HUMANITY MEDICAL CENTER

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

SS#:_____ D.O.B:_____ SEX:_____

LOCAL ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

CELL:_____ HOME PHONE:_____

EMAIL ADDRESS_____

PRIMARY LANGUAGE SPOKEN:_____

If you are a seasonal resident and also reside in another state other than Florida, please list your address
ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

NEXT OF KIN:_____RELATIONSHIP:_____PHONE:_____

ADDRESS:_____

DO YOU HAVE LIVING WILL? YES? NO

EMPLOYER: _____PHONE:_____

ADDRESS:_____

PRIMARY PHYSICIAN:_____ PHONE:_____

ADDRESS:_____

PURPOSE OF APPOINTMENT: _____

PATIENT SIGNATURE:_____DATE:_____

HUMANITY MEDICAL CENTER
Suite 110, 1000 North Hiatus Road, Pembroke Pines, FL 33026
Telephone 954.900.6656| Fax 954.589.1029

HUMANITY MEDICAL CENTER

Today's Date: _____ Patient Name:_____ Date of Birth:_____

PAST MEDICAL HISTORY:_____

_____

_____

_____

PROCEDURE/ SURGICAL HISTORY:_____

_____

_____

_____

ALLERGIES (Please list any allergies):_____

_____

_____

LIST FAMILY HISTORY:

	Diseases or Illness	Age or Age of Death	Reason for Death
Mother:	_____	_____	_____
	_____	_____	_____
Father:	_____	_____	_____
	_____	_____	_____
Paternal Grand Mother:	_____	_____	_____
Paternal Grand Father:	_____	_____	_____
Maternal Grand Mother:	_____	_____	_____
Maternal Grand Father:	_____	_____	_____
Siblings (Brother/ Sister):	_____	_____	_____
Siblings (Brother/ Sister):	_____	_____	_____
Siblings (Brother/ Sister):	_____	_____	_____

SOCIAL HISTORY:_____

_____

_____ _____

Patient's Signature Date

Today's Date: _____ Patient Name:_____ Date of Birth:_____

REVIEW OF SYSTEMS (CHECK LIST):

General-
___Weight loss or gain
___Fatigue
___Fever or chills
___Weakness
___Trouble sleeping

Skin-
___Rashes
___Lumps
___Itching
___Dryness
___Color changes
___Hair and nail changes

Head-
___Headache
___Head injury
___Neck Pain

Ears-
___Decreased hearing
___Ringing in ears
___Earache
___Drainage

Eyes-
___Vision Loss/Changes
___Glasses or contacts
___Pain
___Redness
___Blurry or double vision
___Flashing lights
___Specks
___Glaucoma
___Cataracts
___Last eye exam

Nose-
___Stuffiness
___Discharge
___Itching
___Hay fever
___Nosebleeds
___Sinus pain

Throat-
___Bleeding
___Dentures
___Sore tongue
___Dry mouth
___Sore throat
___Hoarseness
___Thrush
___Non-healing sores

Neck-
___Lumps
___Swollen glands
___Pain
___Stiffness

Breasts-
___Lumps
___Pain
___Discharge
___Self-exams
___Breast-feeding

Respiratory-
___Cough
___Sputum
___Coughing up blood
___Shortness of breath
___Wheezing
___Painful breathing

Cardiovascular-
___Chest pain or discomfort
___Tightness
___Palpitations
___Shortness of breath with activity
___Difficulty breathing lying down
___Swelling
___Sudden awakening from sleep with shortness of breath

Gastrointestinal-
___Swallowing difficulties
___Heartburn
___Change in appetite
___Nausea
___Change in bowel habits
___Rectal bleeding
___Constipation
___Diarrhea
___Yellow eyes or skin

Urinary-
___Frequency
___Urgency
___Burning or pain
___Blood in urine
___Incontinence
___Change in urinary strength

Vascular-
___Calf pain with walking
___Leg cramping

Musculoskeletal-
___Muscle or joint pain
___Stiffness
___Back pain
___Redness of joints
___Swelling of joints
___Trauma

Neurologic-
___Dizziness
___Fainting
___Seizures
___Weakness
___Numbness
___Tingling
___Tremor

Hematologic-
___Ease of bruising
___Ease of bleeding

Endocrine-
___Head or cold intolerance
___Sweating
___Frequent urination
___Thirst
___Change in appetite

Psychiatric-
___Nervousness
___Stress
___Depression
___Memory loss

_____ _____

Patient's Signature Date

HUMANITY MEDICAL CENTER

MEDICATION LIST

PATIENT NAME:_____

Date of Birth:_____ Phone: (_____) _____ - _____

ALLERGIES:_____

	MEDICATION NAME	DOSE	TIMES PER DAY
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

_____ _____

Patient's Signature Date

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HUMANITY MEDICAL CENTER

REQUEST FOR RELEASE OF MEDICAL RECORDS

FROM:_____
Name of Physician, Hospital or Facility

ADDRESS:_____

_____

Phone: (_____) _____ - _____

Fax: (_____) _____ - _____

I hereby request that my medical records, without limitations, including any HIV test results and/or treatment, be released to:

HUMANITY MEDICAL CENTER
Suite 110
1000 North Hiatus Road
Pembroke Pines, FL 33026
Telephone 954.883-2500 | Fax 954.538.0304

This authorization releases my medical records for the following designated purpose:_____

_____

I understand that I am entitled to receive a copy of this release.

_____	_____	_____
Patient's Signature	Printed Name	Date

Date of Birth: _____

_____ _____
Print Name of Legal Guardian (relationship), if applicable Witness

HUMANITY MEDICAL CENTER

INSURANCE INFORMATION, ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

Insurance Information: _____

I hereby authorize and assign payment to Humanity Medical Center LLC for all insurance medical benefits. I also understand my responsibilities of payment for any and all charges not payable under this assignment. Payment, including copays, is expected in full at the time services are rendered.

I understand and agree that, regardless of my insurance status, I am fully responsible for the balance of my account for any professional services rendered including any fees incurred for the collection of debt.

I hereby authorize Humanity Medical Center LLC to release all information necessary to my insurance company(s) to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____	_____	_____
Patient's Signature	Printed Name	Date

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Humanity Medical Center

MALPRACTICE INSURANCE

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR'S at Humanity Medical Center LLC HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

Patient's Signature	Printed Name	Date

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Humanity Medical Center

Telemedicine Consent Form I understand that telemedicine is the use of electronic technology for communication for the purpose of providing healthcare services wherever the doctor and the patient are located. I understand that the institution is based in Florida and likewise uses telemedicine to conduct a consultation with their patients. I understand that with the use of telemedicine, the interaction shall be done through real-time audio-video communication. I understand that the laws that protect privacy and confidentiality, as well as the confidentiality of medical information through the Health Insurance Portability and Accountability Act (HIPPA) also apply to telemedicine. I understand that I will be responsible for any payments or coinsurances that apply to my telemedicine visit. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment; I have the right to access my information and to inspect my medical information that was transmitted through telemedicine; I have the right to privacy where it shall be necessary to seek my consent in order to disclose my information unless those that are permitted by law to disclose without the need of my consent. I understand any lawsuit airing out of this agreement or service shall be brought to the courts of the state of Florida, to the exclusion of other states. With the pronouncements above: I authorize the Institution to provide me their diagnosis, observations, recommendations regarding my condition through telemedicine. Whenever necessary, I authorize the Institution to consult with other physicians or specialists whom they believe to have full knowledge and skills that can address my case. I have read and understood the information provided above, my rights, and obligations regarding telemedicine. I have had the opportunity to ask questions and all of which were answered to my satisfaction. Therefore, I hereby give my consent to the use of telemedicine for medical care.

_____

Patient Signature

Humanity Medical Center

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Patient's Signature	Printed Name	Date

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NO SHOW POLICY

I _____ understand that there will be a $50.00 no show fee that I am fully responsible for if I do not call and cancel my appointment at least 24 hours in advance.

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