



COMMUNITY HEALTH

PATIENT REGISTRATION FORM

Today's Date:		S.S. #:		Primary Care Provider:	
Patient Information					
Title:	First name:	Middle:	Last:	Birth date:	
Sex at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Female-to-Male/Transgender male/Trans man <input type="checkbox"/> Male <input type="checkbox"/> Male-to-Female/Transgender female/Trans woman <input type="checkbox"/> Other, Please Specify: _____			<input type="checkbox"/> Gender queer; neither exclusively male nor female <input type="checkbox"/> Refused to report	
Sexual Orientation:	_____				
Race:	Ethnicity:	Marital status:	How would you like to be reminded about scheduled appointments? <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell phone <input type="checkbox"/> Text <input type="checkbox"/> Email		
Address:					
Home Phone:		Would you like more information about our patient portal? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Work Phone:		(if YES, please enter email below)			
Cell phone:		Email:			
Other family members that are seen here:					
INSURANCE INFORMATION (please give your insurance card to the receptionist)					
Person responsible for the bill:	Birth date:	Address (if different)		Home phone:	
Is the person a patient here?	Is this patient covered by insurance:				
Occupation:	Employer:	Employer address:		Employer phone:	
Primary insurance:		Member ID:		Group #:	
Guarantor's name:	Guarantor's S.S. #:	Birth date:	Patient's relationship to guarantor:		
Secondary insurance (if applicable):		Member ID:		Group #:	
Guarantor's name:			Patient's relationship to guarantor:		
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at the same address):		Relationship to patient:	Home Phone:	Cell Phone:	
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to CAN Community Health. I understand that I am financially responsible for any balance. I also authorize CAN Community Health or my insurance company to release any information required to process my claims.</p>					
Patient/Guardian Signature _____					Dat _____

Name _____
 ID# _____
 Date of Birth ____/____/____



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

Name: _____

Facility/Site/Program: _____

I have received a copy of the CAN Community Health Privacy Practices

Signature: _____ Date: _____

Individual or Representative with legal authority to make health care decisions

If signed by a Representative:

Print Name: _____ Role: _____
(Parent, guardian, etc.)

Witness: _____ Date: _____

If the individual has a representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the representative. ***If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.***

Notice of Privacy Practices given to the individual on: _____
Date

<input type="checkbox"/> Face to face meeting
<input type="checkbox"/> Mailing
<input type="checkbox"/> Email
<input type="checkbox"/> Other _____

Reason Individual or Representative did not sign this form:

- Individual or Representative chose not to sign
- Individual or Representative did not respond after more than **one** attempt
- Email receipt verification
- Other _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual's or Representative signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.

- Face to face presentation(s) _____
- Telephone contact(s) _____
- Mailing(s) _____
- Email _____
- Other _____

Staff Signature: _____ Date: _____

Print Name: _____ Date: _____

Name _____
ID# _____
Date of Birth ____/____/____



COMMUNITY HEALTH

PATIENT INFORMATION RELEASE

USE ONE RELEASE PER PERSON/FACILITY

I, _____, give permission to all staff at CAN Community Health to speak with _____
(Relationship and Contact Number – Please Print)

regarding all aspects of my care, including, but not limited to, making and canceling appointments, billing and insurance matters, housing, and all issues relating to my medical and dental care.

All information hereby authorized by me to be obtained by CAN Community Health will be held strictly confidential and cannot be released by the recipient without my written consent.

I understand that this authorization will remain in effect until revoked by me in writing.

Date Client *(sign)*

Date Client *(print name)*

Date Representative/Guardian *(sign)*

Date Representative/Guardian *(print name & relationship)*

Date Witness *(sign and print name)*

Withdrawal of Consent

Date consent revoked Client/Representative/Guardian Signature

Date Witness *(sign and print name)*

Name _____
ID# _____
Date of Birth ____/____/____



INITIATION OF SERVICES

Client Name: _____

Name of Agency: _____

Agency Address: _____

I consent to entering into a client-provider relationship. I authorize CAN Community Health and their representatives to render routine healthcare. I understand routine healthcare is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue the relationship at any time.

PART II: DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and healthcare operations.

PART III: MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV: ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any healthcare plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V: MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

Client/Representative Signature

Self or Representative's Relationship to Client

Date

Client/Representative Name-Print

Witness

Date

PART VI: WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____.
Client/Representative Signature Date

Witness

Date

Name _____
ID# _____
Date of Birth ____/____/____



AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

Patient's Name: _____ DOB: _____ Patient ID: _____

REQUEST RECORDS FROM:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

SEND RECORDS TO:

Person/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

Other method of communication: _____

I SPECIFICALLY AUTHORIZE RELEASE OF INFORMATION RELATING TO: (initial selection)

- General Medical Records History & Physical Results Family Planning Sexually Transmitted Diseases
- Progress Notes Mental Health (other than psychotherapy notes) HIV/AIDS related information and treatment

All of my health information that the providers have in his or her possession, including information relating to any medical history, mental (excluding psychotherapy notes), or physical condition and any treatment received by me.

Psychotherapy notes: If psychotherapy notes is selected, no other item may be selected. A separate form must be completed. Psychotherapy notes use or disclosure is at the discretion of the author of the note.

Diagnostic test reports (specify type of test(s): _____

Other (specify): _____

HIV/ AIDS related information may be sent via fax

PURPOSE OF DISCLOSURE:

- Continuity of Care Personal use Other (specify): _____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

Notice to Patient:

By signing this form, you grant us consent to disclose your protected health care information to the individual(s) listed above. Our **Notice of Privacy Practices** provides more details on uses and disclosures of your protected health information for treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information. You understand that the above information may be redisclosed by the recipient and may not be protected by federal privacy laws or regulations. You understand that completing this authorization form is voluntary and that treatment will not be denied if you refuse to sign this form.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You are entitled to a copy of this **Consent Form** after you have signed it.

Client/Representative signature

Date

Printed name

Representative's relationship to client

Witness (optional)

Date

Name _____
ID# _____
Date of Birth ____/____/____



CONSENT FOR EMAIL/TEXT COMMUNICATION

Unencrypted email and texting is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email or text may be misdirected, disclosed to, or intercepted by unauthorized third parties. You will not hold CAN Community Health liable if others access your email or text messages from your computer, phone or another mobile device.

By signing below, you may consent to receive email and/or text messages from us regarding your treatment. Email and texts sent to you may be included as a part of your medical record. We will use the minimum necessary amount of protected health information in any communication. Our first email or text to you will verify the email address or mobile phone number you provided.

Please initial next to your choice regarding email or text communication:

_____ I consent to and accept the risk in receiving information via email or text message. I understand I can withdraw my consent at any time.

_____ I consent only to receiving appointment reminders via email or text message. I understand I can withdraw my consent at any time.

Email address: _____

Mobile phone number: (_____) _____

Mobile phone provider: _____

_____ I do not consent to receiving any information via email or text message.

_____ I withdraw my consent to email/text communication. You can also withdraw consent by sending an email to CAN. This will be recorded in your medical record.

If I send an email or text message to CAN Community Health, I will take that as permission to correspond via email. Our reply email will explain that emails are not secure and request that you sign this form the next time you are in our office. I understand that I can change my mind and provide consent later.

Print Name and DOB

Signature

Date

Name _____
ID# _____
Date of Birth _____/_____/_____



NEW PATIENT INITIAL VISIT MEDICAL HISTORY FORM

Welcome to our clinic. Completing the following forms will allow us to personalize your care and assist us in providing you the quality care you deserve from your healthcare providers. Please complete all sections that apply to your particular needs as completely and accurately as possible. If you are uncertain of a specific date of an event, the approximate or "best guess" at the month and year are acceptable. Thank you for choosing us to provide your care and again, welcome to our clinic.

Today's Date: _____ New Patient _____ Returning Patient _____ If Yes, Last visit _____

Preferred Language: English Other _____ Would you like an interpreter Yes No

Idioma preferida

¿Te gustaría un intérprete?

Demographic Information:

Date of Birth: _____ Best Contact Phone #: Home: _____ Cell: _____

Patient Name: _____

Local Address: _____ City: _____ State: _____ Zip: _____

Alternate Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Reason for your visit today: Initial visit only Initial visit AND _____

Newly diagnosed with HIV? (circle one): Yes / No Date Diagnosed: _____

If not, previous HIV provider name/location: (complete release of information) _____

If previous positive HIV Test, but no treatment, please list the location where the patient was tested and any location additional labs were obtained (complete release of information): _____

Name _____
ID# _____
Date of Birth ____/____/____



COMMUNITY HEALTH

YOUR COMPLETE TREATMENT TEAM (PLEASE LIST ALL YOUR PHYSICAL/MENTAL HEALTH CARE PROVIDERS)

MD NAME	SPECIALTY (EX. GI, OB-GYN,PCP...)	WHY CONDITION THEY ARE TREATING	WHERE (CITY, STATE)

MEDICATIONS:

MY PREFERRED PHARMACY

IS: _____ ADDRESS/PHONE#

ALLERGIES: Are you allergic to medication(s), food, tape, iodine, latex or bee-stings? None _____ Yes

Please List Below:

Drug:	Reaction:	Other:	Reaction:
Drug:	Reaction:	Other:	Reaction:
Drug	Reaction	Other:	Reaction
Drug:	Reaction:	Other:	Reaction:

MEDICATIONS:

CURRENT MEDICATIONS Please include DAILY Vitamins/herbals and Over the Counter meds at end of list				
Drug Name:	Dose (Mg.;ml.;units)	How often?	How long? MM/Yr started	If Not from This Clinic the prescribing doctors name and specialty

****ADDITIONAL SPACES ARE PROVIDED AT END OF THE QUESTIONNAIRE IF NEEDED.**

Name _____
ID# _____
Date of Birth ____/____/____



MEDICAL HISTORY

IMMUNIZATION HISTORY

IMMUNIZATION/VACCINE	YEAR	IMMUNIZATION/VACCINE	YEAR
Flu vaccine within last year ____ Yes ____ No ____ Unknown I Would like to receive the Flu Vaccine today ____ Yes ____ No		Hepatitis A Vaccine	
Adult Pneumovax ____ Yes ____ No ____ Unk (yrs 1 st & +5 or max 2 in a lifetime) I Would like to receive the Pneumovax today ____ Yes ____ No		Hepatitis B Vaccine Series of 3	
Tetanus/Tdap ____ Never ____ Unknown < 10 yrs. > 10 yrs.		Tw Inrix Vaccine (Hep A&B combo) Series of 3	
HPV ____ Yes ____ No ____ Unk **LIVE VACCINE		Tuberculosis/PPD	
Zoster (shingles) vaccine ____ Yes ____ No ____ Unk **LIVE VACCINE		Previous POSITIVE result ____ Yes ____ No	
		Previous NEGATIVE Chest X-RAY ____ Yes ____ No	

Have you been HOSPITALIZED within the last year ? <input type="checkbox"/> Yes <input type="checkbox"/> No		
When:	Where:	Treated for:

Name _____
 ID# _____
 Date of Birth ____/____/____



PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

<i>Condition</i>	<i>X</i>	<i>Year</i>	<i>Condition</i>	<i>X</i>	<i>Year</i>	<i>Condition</i>	<i>X</i>	<i>Year</i>
AIDS/HIV			Diabetes Type I (Since Birth)			Irritable Bowel Disease		
ATRIAL FIBRILATION			Diabetes Type II			Liver Disease		
Arrhythmia (other heart rhythm disorder)			Deep Vein Thrombosis			Lung Disease		
Anemia			ENT (eye, nose, throat) disorders			MRSA (Where) _____		
Arthritis			Epilepsy			Myocardial Infarction		
Asthma			Esophageal Varices			Low White Blood Cells requiring hospitalization and/or an Isolation Room		
Atopic Dermatitis			Gastric Ulcer			Peripheral Vascular Disease		
Bleeding Disorders			GERD			Prostate		
Blood Transfusions			Heart Attack			Stroke		
Breast Cancer			Heart Disease			Thyroid		
C-Diff			Hepatitis A			Urinary Tract infections (Chronic)		
Cancer (other): _____ _____			Hepatitis B			Psychiatric/Mental Health diagnosis: _____ _____		
Cancer (other): _____			Hepatitis C					
Crohn's			Herpes			OTHER:		
Congestive Heart Failure			Hyperlipidemia (high cholesterol)			OTHER:		
COPD/Emphysema			Hypertension (high BP)			OTHER:		
Coronary Artery Disease			Hypotension (low BP)			OTHER:		
OTHER: **ABNORMAL PAP SMEAR			OTHER: ABNORMAL Breast exam or mammogram			OTHER:		
OTHER:			OTHER:			OTHER:		

Name _____
 ID# _____
 Date of Birth ____/____/____



PAST SURGICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

<i>Condition</i>	<input type="checkbox"/>	<i>Year</i>	<i>Condition</i>	<input type="checkbox"/>	<i>Year</i>	<i>Condition</i>	<input type="checkbox"/>	<i>Year</i>
Abdominal Aneurism Repair			Coronary Artery Bypass Graft/ CABG			Joint Replacement_____		
Adenoids/Tonsillectomy			Gallbladder removed			Prostate Surgery		
Appendix removed			Heart Surgery			STENTS _____		
Breast Cancer Surgery			Hernia Repair			IMPLANTED PACEMAKER		
Carotid Artery surgery			Hysterectomy <small>Partial__Total</small>			IMPLANTED DEFIBRILATOR		
OTHER:			OTHER:			OTHER:		
OTHER:			OTHER:			OTHER:		

FAMILY MEDICAL HISTORY

RELATION	LIVING <small>Yes/ N=No</small>	AGE	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			

Name _____
 ID# _____
 Date of Birth____/____/____



HIV/AIDS HISTORY

HIV Diagnosis Date / /	City and State when 1 st Diagnosed:
First Service Date AT THIS CLINIC / /	Do You CURRENTLY have AIDS? YES NO UNKNOWN
Prior AIDS Diagnosis If yes, date or month/year / /	Prior AIDS Diagnosis: CITY / STATE:

MISCELLANEOUS SCREENINGS/LABS

LAST PAP (WOMEN) ___Positive / ___Negative	LAST PSA	LAST ORAL CANCER SCREEN
LAST MAMMOGRAM ___Normal / ___Abnormal	LAST RECTAL EXAM-PROSTATE	LAST BONE DENSITY SCAN
# OF PREGNANCIES	LAST COLONOSCOPY	POSITIVE OCCULT BLOOD (STOOL)
# OF LIVE BIRTHS	LAST SIGMOIDOSCOPY	OTHER:
LAST PAP (ANAL, MALE) ___Positive / ___Negative	LAST DENTAL EXAM	OTHER:
OTHER:	OTHER:	OTHER:
**Currently receiving anti-coagulation (Blood Thinner) therapy other than Aspirin	What medication?	Dose?
		Last Pt/INR
		Checked how OFTEN?

SUBSTANCE USE/ABUSE HISTORY

HOW MUCH/HOW OFTEN LAST USE QUIT DATE REQUEST INFO ON QUITTING?

TOBACCO	___Yes ___No				___Yes___ No
ALCOHOL	___Yes ___No				___Yes___ No
STREET DRUGS/type	___Yes ___No				___Yes___ No
PRESCRIPTION NARCOTICS/type	___Yes ___No				___Yes___ No

Name _____
ID# _____
Date of Birth ____/____/____



Other **MEDICAL** issues not covered in questionnaire which the doctor should know about you.

ADDITIONAL MEDICATIONS:

(Continued from Page 1) CURRENT MEDICATIONS Please include DAILY Vitamins/herbals and Over the Counter meds at end of list				
Drug Name:	Dose (Mg.;ml.;units)	How often?	How long? MM/Yr Started	If not from this clinic the prescribing doctor's name and specialty

Printed name

Signature

Date

Name _____
ID# _____
Date of Birth ____/____/____



PATIENT SELF-DETERMINATION ACT QUESTIONNAIRE

To comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes (please welcome packet for more information), please answer the following questions.

Declaration to Decline Life-Prolonging Procedure (Living Will)

- I have made such a declaration
- I have not made such a declaration

Health Care Surrogate

- I have designated a Health Care Surrogate
- I have not designated a Health Care Surrogate

Durable Power of Attorney

- I have appointed a Durable Power of Attorney for Health Care decisions
- I have not appointed a Durable Power of Attorney for Health Care decisions

Do Not Resuscitate Order (DNR)

- I have a DNR Order

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT

Name (print) _____ Signature _____ Date _____

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Name (print) _____ Signature _____ Date _____

PLEASE PROVIDE YOUR HEALTH PROVIDERS WITH COPIES OF ALL YOUR HEALTH-RELATED DOCUMENTS.

Name _____
 ID# _____
 Date of Birth _____/_____/_____



NO SHOW POLICY

What is a “No Show”?

Because we reserve a considerable amount of physician and staff time for your healthcare needs, we require **at least 24 hours’ notice** when rescheduling or cancelling your appointment. **Failure to provide at least 24 hours’ notice to reschedule or cancel your appointment results in a “no show.”**

CAN Community Health is a not-for-profit organization, committed to spending enough time with our patients to provide excellent, high quality care. Because we pay physicians and other staff to be available for you during your scheduled appointment time, when you don’t show up for your appointment, it takes valuable resources away from other patients.

No Show Fees

Failure to provide at least 24 hours advanced notice will result in a no show fee. You will be required to pay any no show fees prior to your next visit, or work out a payment plan with a financial counselor.

Other No Show Penalties

If you have 2 no shows within a 12-month period, you may be required to schedule during one of our designated no show clinic openings to see one of our doctors. Multiple no shows may result in dismissal from the practice. Please be aware that repeated no shows may also disqualify you from receiving Ryan White services.

Appointment Reminders

Reminders are usually provided as a courtesy in advance of your appointment. We call the phone number you provided, so please let us know immediately if your contact information changes. Also, please consider registering on our confidential patient portal, which allows you to easily update your information and select communication preferences, such as text message or email reminders. Our front desk team is happy to set up the portal for you, or help you if you need a password reset. We appreciate your cooperation, as your advanced notice allows us to help sick patients with urgent needs.

If you need to reschedule or cancel your appointment, please call (941) 366-0134 x11910 as soon as possible to let us know.

I have read and understand this policy. I understand that it is my responsibility to notify the clinic at least 24 hours in advance if I am unable to attend my appointment.

Print Name: _____ Date: _____

Signature: _____

Name _____
ID# _____
Date of Birth ____/____/____



PATIENT PORTAL

Our patient portal allows you confidential, 24-hour access to your medical records. It also enables patients to communicate with our practice in a convenient, safe and secure way.

Benefits of using the portal:

- Send Refill Requests
- Keep track of personal medical information
- Send messages to nursing
- Update personal information
- Receive health maintenance reminders
- Receive patient education
- See your upcoming appointments
- See your lab results

Easy sign-up!

Name: _____

Date of Birth: _____

Email Address: _____

**** PLEASE DO NOT USE THE PORTAL FOR URGENT NEEDS ****

Name _____
ID# _____
Date of Birth _____/_____/_____