JUPITER CONCIERGE FAMILY PRACTICE
2141 Alternate A1A South, Suite 200
Jupiter, FL 33477
(561) 743-0005 (561) 743-7623 Fax

PATIENT REGISTRATION

Date: _____

Referred by: _____

Patient Name: _____

Birth Date: __/__/____ (mm dd yyyy) Social Security#: ____ - ___ - _____

Local Address: _____

City/State/Zip Code: _____

Home Phone #: (____) ____ _____ (area code) Cell Phone #: (____) ____ _____ (area code)

Name of Spouse/

Home Fax #: (____) ____ _____ (area code) Significant Other:_____

E-mail Address: _____Marital Status: _____

Alternate Address: _____

City/State/Zip code: _____

Alternate Home Phone #: (____) ____ _____ (area code)

Employer: _____Occupation: _____

Work Phone: (____) ____ _____ (area code) City/State/Zip Code: _____

Name of Insurance Company: _____

_____

Primary Insured: _____Date of Birth: __/__/____ (mm dd yyyy)

Secondary Insurance:_____

Relationship: _____ Social Security #: ____ - ___ - _____

Emergency Contact: _____ Relationship: _____

Home Phone #: (____) ____ _____ (area code) Cell Phone #: (____) ____ _____ (area code)

Pharmacy Name: _____ Phone #: (____) ____ _____ (area code)

Address or Intersection: _____

Patient Name _____

History and Physical

Main reason you came in today: _____

_____

Do you have any medical conditions that have required treatment? _____

_____

_____

_____

List Physicians (past and present) and their specialty: _____

_____

_____

_____

_____

_____

_____

Have you ever had any surgeries or have been hospitalized? If so, please list reasons and dates:

_____

_____

_____

Do you have any allergies/reactions to medicines? If so, please list medications and the reaction you have with them: _____

_____

What type of exercise do you do? _____ How often?_____

Do you smoke now?_____ Have you ever smoked? _____ How much? _____

When did you quit?_____

Do you drink alcohol? _____ If so, what type?_____ How much daily? _____

Do you use any type of recreational drugs? _____

Patient Name:_____

Please list all medications you are taking and how often you take them. (include alternative medicines, vitamins, health food supplements)

Medication Name	Dosage	Frequency	Start Date

Patient Name: _____

FAMILY HISTORY:

Please tell us the health of your family. Are your parents living? If so, what are their ages and list any medical problems they may have including diabetes, high blood pressure, heart attacks, strokes, cancers. If they are deceased, please list their age at death and the cause if known.

Father: _____

Mother: _____

Do you have any brothers or sisters? If so, please state their ages and any health problems:

_____

_____

PREVENTATIVE:

When were you last vaccinated for:

Tetanus _____ Hepatitis B _____

Influenza (flu) _____ Shingles _____

Pneumonia _____

If you are female, when was your last pap smear? _____

Mammogram? _____

Bone Density? _____

Have you ever had a colonoscopy? _____ If so, when? _____

REVIEW OF SYSTEMS:

Are you affected by any of the following conditions? Give the duration and explain.

General:	**YES**	**NO**	**DURATION/EXPLAIN**
Chills?	☐	☐	_____
Fatigue?	☐	☐	_____
Fever?	☐	☐	_____
Recent change in weight?	☐	☐	_____

Patient Name: _____

	YES	NO	DURATION/EXPLAIN
Eyes:			
Blurred vision?	☐	☐	
Wear glasses?	☐	☐	
Wear contacts?	☐	☐	
Ears/Nose/Throat:			
Difficulty hearing?	☐	☐	
Persistent ringing?	☐	☐	
Nasal Congestion?	☐	☐	
Periodontal Disease?	☐	☐	
Dentures present?	☐	☐	
Toothache?	☐	☐	
Heart:			
Chest pain?	☐	☐	
Heart palpitations?	☐	☐	
Swollen legs?	☐	☐	
Lungs:			
Persistent cough?	☐	☐	
Short of breath with activity?	☐	☐	
How much activity?	☐	☐	
Gastrointestinal:			
Abdominal Pain?	☐	☐	
Recent change in appetite?	☐	☐	
Constipation?	☐	☐	
Diarrhea?	☐	☐	
Heartburn?	☐	☐	
Rectal bleeding?	☐	☐	
Black stools?	☐	☐	
Nausea?	☐	☐	
Vomiting?	☐	☐	

Patient Name: _____

Genitourinary	**YES**	**NO**	**DURATION/EXPLAIN**
Burning on urination?	☐	☐	
Blood in urine?	☐	☐	
Sexual problems?	☐	☐	
Get up more than once at night to urinate?	☐	☐	
Lose control of your urine?	☐	☐	
Musculoskeletal			
Arthritis/joint pain?	☐	☐	
Back pain?	☐	☐	
Muscle pain?	☐	☐	
Skin:			
Recent change in mole?	☐	☐	
Persistent rashes?	☐	☐	
Breast mass?	☐	☐	
For women only:			
Date of first day of last menstrual period?			
or			
Year you reached menopause?			
Are your periods irregular?	☐	☐	
Vaginal discharge?	☐	☐	
How often do you examine your breasts?			
Lumps in your breast?	☐	☐	
Do you use birth control? Method?	☐	☐	
Neurologic			
Unsteady on feet?	☐	☐	
Spells of dizziness or light-headedness?	☐	☐	
Frequent or severe headaches?	☐	☐	
Memory Loss?	☐	☐	
Numbness or tingling?	☐	☐	
Trouble sleeping?	☐	☐	

Patient Name: _____

Blood:	**YES**	**NO**	**DURATION/EXPLAIN**
Do you bruise easily?	☐	☐	_____
Ever had a blood transfusion?	☐	☐	_____
Any swollen glands?	☐	☐	_____
Glands:			
Hair loss?	☐	☐	_____
Any intolerance to heat or cold?	☐	☐	_____
Hot flashes?	☐	☐	_____
Allergy:			
Environmental allergies?	☐	☐	_____
Frequent colds?	☐	☐	_____
Psychiatric:			
Any anxiety?	☐	☐	_____
Any depression?	☐	☐	_____
History of any alcohol or chemical dependence?	☐	☐	_____
Sleep problems?	☐	☐	_____

Is there anything else that you would like to discuss with Dr. Rosenberg today? _____

_____

_____

Thank you for taking your time to answer these questions.

Consent for Purposes of Treatment, Payment And Healthcare Operations

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

I, _____ consent to the use or disclosure of my protected health information by Jupiter concierge Family Practice, Inc. for the purpose of diagnosing or providing treatment for me, obtaining payment for my healthcare bills, or to conduct healthcare operations of Jupiter Concierge Family Practice, Inc. I understand that diagnosis or treatment of me by Dr. David C. Rosenberg may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Jupiter Concierge Family Practice is not required to agree to the restrictions that I request. However, if Jupiter Concierge Family Practice agrees to a restriction that I request, the restriction is binding to our physician.

I have the right to revoke this consent in writing at any time, except to the extent that Jupiter Concierge Family Practice or David C. Rosenberg has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a healthcare billing clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis the information may identify me.

I understand I have the right to review Jupiter Concierge Family Practice's Notice of Privacy Practices prior to signing this document, which has been provided me. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in treatment, payment of my bills or in the performance of healthcare operations of Jupiter Concierge Family Practice. The Notice of Privacy Practices for Jupiter Concierge Family Practice is also provided at the front desk, which describes my rights and Jupiter Concierge Family Practice's duties with respect to my protected health information.

Jupiter Concierge Family Practice reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices.

	_____
Patient Signature	Date

Who are we authorized to speak to regarding your medical care?_____