHER HEALTH INSURANCES.** I hereby authorize S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER to apply for Medicare/Medigap, and other health insurance benefits on my behalf. I hereby request reimbursements from any applicable insurance to be made directly to S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER. I certify that the information I have provided with regard to my insurance carrier is correct. I authorize the release of medical information about me to my health insurance carrier and HCFA (Health Care and Finance Administration) agents, as well as any and all other information needed to determine the benefits payable for related service(s). I hereby authorize payment of Medigap benefits be made on my behalf to S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER. I release any holder of Medicare information about me to my insurance carriers, necessary to determine benefits payable for related services.
6. **ATTORNEY OF RECORD:** I authorize my attorney to release to S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER any information detailing my case, case status, or case settlement in connection with date of accident _____ and medical services rendered.
7. **AUTHORIZATION TO APPEAL DETERMINATION:** I authorize the Billing Department of S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER to act on my behalf, as a Designated Representative, to appeal my insurance carrier's determination, if necessary. I understand that communications may contain confidential medical and financial information, including, but not limited to, treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed. I understand the confidential information will only be released as specified in the authorization, or as permitted by law. This authorization is valid for a period of one year.
8. **CONSENT TO PHOTOGRAPH:** I understand that services conducted by S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER may be photographed. The photographs are used to assist in trainings and also as an important tool of the services provided. I understand my information and identity will remain confidential and protected.
9. **CONSENT TO RECEIVE AUTOMATED CALLS.** I consent to receive calls from S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER for my protected healthcare and other services at the phone number(s) listed on the front of this form, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

10. The policy of this facility is to call 911 for all emergencies within the medical center.

THE UNDERSIGNED HEREBY MAKES THE FOLLOWING ACKNOWLEDGEMENTS AND AGREEMENTS REGARDING THE MEDICAL TREATMENT TO BE PROVIDED BY S.M.S., D.O., P.A., d/b/a GULF COAST MEDICAL CENTER AND ANY OF ITS DULY AUTHORIZED AGENTS TO THE PATIENT WHOSE NAME APPEARS ON THIS FORM.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS. I ALSO UNDERSTAND THAT IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.	
_____ Signature of Patient/Guardian	_____ Date
_____ Witness	_____ Account Number