North Florida Medical Clinic
Patient Registration Information

Patient Information	
Last Name:	First Name: MI:
Address:	Maiden Name:
City: State: Zip:	Date of Birth:
Home Phone:	Work Phone:
Cell Phone:	Social Security #:
Gender: Male Female (circle one)	Drivers License #:
Marital Status: M S D W (circle one)	Occupation:
Guarantor Information:	
Last Name:	First Name: MI:
Address:	Maiden Name:
City: State: Zip:	Date of Birth:
Home Phone:	Work Phone:
Cell Phone:	Social Security #:
Gender: Male Female (circle one)	Drivers License #:
Marital Status: M S D W (circle one)	Occupation:
Other Information:	
Please list a friend or relative not living with you.	
Last Name:	First Name: MI:
Address:	City: State: Zip:
Home Phone:	Cell Phone:
Insurance Information (Primary)	**Insurance Information (Secondary)**
Name:	Name:
ID#:	ID#:
Group#:	Group#:
Phone#:	Phone#:
Mailing Address:	Mailing Address:
Effective Date:	Effective Date:
Policy Holder:	Policy Holder:
HMO Information ONLY	
PCP Co-payment:	
Effective Date:	
PCP:	
PCP Phone#:	
Authorization Requirements:	

Who may we thank for referring you?	
Name:	Phone#:
Address:	City: State: Zip:

North Florida Medical Clinic
1361 13th Ave. South, Suite 150
Jacksonville Beach, FL 32250
Phone (904) 242-7177 Fax (904) 242-7433
Kevin M. Holthaus M.D.
Anthony M. Vetere, M.D., FACP David Johnson, MD
Amy Brumfield, PA-C, MHSE Deborah Ghandour PA-C, DHSc

HISTORY AND PHYSICAL

NAME: ______________________ SS#:______________ DATE: __________

ADDRESS: ______________________ OCCUPATION: ______________

PHONE (HOME) ____________ (WORK) ____________ DOB: __________ AGE: _______

CHIEF COMPLAINT: ____

____

DRUG ALLERGIES

____
____
____
____
____
____

CURRENT MEDS

____
____
____
____
____

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
HEART DISEASE:	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE:	☐	☐	☐	☐	☐	☐
STROKE:	☐	☐	☐	☐	☐	☐
CANCER:	☐	☐	☐	☐	☐	☐
DIABETES:	☐	☐	☐	☐	☐	☐
EPILEPSY/CONVULSIONS:	☐	☐	☐	☐	☐	☐
BLEEDING DISORDER:	☐	☐	☐	☐	☐	☐
KIDNEY DISEASE:	☐	☐	☐	☐	☐	☐
THYROID DISEASE:	☐	☐	☐	☐	☐	☐
MENTAL ILLNESS:	☐	☐	☐	☐	☐	☐
OSTEOPORSIS:	☐	☐	☐	☐	☐	☐

HOSPITALIZATION OR SURGERY

REASON	DATE	REASON	DATE

WOMEN ONLY: PREGNANT? [ ] YES [ ] NO PLANNING PREGNACY? [ ] YES [ ] NO

MEDICAL HISTORY

☐ HEADACHE: ______________ ☐ LACTOSE INTOLERENT: ______________ ☐ DEPRESSION: ______________
☐ SHORTNESS OF BREATH: ______________ ☐ GALLBADDER DISEASE: ______________ ☐ GOUT: ______________
☐ HEART PALPITATONS: ______________ ☐ PROSTATE DISEASE: ______________ ☐ SCARLET FEVER: ______________
☐ HEART MURMUR: ______________ ☐ BOWEL IRREGULARITY: ______________ ☐ CHRONIC RASHES: ______________
☐ CHEST PAIN: ______________ ☐ INCOTINENCE: ______________ ☐ RHEUMATIC FEVER: ______________
☐ DIZZINESS / FAINTING: ______________ ☐ SEXUAL/MENSTRUAL DYSFUNCTION: ______________ ☐ MUMPS: ______________
☐ PERIPHERAL VASCULAR DISEASE: ______________ ☐ VENEREAL DISEASE: ______________ ☐ MEASLES: ______________
☐ ALLERGIES / HAY FEVER: ______________ ☐ FREQUENT INFECTIONS: ______________ ☐ RUBELLA: ______________
☐ ASTHMA: ______________ ☐ HEPATITIS: ______________ ☐ POLIO: ______________
☐ BRONCHITIS: ______________ ☐ ANEMIA: ______________ ☐ DIPHTHERIA: ______________
☐ PNEUMONIA: ______________ ☐ ARTHRITIS: ______________ ☐ TETANUS: ______________
☐ ULCER: ______________ ☐ OSTEOPOROSIS: ______________ ☐ OTHER: ______________
☐ GI DISORDER: ______________ ☐ NERVOUSNESS: ______________ ☐ OTHER: ______________

HABITS

☐ SMOKE: PACKS DAILY ______________ ☐ COFFEE: CUPS DAILY ______________ ☐ SLEEP: DIFFICULTY FALLING ASLEEP ___________\

HOW LONG ______________ OTHER CAFFEINE ______________ CONTINUITY DISTURBANCES ___________

INTERESTED IN STOPPING? ___________ ☐ ALCOHOL: TYPE ______________ SNORING ______________

☐ EXERCISE ROUTINE ______________ AMOUNT ______________ EARLY MORNING AWAKENING ___________

______________ ☐ DIET: SALT INTAKE ______________ DAYTIME DROWSINESS ___________

☐ CONTACT WITH BLOOD/BODILY FLUID AT WORK ____ FAT INTAKE ______________ OTHER ______________

North Florida Medical Clinic

Authorizations and Assignment of Benefits

Payment at Time of Service

It is our office policy that payments are due at the time of service. If we have a contract with your insurance company, we will file your insurance. However YOU are responsible for all co-pays, deductibles, and non-covered services at the time of service.

Date: ____________ Signature: ________________________________
(Patient, Parent, or Legal Representative)

Patient Statement

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I certify that the information provided on this form is true and correct to the best of my knowledge. I will notify North Florida Medical Clinic of any changes in this information. A photocopy or other reproduction of this will be as valid as the original.

Date: ___________ Signature: ________________________________
(Patient, Parent, or Legal Representative)

Authorization to Release Information

I hereby authorize North Florida Medical Clinic to furnish my insurance companies, hospitals, referring or consulting physicians and billing agents all information with regard to my medical care.

Date: ___________ Signature: _________________________________
(Patient, Parent, or Legal Representative)

Authorization for Assignment of Benefits

I hereby authorize payment directly to North Florida Medical Clinic for medical benefits, if any, otherwise payable to me under the terms of my insurance.

Date: __________ Signature: _________________________________
(Patient, Parent, or Legal Representative)

Office Policy For No-Show Appointment

I am aware I will be charged an administrative fee of $30.00 for any appointment made by or for myself that is not canceled ***24 hours prior to the Appointment Time.***

Date: __________ Signature: _________________________________
(Patient, Parent, or Legal Representative)