Michael A. Blum, DO
Internal Medicine

New Patient Registration Form

Name: _____ **Date of Birth**: _____
First Middle Last

Address:_____
Street City State Zip Code

Telephone: ( )_____-_____ Alt/Cell No.: ( )_____-_____ **Social Security**: _____-_____-_____

Gender: ☐ Female ☐ Male **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email Address: _____ May we send information here? ☐ YES ☐ NO

Race: ☐ White ☐ Blk/African American ☐ Asian ☐ Other: _____ **Ethnicity**: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Language: ☐ English ☐ Spanish ☐ Other: _____

Previous Primary Care Physician: _____ **Phone Number**: ( )_____-_____

Emergency Contact

Name: _____ **Relationship**: _____
First Middle Last

Telephone: ( )_____-_____ Alt/Cell No.:( )_____-_____

Insurance

Insurance Company: _____ **Subscriber ID**: _____

Mailing Address: _____
Street City State Zip Code

Telephone: ( )_____-_____ Alt No.: ( )_____-_____

We do need a copy of insurance card & photo id

Current Medications

Medication	Strength	Dose	Frequency	Refill Needed	Days Left
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	

Past Medical History

Chronic and/or Current Health Issues or Diagnosis:

1.	Date Diagnosed:
2.	Date Diagnosed:
3.	Date Diagnosed:
4.	Date Diagnosed:
5.	Date Diagnosed:
6.	Date Diagnosed:

Allergies

☐ **No Known Drug Allergies**

Allergies	Reaction:

Surgical History

Surgeries and dates:

Date:	Surgery:
Date:	Surgery:
Date:	Surgery:
Date:	Surgery:
Date:	Surgery:
Date:	Surgery:

Hospitalization

Hospitalizations and dates:

Date:	Reason:
Date:	Reason:
Date:	Reason:
Date:	Reason:
Date:	Reason:
Date:	Reason:

Family History

	Alive	Deceased	Age	Illness	Cause of Death
Mother					
Father					
Sibling - Sister					
Sibling - Brother					
Daughter					
Son					

☐ Adopted ☐ Unknown Family History

Social History

Tobacco: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked If yes, how many per day: ____ How many years? _____

Former Smokers: How long since last smoked: _____

Alcohol: ☐ Drink Daily ☐Hx of Alcoholism ☐ Occasional Drinker ☐ Do not drink If yes, ____ drinks per ☐ day ☐week

How often did you have 6 or more drinks on one occasion: ☐ Never ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Caffeine: ☐ Yes ☐ No If yes, how many per day: _____

Do you need caffeine in the morning or through the day? ☐ Yes ☐ No Do you get headaches, fatigue, low energy, or irritability when you do not get your morning or afternoon caffeine? ☐ Yes ☐ No Do you have to drink more caffeine now to get you through the day? ☐ Yes ☐ No Do you drink caffeine even if it gives you anxiety or makes you shaky? ☐ Yes ☐ No

Drugs: ☐ IV Drug User ☐ Illicit Drug Use ☐ Former Drug User ☐ Never Used Drugs If yes, name of drug: _____

Sexual Activity: ☐ Sexually Active ☐ Not Sexually Active With: ☐ Men ☐ Women

Safe Sex Practices: ☐ Abstinence ☐ Condoms ☐ Other: _____

Exposure to STD: ☐ Yes ☐ No Exposed to: _____

Last Menstrual Period: _____/_____/_____

Employment: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student Place of employment: _____

Preventative Measures

Measure:	Circle One:	Date Completed	Facility/Physician Completed
Colon Cancer Screening	Colonoscopy / Sigmoidoscopy / Stool Card		
Mammogram			
Cervical Cancer Screening	PAP Smear / HPV Screening		
Osteoporosis Screening	Dexa Scan		
Eye Exam	Routine Eye Exam / Diabetic Eye Exam		

Specialist Currently Seeing

Physician	Reason

Review of Systems

Please only check the symptoms that apply to you. By not selecting these symptoms, you are indicating you do not have them.

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Sleep Disturbance
- ☐ Change in Appetite

Ophthalmologic
- ☐ Blurred Vision
- ☐ Contact Lens
- ☐ Corrective Lens
- ☐ Double Vision
- ☐ Eye Redness
- ☐ Eye Pain/Irritation
- ☐ Tearing/Discharge
- ☐ Dry Eye

Ears, Nose & Throat
- ☐ Difficulty Hearing
- ☐ Hay Fever
- ☐ Ear Pain
- ☐ Ear Discharge
- ☐ Ringing in the Ears
- ☐ Nosebleed
- ☐ Nasal Congestion
- ☐ Nasal Discharge
- ☐ Sinus Pain
- ☐ Dry Mouth
- ☐ Mouth Sores
- ☐ Gum Bleeding
- ☐ Tongue Sores
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Snoring

Respiratory
- ☐ Dyspnea
- ☐ Cough
- ☐ Cough w/ Phlegm
- ☐ Pain w/ Inspiration
- ☐ Asthma
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Shortness of Breath at Rest
- ☐ Shortness of Breath w/ Exertion

Cardiology
- ☐ Chest Pain
- ☐ Chest Pain at Rest
- ☐ Chest Pain w/ Exertion
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling in Hands/Feet
- ☐ Weakness

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Vomiting
- ☐ Flatulence
- ☐ Change in Bowel Habits
- ☐ Blood in Stool
- ☐ Difficulty Swallowing

Genitourinary
- ☐ Frequent Urination
- ☐ Difficulty Urinating
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Vaginal Discharge
- ☐ Penile Discharge
- ☐ Erectile Dysfunction
- ☐ Genital Sores

Musculoskeletal
- ☐ Muscle Pain
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Gout
- ☐ Painful Joints
- ☐ Joint Swelling
- ☐ Limited Range of Motion

Skin
- ☐ Hair Changes
- ☐ Laceration
- ☐ Rash
- ☐ Dry Skin
- ☐ Itching
- ☐ Hives
- ☐ Bruising
- ☐ Mole(s)
- ☐ Nodule(s)
- ☐ Eczema

Neurologic
- ☐ Headache
- ☐ Dizziness
- ☐ Fainting
- ☐ Tingling/Numbness
- ☐ Tremor
- ☐ Restless Legs
- ☐ Seizures
- ☐ Difficulty Speaking
- ☐ Memory Loss
- ☐ Balance Difficulty
- ☐ Gait Abnormality
- ☐ Stroke

Psychiatric
- ☐ Changes in Mood
- ☐ ADHD
- ☐ Depressed Mood
- ☐ Anxiety
- ☐ Nervous Breakdown
- ☐ Suicidal Thoughts
- ☐ Stressors
- ☐ Delusions
- ☐ Substance Abuse
- ☐ Mental or Physical Abuse
- ☐ Eating Disorder
- ☐ Psychiatric Condition

Patient Authorization & Consent

I, _____, hereby voluntarily consent to medical treatment, including diagnostic procedures, surgical and other medical services, provided by MICHAEL A BLUM, DO PA or his authorized designees, as they may in their professional judgment be necessary to provide appropriate medical, surgical or emergency care.

I authorize MICHAEL A BLUM, DO PA to submit claims to my insurance company for services rendered by my medical providers.

I authorize the release of any medical information necessary in order to process this assignment on the claim.

I authorize payment to be made to MICHAEL A BLUM DO PA for services provided by him.

Initials: _____

Patient Information Form – Financial Agreement

ALL PROFESSIONAL FEES RE DUE AT THE TIME OF THE SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

1). Services are rendered to the patient, not the insurance company. Our office will file your insurance if proper information is received.
   a) You are responsible for co-pays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance at the time of your appointment.
   b) For unpaid claims over 90 days, it is your responsibility to follow up with your insurance company and the balance may be considered due and payable.
2). It is your responsibility to notify our front desk of any insurance or address changes.
3). You will be responsible for any changes that occur if changes to your current insurance are not communicated at the time of service.
4). Expenses incurred to collect patient-responsible debt may be charged to the patient or guarantor.
5). There will be a $25 fee for any returned checks.

Initials: _____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding me protected health information it can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have reviewed MICHAEL A BLUM, DO PA's Notice of Privacy Practices, which is displayed in the patient waiting room. I understand that I am entitled to receive a copy of this document at no cost to me.

Patient requested copy: ☐ YES ☐ NO Initials: _____

Consent to Release Medical Information to Personal Representative

I, _____, hereby consent to have my information releases to the following individuals. This consent will remain in effect until otherwise notified by me in writing.

☐ Appointment Times ☐ Medical Information ☐ Billing/Demographic Information OR ☐ Do NOT Release Any Information

Name	Relationship	Phone Number
_____	_____	(_____) _____-_____
_____	_____	(_____) _____-_____

Patients Signature: _____ Date: _____

Office Policies

In order to provide you with good service it is of great importance we have your current address and phone number on file. Please be sure to contact us if your phone number and/or address changes. This information will be utilized to remind you of your appointment date and time.

- Cancelation/No Show Policy
  Any cancellations, broken appointments or no shows in which a 24-hour notice is not provided will result in a service charge of $50.00 for office visits and $100.00 for diagnostic appointments, as this denies the opportunity of another patient being seen who could have been provided care.
- Late Arrival Policy
  The clinic has a limit waiting time for your appointment. If you are more than 10 minutes late to your appointment it will be rescheduled for a later date.
- Repeat of Cancellation/No Show Policy
  First no show will result in a verbal notification which will be logged in your medical chart. Second no show will result in a warning letter being mailed to you. A third no show will result in the termination of services.

If we terminate our service with you, we will be happy to transfer a copy of your medical records to your new physician upon receipt of a signed authorization to release records.

I have been informed and understand the policies listed above. I also understand if I fail to provide a 24-hour notice of a broken appointment I will incur a service charge of $50.00 to $100.00 depending on the type of appointment.

Initials: _____

Consent for Prescription Reconciliation

I, _____, hereby consent to have my prescription history reconciled via pharmacy billing information.

Pharmacy Name: _____

Location: _____

Telephone: ( )_____-_____

Initials: _____

Chronic Care Management Consent

☐ I agree to be enrolled in the Medicare Chronic Care Management Program, to be managed by my primary care physician of Internal Medicine: Michael A. Blum, DO PA. I understand that I can revoke this consent at any time in writing.

☐ I do not wish to participate in the Chronic Care Management Program.

Initials: _____

Attorney/Adjuster/Case Manager Information

Name: _____

Phone Number: ( )_____-_____ Ext: _____ Fax Number: ( )_____-_____

Company: _____

Date of Injury: _____/_____/_____

Claim Address: _____ State: _____ Zip: _____

Claim Number: _____

Michael A Blum D.O.

Internal Medicine

Patient Authorization to Release Medical Records

Patient Name: _____ Date of Birth: _____
First Middle Last

1. Please release the requested information:

☐ TO: MICHAEL A BLUM DO PA
Address: 1111 SE Federal Hwy, Suite 330
Stuart, FL 34994
Phone: (772) 249-0260
Fax #: (772) 249-0137

☐ FROM: _____
Address: _____
_____
Phone: _____
Fax: _____

I authorize this information to be disclosed in the following ways:

☐ Written/Photocopy/Paper ☐ Verbal ☐ Faxed ☐ Electronically

2. Reason for Release: _____

3. Specific Reports to Disclose:

☐ Visit Notes	☐ Laboratory Results	☐ Consultation Report
☐ Health Summary	☐ Radiology Reports	☐ Immunization Record
☐ Appointment History	☐ Discharge Summary	☐ Films or disc w/ Images
☐ Progress Notes	☐ Operative Report	☐ Pharmacy History

☐ Entire Health Record: (including but not limited to, information regarding medical/health treatment, insurances, demographics and other referral documents.)

☐ Other (Specify): _____

4. I give specific authorization to disclose the following information:
   - ☐ HIV Test Results
   - ☐ Drug and Alcohol Abuse Treatment Records
   - ☐ Documentation of AIDS Diagnosis
   - ☐ Psychiatric/Mental Health Treatment Records

5. Dates of Treatment: ☐ ALL Dates From: _____ To: _____

I understand that I may withdraw or revoke my permissions at any time. If I withdraw my permission, my information may no l longer be used or released for the reason covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying MICHAEL A BLUM DO PA in writing.

My treatment will not be based on the completion of this of this form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Florida privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient or Patient Representative Authority of Representative to Act for Patient

Identification verified by: _____ (circle type) DL-SS-Legal Document-Picture ID-(other) _____

To the party receiving this information: Information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits from making any further disclosure of it without specific written consent of the persons to who it pertains, others information is not sufficient for this purpose. For Patient Records Applicable Under Federal Law 42 CFR part 2