Gulf Coast Medical Center

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 #: _____

PATIENT NAME (Last) (First) (Middle) Date of Birth (mm/dd/yyyy)

SEX ❑ MALE ❑ FEMALE ❑ TRANSGENDER SOCIAL SECURITY NO.

LOCAL ADDRESS CITY STATE ZIP CODE

PERMANENT ADDRESS CITY STATE ZIP CODE

HOME PHONE WORK PHONE CELL PHONE

EMAIL ADDRESS

EMAIL ADDRESS NOTIFICATION ❑ DO NOT WISH TO BE CONTACTED ❑ YES, I WOULD LIKE TO BE CONTACTED BY EMAIL AND USE ONLINE FEATURES PROVIDED BY GCMC

MARITAL STATUS: ❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ WIDOWED ❑ SIGNIFICANT OTHER

RACE ETHNICITY LANGUAGE PREFERENCE ❑ ENGLISH ❑ SPANISH ❑ OTHER_____

❑ HEARING IMPAIRED ❑ VISION IMPAIRED

DO YOU HAVE AN ADVANCE DIRECTIVE? ❑ YES ❑ NO WOULD YOU LIKE INFORMATION PERTAINING TO ADVANCE DIRECTIVES? ❑ YES ❑ NO

ARE YOU EMPLOYED: ❑ YES ❑ NO ❑ RETIRED ❑ STUDENT

EMPLOYER ADDRESS CITY STATE ZIP CODE

PREFERRED PHARMACY PREFERRED PHARMACY PHONE

IN CASE OF EMERGENCY, CONTACT:

NAME (Last, First, Middle) RELATIONSHIP

ADDRESS CITY STATE ZIP CODE

HOME PHONE WORK PHONE CELL PHONE RELATIONSHIP

INSURANCE INFORMATION ***PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST***

ARE YOU INSURED? ❑ YES ❑ NO

INSURANCE/CARD HOLDER'S NAME (Last, First, Middle) INSURED'S DOB

INSURANCE COMPANY ID# GROUP # PHONE

Health Habits: Do you visit the dentist regularly? ❑ Yes ❑ No Approximate date of last dental appointment _____

How do you identify yourself? ❑ Heterosexual ❑ Homosexual ❑ Bisexual ❑ Questioning

History of Sexually Transmitted Diseases? ❑ Yes ❑ No Do you practice safe sex? ❑ Yes ❑ No

Have you ever had a blood transfusion? ❑ Yes ❑ No
If yes, please give approximate dates:

Check which substances you use and describe how much you use.

	Caffeine	❑ None	❑ 1 or 2	❑ 3-4	❑ 5 or more
	Tobacco	❑ None	❑ 1 pack/wk	❑ 1 pk/day	❑ 2 pks/day
	When did you stop smoking?		How long did you smoke?		
	Drugs	❑ None	❑ Prescription		❑ Recreational
	Alcohol	❑ None	❑ Social	❑ 1-2 day	❑ 3 or more/day

Diet/Exercise: Type of Diet: _____

Do you exercise? (Circle one)
No Minimal Moderate

Victimization *(Please circle):*
Physical Abuse Sexual Abuse Elder Abuse
Adult Molested as Child Robbery Victim
Assault Victim Dating Violence Domestic Violence
Human Trafficking Other: _____

Would you consider your housing to be: ❑ Stable ❑ Unstable

Fall Risk: Have you fallen any time during the past year? ❑ Yes ❑ No
How many falls?_____When?_____
Injury?_____

Do you need help with every day activities like preparing a meal or shopping?
❑ Yes ❑ No

Other:

Spiritual or Cultural Preferences?

Healthcare Proxy

Durable Power of Attorney for Healthcare

Advance Directive ❑ Yes ❑ No
Name:_____
Relationship:_____
❑ Patient unable/unwilling to discuss advance directive

Are you straining to hear the TV or people talk? ❑ Yes ❑ No

Occupational: Are you employed? ❑ Yes ❑ No

Occupation:

Check if your work exposes you to the following:

- Stress
- Heavy Lifting
- Repetitive Motion

Primary Care Giver

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:_____

OVER

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.
2. **CONSENT FOR TREATMENT OF A MINOR**: As a parent or legal guardian, I consent to the healthcare services and the prescribing of any medicinal drug the medical provider deems medically necessary for my child.
3. **PRESCRIPTION DRUG MONITORING PROGRAM (PDMD).** Patient gives Gulf Coast Medical Center and its providers and/or designees of prescribing provider permission to consult the Prescription Drug Monitoring Program prior to dispensing prescriptions for all controlled substances to review dispensing history, as required by the State of Florida (Florida House Bill 21 (2018).
4. **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.
5. **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.
6. **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.
7. **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.
8. **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.
9. **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.
10. **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.
11. **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.
12. **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

❑ NOTICE OF PRIVACY PRACTICES POLICY SIGNED Date Scanned: _____ Initials: _____

OVER