Matthew Bagan D.O.
18308 Murdock Circle, Ste 105
Port Charlotte, FL 33948
PH: 941-743-4150

REGISTRATION PACKET

PATIENT NAME: _____DOB: _____AGE: _____HEIGHT: _____WEIGHT: _____

REASON FOR YOUR VISIT: _____

REFERRING PHYSICIAN: _____

HISTORY OF PRESENT ILLNESS

LOCATION: _____Where on the body symptom occurs

DURATION: _____When did it start? How long does it last?

SEVERITY: _____ Pain on a scale of 1-10

QUALITY: _____Burning, sharp, stabbing…

TIMING: _____When it occurs; after meals or exercise, etc.

CONTEXT: _____Situations associated with symptoms

MODIFYING FACTORS: _____Things that make symptoms better or worse

ASSOCIATED SIGNS/SYMPTOMS: _____other things that happen when symptom occurs

MEDICAL HISTORY: PLEASE CIRCLE IF ANY OF THESE SYMPTOMS ARE CAUSING YOU PROBLEMS

Nausea	Diarrhea
Vomiting	Constipation
Heartburn	Change in Stool Shape
Reflux	Change in Bowel Habits
Difficulty Swallowing	Bleeding per rectum
Loss of appetite	Painful Hemorrhoids
Black Stools	Fecal Incontinence
Abdominal Bloating	Abdominal Pain / location _____

MEDICAL HISTORY: PLEASE CIRCLE IF YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS

Colon Polyps	Ulcers	Hepatitis	AFib	Joint replacement
Diverticulitis	Kidney Disease	HIV/AIDS	Defibrillator	
IBS	Anemia	Heart Disease	Pacemaker	
Colitis	Diabetes	Cardiac Stents # __	Stroke/TIA	

Cancer (Type) _____

Other: _____

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SURGICAL HISTORY: PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING

Colonoscopy Year: _____ EGD (Upper Endoscopy) Year:_____

Hysterectomy Year: _____ Gallbladder Year:_____ Weight Loss Surgery Year:_____

Colon Resection Year:_____ Appendectomy Year:_____ Hernia Repair location/Year_____

Other: _____

FAMILY HISTORY: PLEASE CIRCLE IF YOU HAVE ANY BLOOD RELATIVE WITH CANCER

Colon Cancer / Who: _____ Breast Cancer /Who: _____ Gastric Cancer /Who: _____

Marital Status: _____ Occupation: _____

Tobacco Use: Never _____Quit/When_____ Current/pack per day _____

Alcohol Use: Never _____Rarely_____ Moderate_____ Heavy_____

Recreational Drug use: No _____ Yes_____Type_____

DRUG ALLERGIES_____

BLOOD-THINNING MEDS: Coumadin, Plavix, Pradaxa, Effient, Eliquis, or Aspirin? _____

CURRENT MEDICATIONS WITH DOSAGES: (CAN ALSO BRING US A LIST TO COPY)

_____

_____

_____

_____

_____

_____

PATIENT SIGNATURE: _____DATE: _____

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PATIENT NAME: _____ DATE OF BIRTH: _____

PHARMACY

NAME: _____

LOCATION: _____

PHONE: _____

HAVE YOU HAD A COLONOSCOPY?

YES: _____ NO: _____ DATE: _____

HAVE YOU HAD A PAP SMEAR?

YES: _____ NO: _____ DATE: _____N/A_____

HAVE YOU HAD A MAMMOGRAM?

YES: _____ NO: _____ DATE: _____N/A_____

DO YOU CURRENTLY SMOKE?

YES: _____ NO: _____ DATE QUIT: _____

HAVE YOU EXPERIENCED A FALL IN THE LAST 12 MONTHS?

YES:_____NO_____

IF YES, HOW MANY FALLS AND HAVE YOU SUSTAINED ANY INJURIES?_____

_____

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PATIENT INFORMATION

OFFICE: MBF DATE: _____

LAST NAME: _____ FIRST NAME: _____ M.I. _____

SSN: _____ DOB: _____ SEX: M / F

ADDRESS: _____ APT/SUITE #: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____

EMPLOYER: _____ WORK PHONE: _____

MARITAL STATUS: _____ IS YOUR SPOUSE WORKING OR RETIRED: _____

SPOUSE NAME: _____ SPOUSE DOB: _____

SPOUSE SSN: _____ SPOUSE CONTACT NUMBER: _____

_____

ALTERNATE ADDRESS

___ I DO NOT HAVE AN ALTERNATE ADDRESS

ALTERNATE ADDRESS: _____ APT/SUITE #: _____

CITY: _____ STATE: _____ ZIP: _____

_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ PLAN ID: _____

GROUP #: _____ PHONE #: _____

SECONDARY INSURANCE: _____ PLAN ID: _____

GROUP #: _____ PHONE #: _____

_____

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EMERGENCY CONTACT INFO

NAME: _____PHONE: _____

RELATIONSHIP TO CONTACT: _____GUARDIAN: _____

ADDRESS: _____APT/SUITE #: _____

CITY: _____STATE: _____ ZIP: _____

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR RACE?

___ ASIAN ___ CAUCASIAN ___ BLACK/AFRICAN AMERICAN ___ HISPANIC

___ SUBCONTINENT ASIAN AMERICAN ___ ASIAN PACIFIC AMERICAN ___ NATIVE AMERICAN

___ AMERICAN INDIAN/ ALASKAN NATIVE ___ HAWAIIAN ___ PACIFIC ISLANDER

___ MORE THAN ONE RACE ___ OTHER ___ DECLINE TO ANSWER

PLEASE SELECT ONE ETHNIC GROUP THAT BEST DESCRIBES YOUR ANCESTRY:

___ HISPANIC OR LATINO ___ NON-HISPANIC OR LATINO

___ DON'T KNOW ___ DECLINE TO ANSWER

WHAT LANGUAGE DO YOU FEEL MOST COMFORTABLE USING WHEN DISCUSSING YOUR HEALTHCARE?

___ ENGLISH ___ SPANISH ___ GERMAN ___ FRENCH

___ ITALIAN ___ RUSSIAN ___ PORTUGUESE ___ CHINESE

___ OTHER ___ DECLINE ___ DON'T KNOW ___ HAITIAN CREOLE

WE ARE DEDICATED TO PROVIDING THE BEST CARE POSSIBLE TO OUR PATIENTS. WE CAN BETTER ACCOMPLISH THIS GOAL BY OBTAINING YOUR OPINION ON HOW WE ARE DOING. MAY WE CONTACT YOU BY E-MAIL, MAIL, TEXT, OR TELEPHONE FOR OUR SURVEY?

___ YES ___ NO

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE:

A COPY OF THE NOTICE OF PRIVACY PRACTICES WAS GIVEN TO ME. IF YOUR PAPERWORK WAS MAILED YOU WILL BE SUPPLIED A COPY WHEN YOU COME IN FOR YOUR OFFICE VISIT. IF I CAME IN FOR HEALTHCARE SERVICES IN AN EMERGENCY TREATMENT SITUATION, I WAS GIVEN THE NOTICE AS SOON AS REASONABLY PRACTICABLE AFTER THE EMERGENCY TREATMENT SITUATION.

_____ _____

SIGNATURE OF PATIENT OR REPRESENITIVE **DATE**

_____

PRINTED NAME OF PATIENT OR REPRESENITIVE

****FOR OFFICE USE ONLY****

IF AN ACKNOWLEDGMENT IS NOT OBTAINED, PLEASE COMPLETE THE INFORMATION BELOW:

PATIENT'S NAME: _____

DATE OF ATTEMPT TO OBTAIN ACKNOWLEDGMENT: _____

REASON ACKNOWLEDGEMENT WAS NOT OBTAINED:

___ PATIENT/FAMILY MEMBER RECEIVED NOTICE BUT REFUSED TO SIGN ACKNOWLEDGMENT
___ EMERGENCY TREATMENT SITUATION
___PATIENT WAS INCAPACITATED AND NO FAMILY MEMBER WAS PRESENT
___ UNABLE TO COMMUNICATE DUE TO LANGUAGE BARRIERS
___ OTHER (PLEASE DESCRIBE BELOW)

_____

_____

_____

_____ _____

SIGNATURE OF EMPLOYEE DATE

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Assignment of benefits/ right to payment authorization, patient responsibility, and release of information form.

GENESISCARE USA OF FLORIDA- MBF
PO BOX 947152
ATLANTA, GA 30394

I, the undersigned, assign to the provider/entity referenced above, my rights and benefits in any medical insurance plan, health benefit plan, or other source of payment for healthcare services in connection with medical services provided by provider, its employees, and agents. I understand that this document is a direct assignment of my rights and benefits under my plan.

I authorize my insurance company to pay provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by provider are owed to provider and I agree to remit those funds directly to provider.

PATIENT RESPONSIBILITY

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my plan or for which I am responsible for payment under my plan. To the extent no coverage exists under my plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my plan.

RELEASE OF INFORMATION

I authorize provider and/ or its agents to release any medical or other information about me in its possession to my plan, the social security administration, any state administrative agency, or their intermediaries or fiscal agents required in connection with any claim for services rendered to me y my provider.

A photocopy of this assignment/authorization shall be considered as effective and valid as the original.

_____ _____

Signature of patient/person legally responsible **Date**

_____ _____

Print name of patient/person legally responsible **Date**

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PATIENT CONSENT FOR DISCLOSURE TO INVOLVED INDIVIDUALS

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Our physicians and staff know that communicating with you about your healthcare is important. By completing this form, you give us permission to provide messages, and/or/ discuss information about your healthcare with the individuals designated below. I understand that I may cancel or update this information at any time by notifying a representative of the physician office.

I give permission to allow physicians and staff to discuss relevant medical, billing, and insurance information with the individuals I listed below (examples, spouse, relatives, friends, etc.) I understand that my healthcare provider will use professional judgement to determine what information about my healthcare my be discussed with the designated individuals below.

INVOLVED INDIVIDUAL	RELATIONSHIP TO PATIENT	PHONE NUMBER

PATIENT/AUTHORIZED REPRESENTATIVE

SIGNATURE: _____ **DATE:** _____**TIME:** _____

PRINTED NAME OF AUTHORIZED REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT: _____
***IF SIGNED BY A PATIENT-AUHORIZED REPRESENTATIVE, SUPPORTING LEGAL DOCUMENTATION MUST ACCOMPANY THIS AUTHORIZATION FORM.**

Note: GenesisCare USA expressly reserves the right to disclose information to others who may not be on the list if and to the extent allowed by HIPAA, including but not limited to disclosures for treatment, payment, or healthcare operations.

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TELEPHONE CONSUMER PROTECTION ACT (TCPA) CONSENT FORM

Active communication with our patients is a key element in providing high quality health care services. To that end, GenesisCare USA desires to communicate timely information regarding health care services and functions to you in the most effective means possible, including via automated telephone and text messaging. Federal law requires that we obtain your consent prior to communicating with you via these means. Please read and sign below so that we can communicate with you for these important purposes. We apologize for the formality of this consent, but it is required under law.

I, the patient, authorize the use of my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I consent to receiving messages from my healthcare provider, when necessary, and I consent to allowing messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided to me.

I also authorize any of GenesisCare USA independent contractors' agents and/or affiliates to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice or other messaging system, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods eve if I am charged for the call, as well as through any email address or other personal contact information supplied by me. I expressly consent to receive any such automated calls. I understand that, depending on my plan, charges may apply to certain calls or text messages. I also understand that communication platforms may transmit information via unsecure methods which includes a risk that the information could be viewed by an unintended third party. I understand these risks and consent to having these communications sent unsecure.

_____

PATIENT SIGNATURE (OR SIGNATURE OF PATIENT'S AUTHORIZED REPRESENTATIVE)

_____

PRINTED PATIENT NAME

_____

DATE