



NEW PATIENT REGISTRATION								
Patient's last name:		First name:		Middle name:		Previous name:		
Street address:			Apartment/ Suite		City:		State:	ZIP code:
Home phone: () -		Cell phone: () -		Work phone: () - Ext:		Email address:		
Patient Date of Birth: / /			Patient Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status: <input type="checkbox"/> single <input type="checkbox"/> marriec <input type="checkbox"/> divorced <input type="checkbox"/> widowed <input type="checkbox"/> other			
Social Security no.: - -		Employer Name and Address:						
Employment Status:	<input type="checkbox"/> full time	<input type="checkbox"/> part time	<input type="checkbox"/> not employed	<input type="checkbox"/> retired	<input type="checkbox"/> military	<input type="checkbox"/> student- ft	<input type="checkbox"/> student- pt	
EMERGENCY CONTACT								
Name of emergency contact person:			Relationship to patient:		Home phone no.: () -		Work phone no.: () -	
Mailing address:				City:		State:	ZIP code:	
RESPONSIBLE PARTY (GUARANTOR)								
The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip this section								
Guarantor's last name:		Guarantor's first name:			Guarantor's middle name:			
Guarantor's date of birth: / /		Guarantor's Social Security No.: - -			Guarantor's phone number: () -			
Guarantor's mailing address:				City:		State:	ZIP code:	
Patient's relationship to guarantor:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other, please specify:				
INSURANCE INFORMATION								
Name of primary insurance:		Subscriber number:		Policy insured's name, if not patient:		Group name / number		
Patient's relationship to insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other, please specify:				
Name of secondary insurance:		Subscriber number:		Policy insured's name, if not patient:		Group name / number		
Patient's relationship to insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other, please specify:				
OTHER INFORMATION								
Have you signed an Advanced Healthcare Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Your preferred pharmacy:			Pharmacy address:			Pharmacy telephone: () -		
May we leave appointment, test and medication info with family/household members and on your home voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No								
May we send you information regarding Cambridge events, health news updates and insurer/HMO announcements? <input type="checkbox"/> Yes <input type="checkbox"/> No								
If you answered "Yes" to the question above, where should we send these? <input type="checkbox"/> home address <input type="checkbox"/> email address <input type="checkbox"/> both								
How did you hear about our office, or who referred you to us?								

Signature of Patient or Patient's guardian/representative

Date



FINANCIAL POLICY, ASSIGNMENT INFORMATION, AND RELEASE OF INFORMATION

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guardian or representative. I authorize (assign) any insurance or Medicare benefits to be paid directly to Cambridge Medical Group or its assignees. I agree that I am responsible for any non-covered services, supplies, co-payments or deductibles. I am responsible for knowing how my insurance plan works, and have requested medical services for this office. This acceptance and assignment will be in force for all future services by practitioners from this office.

I understand that diagnosis or treatment of me by Cambridge Medical Group may be conditioned upon my consent as evidenced by my signature on this document.

I agree to provide 24 hours advance notice should I need to cancel or reschedule an appointment. I understand and agree that a \$25 fee will be charged for any broken appointment for which I do not provide 24 hours advance notice.

Signature of Patient or Patient’s guardian/representative

Date

Printed name of person signing above

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my health care, Cambridge Medical Group originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality.

I understand that Cambridge Medical Group maintains a *Notice of Privacy Practices* that provides a more complete description of protected health information uses and disclosures. The most recent version of this Notice is available from the receptionist. I understand that Cambridge Medical Group reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional written copy of this Notice at any time.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed.
- The right to revoke my consent to use or disclosure of my protected health information by notifying Cambridge Medical Group, in writing, of such revocation.

I have had an opportunity to receive and review the *Notice of Privacy Practices* of Cambridge Medical Group.

Signature of Patient or Patient’s guardian/representative

Date

Printed name of person signing above



CONSENT FOR TREATMENT

I, _____, HEREBY AUTHORIZE **Cambridge Medical Group of West Boynton**, the attending Clinician, or the Clinician designated by him/her and other Practice employees; to examine and treat me. I also authorize such treatment and procedures, as deemed necessary by the Clinician, including but not limited to, the taking of x-rays, medications, blood samples, urine samples and other therapies as deemed necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made or implied to me as to the results that may be obtained by examination and treatment.

I hereby certify that I understand the above authorization.

WITNESS

PATIENT SIGNATURE

DATE & TIME

PATIENT OR PERSON
AUTHORIZED CONSENT

RELATIONSHIP TO PATIENT

Cambridge Medical Group

Consent for Release of Protected Health Information

I, _____, consent to the release of protected health information that is required to carry out treatment, payment of healthcare operations on my behalf.

I have read the Notice of Privacy Practices and am aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I understand that Cambridge Medical Group is not required to agree with my requested restrictions. I also understand that once Cambridge Medical Group agrees to my restrictions, it must comply with those restrictions.
- I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement that is signed by me.
- I understand that Cambridge Medical Group must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
- Cambridge Medical Group has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the Notice accordingly; and we will inform you of any revisions by posting the information in the waiting room and the receptionist will hand out a copy of such revision.
- I hereby acknowledge that I have received a copy of Cambridge Medical Group Notice of Privacy Practices.
- For Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Cambridge Medical Group.

Date:

Witness:

Printed Name of Patient

Printed Name

Signature

Signature



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 Cmgfl.com

**Are you transitioning from another primary care provider or specialist?
 Cambridge Medical Group is happy to provide you with excellent healthcare.**

When transitioning between healthcare providers it is important to keep CMG up to date with your medical records. This information enables us to know your medical history and to individualize your healthcare plan.

Please see our front desk staff or your Welcome Packet for the *Transition of Care Form* giving our Medical Records Staff permission to obtain your medical records from your current provider(s). If you have any questions, please let the front desk or your clinical team know and we will be happy to answer them.

We encourage you to have an active role in your healthcare. Examples of ways to be more involved include but are not limited to, the following: open discussions about health, personal and social issues, keeping up to date on immunizations, behavioral health issues, health condition and management, functional independence, managing obstacles to care, health insurance, work plans, independent living issues and taking advantage of community services available to you.

To help us know you and your health better, please complete the following information: **(Print Please)**

Name: _____ Date of Birth: _____
 Current Provider(s): _____ Phone Number: _____
 Specialist(s): _____ Phone Number: _____
 Primary Diagnosis: _____ Secondary Diagnosis: _____
 Current Medication(s) with dosage: _____

Main Concern	Related Current Information (Hospitalizations, Surgeries, Procedures/Tests)	Current Plans / Interventions	Date – Initials	Review Date

Topics to Review during Office Visit:

Health Promotion	Health Insurance	Immunizations	Independent Living Issues
Health Condition	Functional Independence	Work Plans	Community Inclusion
Management	Obstacles to Care	Retirement Plans	Other

If you have any questions, please ask your provider or any member of the CMG staff.

Patient History

Patient Name: _____ Patient DOB: _____

Social Security #: _____ Date of Last Exam: _____

Which of the following conditions are **you currently being treated/have been treated** for (Please circle all that apply)?

- | | |
|---|---------------------------|
| -Heart Disease/Murmur/Angina | -Headaches/Migraines |
| -High Blood Pressure/Low Blood Pressure | -Anemia or Blood Problems |
| -Depression/Anxiety | -Cancer |
| -Thyroid Problems | -Stroke |
| -Shortness of breath/Asthma | -Seizures |
| -Lung Problems/Cough | -Tonsillitis |
| -Liver Problems/Hepatitis | -High Cholesterol |
| -Psychiatric Care | -Diabetes |
| -Sinus Problems/Allergies | -Kidney/Bladder Problems |
| -Eye Disorder/Glaucoma | -Heartburn(reflux) |
| -Neurological problems | -Ulcers/Colitis |
| -Swollen Ankles | -Ear Problems |
| -Other: _____ | |

Please answer the following questions to the best of your ability.

Have you had a **Sexually Transmitted Disease**? Yes/No If Yes, Diagnosis: _____

Have you ever been hospitalized? Yes/No If yes, what for? _____

Please describe any current or past medical treatment not listed above:

Past Medical Gynecological History (Females)

How many times have you been pregnant? _____ Date of last Pap Smear _____

Have you had any abnormal Pap Smears? Yes/No If yes, Diagnosis? _____

Date of last Mammogram _____ **Where:** _____ **Result:** _____

Patient History Continued

Please list your Past Surgeries (Year/Surgery Type)

Please list your current Medications:

Please list any previous/current Allergies:

Are you allergic to penicillin or any other drugs? Y/N Please list others

Social History (Please circle if you have had any of the following, if yes provide the exam date):

Influenza Vaccine (Flu) **Yes/No** _____ Pneumonia Vaccine **Yes/No** _____
Colorectal Screening: Stool card **Yes/No** **Date:** _____ Colonoscopy **Yes/No** **Date:** _____
 Echocardiogram **Yes/No** _____ EKG **Yes/No** _____

Do you exercise daily/weekly? **Yes/ No**
 Do you currently smoke or chew tobacco? **Yes/No** Have you in the past? **Yes/No** How many per day? ____
 Do you drink alcohol, beer or wine? **Yes/No** Have you in the past? **Yes/No** How many per week?
 Do you currently drink coffee and or tea **Yes/No** How many per day? _____
 Do you use seatbelts while driving? **Yes/No** Do you wear a helmet while riding a bike **Yes/No**

Family History

<u>Father</u>	Alive/Deceased	<u>Diabetes</u> Yes/No	<u>Hypertension</u> Yes/No	<u>Heart</u> Yes/No	<u>Mental</u> Yes/No	<u>Cancer</u> Yes/No
<u>Mother</u>	Alive/Deceased	<u>Diabetes</u> Yes/No	<u>Hypertension</u> Yes/No	<u>Heart</u> Yes/No	<u>Mental</u> Yes/No	<u>Cancer</u> Yes/No
<u>Siblings</u>	Alive/Deceased	<u>Diabetes</u> Yes/No	<u>Hypertension</u> Yes/No	<u>Heart</u> Yes/No	<u>Mental</u> Yes/No	<u>Cancer</u> Yes/No



Please list any Specialists you are currently seeing:

PROVIDER NAME	SPECIALTY

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is completed, true and accurate.

Patient/Legal Guardian Signature _____ Date _____