Jupiter Family Healthcare
www.jupiterfamilyhealthcare.com

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4600 Military Trail, Suite 115, Jupiter, FL 33458
Phone (561) 776-5252 Fax (561) 776-5255

**PATIENT REGISTRATION—PLEASE PRINT**

**Today's Date:** _____ **Referred by:** _____

**Patient's Name**: _____
**Last** **First** **M.I.**

_____ _____ **M or F**
**Patient's Date of Birth** **Patient's Social Security Number** **Sex**

**Primary Address:** _____
**Street** **Apt/Unit #**

_____
**City** **State** **Zip Code**

**Secondary Address:** _____
**(if have, Northern)** **Street** **City** **State** **Zip Code**

_____ _____ _____
**Home Phone** **Cell Phone** **Work Phone**

_____ _____
**Employer** **Email address (for use of patient portal)**

_____ _____
**Marital Status** **Spouse's Name**

_____ _____
**Primary Insurance** **Secondary Insurance**

_____ _____ _____
**Subscriber's Name (relationship of other than self)** **DOB** **Social Sec No.**

_____ _____ _____
**Emergency Contact person** **Relationship to Patient** **Phone Number**

_____ _____
**Local Pharmacy** **phone number** **Mail Order Pharmacy** **Phone Number**

**Race:** (circle one): African American Hispanic White Other Race_____
(insurance request)
**Ethnicity:** (circle one) Hispanic or Latino Non Hispanic or Latino Refuse to report

**Primary Language:** _____ (2/17)

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## 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 CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

I consent to the use or disclosure of my protected health information by Jupiter Family Healthcare / Richard A. DeLucia, Jr, MD PA (hereafter referred to as "Jupiter Family Healthcare") for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Jupiter Family Healthcare. I understand that diagnosis or treatment of me by any of the providers may be conditioned upon my consent as evidenced by my signature on this document.

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

I have the right to revoke this consent, in writing, at any time, except to the extent that Jupiter Family Healthcare or its practitioners have 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(s), another healthcare provider, a health plan, my employer, or a healthcare billing clearinghouse. This protected healthcare information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

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

Jupiter Family Healthcare 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.

**If you want your health information / billing information discussed with anyone, please indicate their name and relationship below.**

**Print Name** _____ **Relationship** _____

**Signature of Patient, Parent or Guardian** _____ **Date** _____

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# TEST RESULTS POLICY

**It is our policy to notify patients of their results either by phone, email, mail or with a follow up office visit. In the space provided below, please provide a phone number where you can be reached. If we cannot reach you directly and you wish, we will leave a message at that number with your actual test results, and/or with instructions regarding a needed medical office visit follow up. If you do not write in a phone number we will provide you with an office visit to review your results.**

**Phone Number:**_____ **Date:**_____

**Patient Signature:**_____

**Thank you for your cooperation,**

**The staff of Jupiter Family Healthcare**

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**Insurance and Payment Policies**

I, the undersigned, authorize Jupiter Family Healthcare to furnish information to insurance carrier(s) or its representative, my attorney or representative, or the healthcare administration (when applicable) concerning my illness(es) and/or treatment.

I further authorize my insurance carrier or Medicare, or my attorney, to pay directly to Jupiter Family Healthcare any medical expenses payable under the terms of the contract for services rendered to myself or my dependent(s).

I also agree that I am responsible for any balance not covered by the insurance carrier or Medicare. **Any patient balance greater than thirty (30) days old will be sent to collections**. I further agree that, in the event my account must be referred to a collection agency or an attorney for collection, I shall be responsible for any and all costs resulting from such action, including but not limited to agency fees, attorney fees, filing, serving and recording fees. I am aware that an interest rate of 1.5% per month will be added to all delinquent accounts.

I am aware that a $35.00 fee will be charged for all returned checks

I am aware that there will be a **$ 25.00 charge** for any appointment **not cancelled 24 hours in advance** and a **$50.00 charge** if these appointments are for physicals or procedures such as ECHO's, Stress Tests, nerve conduction tests, or minor skin surgeries.

I understand co-payments and/or deductibles are due at the time the services are rendered.

I understand it is my responsibility to keep Jupiter Family Healthcare apprised of all changes in insurance coverage and address changes. I further agree to furnish any new/changed insurance information before services are rendered. I understand failure to do so may delay the processing of my insurance claim. I understand some carriers have timely filing limits. If I fail to provide the correct insurance information at the time of service, I understand I will be responsible to pay the balance in full.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Responsible Party | Print Name | Date |

PLEASE PROVIDE US YOUR INSURANCE CARD AND DRIVERS LICENSE SO WE MAY MAKE A COPY OF EACH.

# Jupiter Family Healthcare
## Preventative Services Education

The promotion of healthy lifestyles and the early identification of potential health risks will benefit you and are important to us. In accordance with the current United States Preventative Task Force (USPSTF) guidelines, we have put together the following information for your guidance. Please read this preventative education sheet and feel free to discuss any of the topics with our staff. Only you can take appropriate actions to maintain your health and well being.

1) Lifestyle Changes:

Diet and Exercise:

A healthy diet and regular exercise are the most effective ways to maintain good health, longevity and increase you quality of life. Choose a diet low in saturated fat, cholesterol, sugar and salt; eat plenty of vegetables, fruits, grains which provide vitamins, minerals, and fibers, lean meats, pastas, etc. Thirty minutes of exercise, three to five times a week (walking, swimming, etc.) will keep your heart and bones healthy.

Substance Abuse

Use of tobacco is known to cause heart disease, strokes and lung cancer. Excessive alcohol intake is associated with many illnesses including cancer, liver disease and impaired judgment (as in driving). Illicit drug use has many risks such as AIDS, hepatitis, heart problems, and mental and social disorders.

Sexual Behavior

Certain sexual practices (i.e., promiscuity, unprotected sex) can expose you to potentially fatal disease such as AIDS, Sexually transmitted diseases and common other infections.

Excessive Sun Exposure

Causes skin cancer. Always wear sunscreen when exposed in the sun. The higher the SPF (sun protection factor) you use, the higher the protection level against the ultraviolet rays.

Injury Prevention

Take advantage of the many safety products that are important in preventing serious injury. These include seat belts, bicycle helmets and other protective gear, safe work habits (lifting, bending, etc.), smoke detectors, firearm safety, water safety practices for adults and children, CPR training for household members, poison prevention, etc.

Dental Health

Brush and floss regularly; see your dentist for routing visits every six months.

**Preventative Services Education continued**

**2) Physical Examination -- Preventative Measures offered**

The following recommendations are for healthy individuals without symptoms of illness. Special conditions may change the frequency and type of tests you desire.

**Birth - 4 years:**

Newborn: hemoglobin, PKU, thyroid screening
Childhood immunizations: check with the doctor
Well Child Checkups
Growth and development issues

**4 years to 18 years:**

Kindergarten immunizations and booster shots
Well child, adolescent, school, and sports physicals
(safe sexual practices, injury protection, i.e. seat belts, bike helmets, substance abuse, smoking)
Growth and development issues

**18 years to 49 years:**

Routine physicals yearly for women and every 1-3 years for men
including pap smears, breast exams, mammograms in mid 30's, testicular exams, cholesterol screen, blood pressures, and other lab work
Adoption of healthy lifestyle practices (i.e. diet, exercise, smoking cessation)
Immunization boosters (tetanus, hepatitis, influenza)

**50 years to 65 years:**

Yearly physicals for males and females including pap smears, breast exams, mammograms, cholesterol screen, blood pressures, and other labs, estrogen replacement therapy, prostate exams, osteoporosis screening, colon cancer screen consisting of stool tests for blood and colonoscopy.
Adult immunizations (tetanus, yearly influenza vaccines)

**65+ years**

Yearly physicals as for 50 years and also the pneumonia vaccine

**3) Advance Directives:**

A document called a Living Will advises your family and physicians of your desire should you become incapacitated and unable to make decisions regarding your healthcare.

Have you prepared a living will: Yes _____ No _____
If so, please provide us a copy

Please sign below to acknowledge that you have read and understand this information.

_____ _____ _____
Signature Print Name Date

**Thank you for visiting Jupiter Family Healthcare today. Please fill out the questions below to the best of your ability so that we may best serve you.**

**NAME**:_____

**AGE**: _____

MAIN REASON YOU CAME IN TODAY:

_____

_____

DO YOU HAVE ANY MEDICAL CONDITIONS THAT HAVE REQUIRED TREATMENT?

_____

_____

_____

_____

HAVE YOU EVER HAD ANY SURGERIES OR HAVE BEEN HOSPITALIZED? If so, please list reasons and dates below:

_____

_____

_____

PLEASE LIST MEDICINES YOU ARE TAKING AND HOW OFTEN YOU TAKE THEM (Include alternative medicines, vitamins, health food supplements):

_____

_____

_____

DO YOU HAVE ANY ALLERGIES TO MEDICINES? If so, which ones and what happens?

_____

DO YOU SMOKE OR HAVE YOU EVER SMOKED? If so, how much?

_____

DO YOU DRINK ALCOHOL? If so, how much daily?

_____

DO YOU USE ANY TYPE OF RECREATIONAL DRUGS?

_____

**SOCIAL HISTORY:**

How long have you lived in the area: _____

What is your current occupation: _____

How far did you go in school: _____

Are you married? Yes ____ No ____

Do you have any children? Yes ____ No ____

If so, how many. Please list their ages:

_____

_____

_____

**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 _____

Influenza (flu) _____

Pneumonia _____

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

Mammogram? _____

Bone Density Testing ? _____

If you are over 50 y.o., when were you last tested for colon cancer:

Stool Cards: _____

Colonoscopy: _____

## REVIEW OF SYSTEMS: Adult / Adolescents older than 12 yrs

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

| | | YES | NO | DURATION / EXPLAIN |
|---|---|---|---|---|
| **General**: | Frequent illness? | ____ | ___ | _____ |
| | Fatigue? | ____ | ___ | _____ |
| | Recent change in weight? | ____ | ___ | _____ |
| **Skin:** | Persistent rashes? | ____ | ___ | _____ |
| | Recent change in mole? | ____ | ___ | _____ |
| | Bruise easily? | ____ | ___ | _____ |
| **Eyes:** | Difficulty with vision? | ____ | ___ | _____ |
| | Eye Pain | ____ | ___ | _____ |
| **Ears:** | Difficulty hearing? | ____ | ___ | _____ |
| | Persistent ringing? | ____ | ___ | _____ |
| | Frequent ear aches? | ____ | ___ | _____ |
| **Nose/Throat** | Post nasal drip? | ____ | ___ | _____ |
| | Frequent nosebleeds? | ____ | ___ | _____ |
| | Hoarseness? | ____ | ___ | _____ |
| | Difficulty swallowing? | ____ | ___ | _____ |
| **Heart/Lung** | Chest pain? | ____ | ___ | _____ |
| | Heart palpitations? | ____ | ___ | _____ |
| | Pain or short of breath with exercise? | ____ | ___ | _____ |
| | Persistent cough? | ____ | ___ | _____ |
| | Coughing up blood? | ____ | ___ | _____ |
| | Breathing difficulty at night? | ____ | ___ | _____ |
| | Frequently swollen legs? | ____ | ___ | _____ |
| **Gastrointestinal** | | | | |
| | Recent change in appetite? | ____ | ___ | _____ |
| | Heartburn? | ____ | ___ | _____ |
| | Nausea/Vomiting? | ____ | ___ | _____ |
| | Diarrhea/Constipation? | ____ | ___ | _____ |
| | Change in bowel movement? | ____ | ___ | _____ |
| | Rectal bleeding? | ____ | ___ | _____ |

**REVIEW OF SYSTEMS**: **Adults / Adolescents older than 12 yrs**

| | | YES | NO | DURATION / EXPLAIN |
|---|---|---|---|---|
| **Musculoskeletal** | | | | |
| | Swollen joints? | ____ | ___ | _____ |
| | Arthritis/joint pain? | ____ | ___ | _____ |
| | Leg cramps? | ____ | ___ | _____ |
| **Genitourinary** | | | | |
| | Genital problems? | ____ | ___ | _____ |
| | Urinate frequently? | ____ | ___ | _____ |
| | Get up more than once at night to urinate? | ____ | ___ | _____ |
| | Lose control of your urine? | ____ | ___ | _____ |
| | Blood in urine? | ____ | ___ | _____ |
| | Sexual problems? | ____ | ___ | _____ |
| | **For Women Only:** | | | |
| | Date of first day of last menstrual period? | | | _____ |
| | Or date you reached menopause? | | | _____ |
| | Are your periods irregular? | ____ | ___ | _____ |
| | Vaginal discharge? | ____ | ___ | _____ |
| | Lumps in your breast? | ____ | ___ | _____ |
| | Do you use birth control? Method? | ____ | ___ | _____ |
| **Neurologic** | Frequent or severe headaches? | ____ | ___ | _____ |
| | Spells of dizziness or light-headedness? | ____ | ___ | _____ |
| | Depression / Anxiety? | ____ | ___ | _____ |
| | Trouble sleeping? | ____ | ___ | _____ |
| | Memory Loss? | ____ | ___ | _____ |
| | Unsteady on feet? | ____ | ___ | _____ |

Is there anything else that you would like to discuss with your provider today?

_____

_____

_____

**Other Physician's and Specialists:** _____

_____

**Thank you for taking your time to answer these questions.**

**REVIEW OF SYSTEMS**: **Children less than 12 yrs.**

| | YES | NO | DURATION / EXPLAIN |
|---|---|---|---|
| **General** | | | |
| Problems with pregnancy or delivery of your child? | ____ | ___ | _____ |
| Exposure to smoke? | ____ | ___ | _____ |
| Frequent ear infections? | ____ | ___ | _____ |
| Repeated colds or sore throats? | ____ | ___ | _____ |
| Problems with urination? | ____ | ___ | _____ |
| Concerns with vision? | ____ | ___ | _____ |
| Concerns with hearing? | ____ | ___ | _____ |
| Needs immunizations updated? | ____ | ___ | _____ |
| Exhibit any type of nervous behavior? | ____ | ___ | _____ |
| Recent changes in homelife? | ____ | ___ | _____ |
| **School** | | | |
| Problems with grades? | ____ | ___ | _____ |
| Concern with conduct? | ____ | ___ | _____ |

**Growth and Development**

Do you have any concerns about your child's growth and development including speech, height, and weight?

_____

_____

Is there anything else that you would like to discuss with your provider today?

_____

_____

_____

**Other Physician's and Specialists:** _____

_____

**Thank you for taking your time to answer these questions.**