DOCTOR 4UCLINIC
REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home/cell phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ____________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Personal Email Address:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize doctor 4uclinic or insurance company to release any information required to process my claims.

Patient/Guardian signature ____________________ *Date* ____________

// Doctor4UClinic

5318 34th St West,
Bradenton, FL. 34210
(941)-758-0205
Fax: (941)-758-0132

Doctor4UClinic

General Consent to Treat and Patient Acknowledgements

The following are the conditions for services provided by **Doctor4UClinic** for the patient whose name appears at the bottom of this page.

Consent for Medical Treatment:
I/we voluntarily consent to medical treatment and diagnostic procedures provided by **Doctor4UClinic** and associated physicians, clinicians and other personal. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by the physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

Assignment of Insurance Benefits:
I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and **Doctor4UClinic**. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/ we understand that **Doctor4UClinic** can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected, I/we shall pay all collections fees and cost, including reasonable attorney's fees. For Medicare beneficiaries, I/we provided all necessary information for proper assignment of Medicare benefits.

____ __________
Signature (Patient, Parent, Guardian or Legally Authorized Representative) Date

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Consent for Use and Disclosure of Health Information

This notice describes how medical information about you may be used ad disclosed, your rights as a patient and the ways for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (HIPPA Privacy Act.), we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

We may release of disclose your health information:

- **For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.**
- **For billing and collection purposes, we may release records of your health care and information that y have provided to your insurance carrier or other financially responsible parties.**
- **For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.**

Specifically, you authorize the release of any information pertinent to your case to any insurance company adjusted, attorney involved in case for the purpose of obtaining payment on your health claims.

We will use your personal address and telephone number to contact you regarding your appointments. To send you information about our clinic, office events or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization, for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health related information should be provided to the **Front Desk** in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like this information in a different form, please advice in writing as to your preferences.

Information that we use or disclose on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect f our privacy activities, you should direct your complaint in writing to the Clinic Director.

If you would like further information about our privacy policies and practices, please see the "Notice of Privacy Practices" binder in reception or ask for a copy at the Front desk.

______________________________	______________________________	____________	__________
Name (Printed Please)	Signature	Date of Birth	Date

______________________________	______________________________	____________
Personal Representative (Printed)	Personal Representative Signature	Date

Doctor4UClinic

5318 3th St West
Bradenton, Fl. 34210
(941)-758-0205

Financial Policy

It is our goal to provide our valuable patients with the best quality care and service possible. The following financial policy outlines your financial responsibility for services rendered to you. This office files insurance claims on behalf of our insured patients, both as a courtesy and as a part of our provider agreements with certain insurance carriers. We require photo identification and an insurance card in order to file insurance claims on your behalf.
Under these agreements, patients are responsible for payment of insurance deductibles and co-payments at the time the service is rendered. In addition, patients are responsible for payment in full for services that are considered to be "non-covered" by your insurance carrier for any reason.
Under most HMO plans, you must request that your insurance company assign a Primary Care Physician to you prior to your visit, in order for your visit/service to be covered. Please b advised that our office does not participate in any form of Medicare HMO plan and payment in full is required at the time of service.
Our office accepts cash, debit/ATM cards and credit cards (Visa, Master Card, Discover and American Express).
Thank you for allowing us to participate in your health care plan and for your compliance with our policies.

_______________________________________ _____________
Patient or Designee/Guardian Signature Date

Doctor4UClinic

Family Practice and Walk In Clinic
Initial Patient History

Name of Patient: ___________________________ **Date of Birth:** ___________ **Date:** ______
Chief Complaint/Reason for visit: ____
____
____

Current Medical Condition: ____
____
____

Current Medications and Supplements: ____
____
____
____

HPI (Doctor Only): ____
____
____

Reason for Service: Do you have any of the following systems?

Headaches: ______________	Dizziness: _______________	Nocturia: ______________
Cough: ______________	Nausea: ________________	Dysuria: _______________
Fatigue: ______________	Vomiting: _______________	Urgency: _______________
Blurred Vision: ___________	Indigestion: _____________	Incontinence: ___________
Other Vision Problems: ___	Diarrhea: _______________	Regular Periods: _________
Tinnitus: ______________	Heartburn: ______________	Heavy Flow: ____________
Sleep Apnea: __________	Constipation: ____________	Vaginal Discharge: ______
Excessive Thirst: _________	Snoring: ________________	Painful Breasts: __________
Excessive Hunger: ________	Insomnia: _______________	Mood Changes: __________
Chest Pain: _____________	Food Cravings: ___________	Cold Intolerance: _________
Palpitations: ____________	Muscle Aches: ___________	Cold Extremities: _________
Shortness of Breath: _____	Joint Pains: ______________	Poor Memory: ___________
Swelling of Ankles or Feet: _	Joint Swellings: ___________	No. of Pregnancies: ______
Asthma: _______________	Joint Stiffness: ___________	No. of Children: __________
Difficulty in Breathing: ___	Frequent Urination: _____	Date of last Gyn. Exam: ___
Are you on the pill? _____	Fevers: ________________	Shaking Chills: __________
Sudden Weight Loss: ____	Loss of Hearing: _________	Nose Bleeds: ____________
Toothaches; ____________	Bleeding Gums: _________	Coughing up Blood: ______
Difficulty swallowing: ____	Stomach Pain: __________	Blood in Stool: ___________
Blood in Urine: __________	Burning while Urinating: __	Black or Tarry Stool: ______

Allergies: ____

Past Medical History:

Cancer: _________________	Hepatitis: _______________	
Arthritis: _______________	Diabetes: _____________	High Blood Pressure: _____
Gout: _________________	Low Sugars: ___________	Heart Disease: ___________
Anemia: _______________	Acid Reflux: ___________	Lung Problems: __________
Anorexia Nervosa: ______	Urinary Infections: _____	Rheumatic Fever: ________
Bulimia: _______________	Other Conditions: _______________________________________	

Any Surgeries: ____

Family History: **Living** **Deceased**

	Age	State of Health	Cause of Death	Age at Death	Overweight?
Father:	___	____________	____________	___	___
Mother:	___	____________	____________	___	___
Brother:	___	____________	____________	___	___
Sister:	___	____________	____________	___	___
______:	___	____________	____________	___	___
______:	___	____________	____________	___	___
______:	___	____________	____________	___	___

Social History:

Do you smoke? **Y/N** If yes, how much? ________________________

Do you take alcohol? **Y/N** If yes, how much? ________________________

Name of regular doctor? ____________________________________

Signature of Patient: ___________________________ **Date:** ___________

Reviewed by: ________________________________ **Date:** ___________