PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Legal Name *(Last):* _____ *(First):* _____

(Middle Name): _____ **Preferred Name**: _____

Social Security Number: _____-_____-_____ **Birth Date:** _____/_____/_____

Sex Assigned at Birth: ☐ Male ☐ Female **Pronouns:** _____

Gender Identity: *(Check all that apply)*:

___ Male ___ Female ___ Nonbinary ___ Transgender ___ Prefer not to answer

My Gender Description: _____

ADDRESS AND CONTACT INFORMATION

Address: _____ **Apt/Suite #:** _____

City: _____ **State:** _____ **ZIP Code:** _____

Primary Phone: (_____) _____-_____ ☐ **Cell** ☐ **Home/Landline** ☐ **Work**

Secondary Phone: (_____) _____-_____ ☐ **Cell** ☐ **Home/Landline** ☐ **Work**

Primary Email Address: _____

☐ *I hereby give my consent for NSU Health to contact me electronically via Text Message and/or E-mail.*

SMS Terms & Conditions: https://nsuhealth.nova.edu/patient-information/sms-terms.html

Patient or Patient's Authorized Representative Initials _____

DEMOGRAPHIC INFORMATION

Marital Status: ___ Married ___ Single ___ Widowed ___ Divorced ___ Partnered

Spouse/Partner's Name: _____

Employment Status: ☐ Full time ☐ Part Time ☐ Retired ☐ Unemployed

Student Status: ☐ Full time Student ☐ Part Time Student ☐ Not A Student

Race: (Check all that apply)

☐ Black or African American/Afro- Caribbean
☐ Native Hawaiian or Pacific Islander
☐ Arab American/Persian American/Middle Eastern
☐ Asian or Asian American
☐ Hispanic or Latina/Latino
☐ Native American or Alaska Native
☐ White/Caucasian
☐ Multiracial
☐ Decline to Specify
Other: _____

PATIENT REGISTRATION FORM

Patient's Name: _____

Ethnicity: (Check all that apply)

☐ Unknown

☐ Hispanic or Latina/Latino

☐ Not Hispanic or Latina/Latino

☐ Decline to Specify

Other: _____

Preferred Language: _____ **Religion:** _____ **Church:** _____

Are you a Veteran? ☐ Yes ☐ No

Special Considerations: (Check all that apply)

☐ Visual limitations ☐ Hearing loss ☐ Physical limitations ☐ Developmental disability

PARENT/GUARDIAN INFORMATION (if patient is a minor):

Last Name: _____ **First Name:** _____

Relationship: _____

Address *(if different)*: _____ **Apt/Suite #:** _____

City: _____ **State:** _____ **ZIP Code:** _____

Primary Phone Number: (_____) _____-_____ ☐ **Cell** ☐ **Home/Landline** ☐ **Work**

EMERGENCY CONTACT INFORMATION

Name: _____ **Relationship:** _____ **Phone:** (_____) _____-_____

Name: _____ **Relationship:** _____ **Phone:** (_____) _____-_____

PREFERRED PHARMACY INFORMATION

Is your preferred pharmacy Nova Southeastern University Pharmacy? ☐ Yes ☐ No

Pharmacy: _____ **Phone:** (_____) _____-_____ **Fax:** (_____) _____-_____

Address: _____ **City:** _____ **State:** _____ **ZIP Code:** _____

PATIENT REGISTRATION FORM

Patient's Name: _____

GUARANTOR INFORMATION (*Financial Responsibility*)

Is the patient the guarantor? ☐ Yes ☐ No (If the guarantor is not the patient, provide the following information regarding the guarantor who is responsible for payment):

Patient's Relationship to Guarantor: _____

Guarantor Last Name: _____ **First Name:** _____ **MI:** _____

Address: _____ **Apt/Suite #:** _____

City: _____ **State:** _____ **ZIP Code:** _____

Primary Phone Number: (_____) _____-_____ ☐ **Cell** ☐ **Home/Landline** ___ **Work Primary**

Email Address: _____ **Social Security Number:** _____-_____-_____

Birth Date: _____ /_____/_____ **Sex Assigned at Birth:** ☐ Male ☐ Female

Guarantor's Employer: _____

PRIMARY INSURANCE INFORMATION

(Please upload the front and back of your insurance card(s) and bring with you to your visit.)

Primary Insurance Company: _____

Policy ID # _____ **Group #** _____

Customer Service or Benefits Phone Number: (_____) _____-_____

Is the Patient the primary policy holder? ____ Yes ____ No

Is the Guarantor the primary policy holder? ____ Yes ____ No

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company: _____

Policy ID # _____ **Group #** _____

Customer Service or Benefits Phone Number: (_____) _____-_____

Is the Patient the primary policy holder? ____ Yes ____ No

Is the Guarantor the primary policy holder? ____ Yes ____ No

PATIENT REGISTRATION FORM

Patient's Name: _____

I certify that all information is my personal information and has not been fraudulently derived. I understand that it is my responsibility to notify NSU Health of any changes to the above instructions.

I hereby assume responsibility to pay the costs of all services provided by NSU Health.

_____

Printed Name of Patient or Patient's Authorized Representative

_____ _____/_____/_____

Signature of Patient or Patient's Authorized Representative **Date**

If signed by the Patient's Representative, please print name, and describe relationship to patient or other authority to act:

_____ _____

Name of Representative **Relationship to Patient**

For Student Use Only

NSU ID: N _____

College: _____

NSU Health

PATIENT HISTORY FORM

PATIENT INFORMATION:

Patient's Legal Name: _____ **Today's Date:** _____

Social Security Number: _____ **Date of Birth:** _____

PAST MEDICAL HISTORY:

Previous Physician's Name: _____ **Date of last exam:** _____

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

Have you ever been tested for hepatitis A, B or C? ☐ Yes ☐ No

Which hepatitis virus? _____

Have you been vaccinated for hepatitis B? ☐ Yes ☐ No

If yes, date vaccine series completed? _____

Have you been vaccinated for hepatitis A? ☐ Yes ☐ No

If yes, date vaccine series completed? _____

Last Tuberculosis (TB) Screening? _____

Result of TB screening: ☐ Positive ☐ Negative

If positive TB screen date of last chest x-ray: _____

Result of chest x-ray: ☐ Positive ☐ Negative

Have you had a sexually transmitted disease? ☐ Yes ☐ No

Diagnosis: _____

Which of the following conditions are you currently being treated or have been treated for in the past? (Please Check)

____Heart disease / Murmur / Angina
____Diabetes
____Stroke
____Lung problems / Cough
____Low blood pressure
____Arthritis
____Neurological problems
____Tonsillitis
____Swollen ankles
____Thyroid problems
____Shortness of breath
____High cholesterol
____Kidney/Bladder problems
____Seizures
____Sinus problems
____Heartburn (reflux)
____Cancer
____Depression / Anxiety
____Ear problems
____Eye disorder / Glaucoma
____Asthma
____High blood pressure
____Liver problems / Hepatitis
____Headaches / Migraines
____Seasonal allergies
____Anemia or blood problems
____Ulcers / Colitis
____Psychiatric care

NSU Health

PATIENT HISTORY FORM

Patient's Name: _____

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

_____

_____

Please list your past surgeries:

_____

_____

Are you Allergic to penicillin or any other drugs? ☐ Yes ☐ No

Please list:

_____

_____

Social and Preventative History:

Do you currently smoke or chew tobacco? ☐ Yes ☐ No

If no, have you in the past? ☐ Yes ☐ No How many packs per day? _____

Do you drink alcohol, beer, or wine? ☐ Yes ☐ No

If no, have you in the past? ☐ Yes ☐ No How many drinks per week? _____

Do you currently drink coffee and/or tea? ☐ Yes ☐ No

If yes, how many cups per day? _____

Do you exercise daily/weekly? ☐ Yes ☐ No

Do you use seatbelts while driving? ☐ Yes ☐ No

Do you wear a helmet while riding a bike? ☐ Yes ☐ No

Family History:

	Living	Age (or age at death)	List serious illnesses
Mother	◯ Yes ◯ No	_____	_____
Father	◯ Yes ◯ No	_____	_____
Sister(s)	◯ Yes ◯ No	_____	_____
Brother(s)	◯ Yes ◯ No	_____	_____

PATIENT HISTORY FORM

Patient's Name: _____

Has any member of your family (including children and parents) had any of the following:

Illness	Which family member?
Anemia or Blood diseases	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart disease	_____
High Blood Pressure	_____
HIV Disease/AIDS	_____
Mental Illness/Depression	_____
Stroke	_____
Other serious illness	_____

FEMALES: GYNECOLOGICAL HISTORY:

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

Have you had an abnormal Pap Smear? ☐ Yes ☐ No Diagnosis: _____ Follow up: _____

Date of ast Mammogram: _____ Mammogram Results: _____

Have you ever had a breast biopsy: ☐ Yes ☐ No Biopsy results: _____

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

Patient/Legal Guardian Signature: _____ **Date:** _____

HIPAA NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

I acknowledgment that I have received a copy of the NSU Health HIPPA Notice of Privacy Practices.

_____ _____

Patient Name (Print) **Patient Signature**

_____

Date

If completed by a patient's representative, please print, and sign your name in the space below.

_____ _____

Patient's Representative Name (Print) **Patient's Representative Signature**

_____

Date

For Office Use Only

I have made a good faith effort to obtain written acknowledgement of receipt of the NSU Health Notice of Privacy Practices. However, an acknowledgement was

- o Patient refused to sign.
- o Patient unable to sign or initial because:
- o Due to an emergency, it was not possible to obtain an acknowledgement.
- o Other:

_____ _____

Employee **Date**

File in Patient Chart

CONSENT AND AGREEMENT FOR TREATMENT AND RELEASE OF INFORMATION FOR TREATMENT AND HEALTHCARE OPERATIONS

Please read the following information carefully. After you have read this Consent and Agreement for Treatment ("Agreement") please sign your name below to accept the terms of this agreement.

1. **Authorization for Routine Medical Treatment:** I hereby consent to such medical treatment for myself or my child which in the judgment of my health care provider may be considered necessary or advisable while a patient at NSU Health, and it's health care providers, employees and agents ("NSU").

2. **Teaching Facilities:** I am aware that the NSU Health are teaching facilities, and as a result, medical residents, medical students, and other medical career students will be involved in my care and treatment under appropriate supervision of clinical faculty. I am aware that NSU Health does not involve medical residents, medical students, and other medical career students in my care and treatment. In addition, I am aware that should I access care and treatment at any other NSU Health for any reason that medical residents, medical students, and other medical career students will be involved in my care and treatment under appropriate supervision of clinical faculty.

3. **Appointments and Cancellation Policy:** The clinic time of the medical resident and clinical faculty is scheduled by appointment. It is essential that all appointments be kept promptly. When an appointment cannot be kept, the clinic must be notified at least 24 hours in advance. Patients that miss THREE (3) scheduled appointments may be DISMISSED from NSU Health. In the event that you are dismissed, NSU Health will be available for emergencies during the normal hours of operation for a period of 30 days from the date of the third missed appointment to provide you with ample opportunity to select a medical provider of your choice.

4. **Right to Discontinue Treatment:** NSU Health has the right to discontinue treatment. In such cases, the patient or patient's representative agrees to accept full responsibility for pursuing alternate professional medical care. A letter will be sent informing the patient or patient's representative that treatment is being discontinued. All records pertaining to the treatment and diagnosis of patients are the property of NSU Health. Records and X-rays will be duplicated upon written request with reasonable charge to the patient.

5. **Financial Agreement:** I hereby agree to pay usual and customary charges for all services provided by NSU to the patient, except those covered by insurance (which includes all commercial and government third party payors). I understand that I am personally responsible for payment for any non-covered services, health insurance deductibles and co-insurance. In the event that I fail to fulfill any of the obligations in this section, I agree to pay any and all collection costs incurred by NSU in the enforcement of this section.

6. **Risks of Treatment:** The students and/or residents under the appropriate supervision of clinical faculty at the NSU Health are available to answer any questions concerning the potential risks and complications involved with specific procedures, and reasonable alternatives to the proposed

Patient/Representative's Initials: _____

treatment. In the Student Medical Center clinical faculty are available to answer any questions concerning potential risks and complications involved with specific procedures, and reasonable alternatives to the proposed treatment. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of my treatment.

7. **Laboratory Bills:** I understand the outside reference laboratory ("laboratory") will bill me directly for all laboratory tests performed by said laboratory. I understand that the fee schedule and/or costs for laboratory tests performed by NSU shall be available to the patient upon request,

8. **Patient Records:** I understand that all original records and diagnostic aids, such as x-rays, are the property of NSU Health. I understand that the NSU will own the original records. I also understand that I may obtain copies of the records at a reasonable cost, upon written request, based upon established policies of the NSU Health.

9. **Consent to Photograph:** I understand that photography, video recordings, other imaging and audio recordings ("images and/or recordings") may be recorded to document my care and treatment. I understand that NSU Health will own these images and/or recordings. I also understand that I may obtain copies of the images and/or recordings at a reasonable cost, upon written request, based upon established policies of NSU Health.

10. I hereby authorize and consent to NSU to release medical information to obtain payment as described in NSU to release medical information to obtain payment as described in the NSU Privacy Notice. This authorization will include where applicable psychiatric, alcohol, drug abuse, and laboratory results of HIV Infection (Human Immune Deficiency Virus) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS). I authorize NSU to provide necessary information to the patient's insurance carrier or other payer for payment purposes, and I authorize my insurance company/payer to pay NSU for services filed on my behalf. This assignment remains effective until I revoke it in writing.

11. **Change of Student/Resident/Clinical Faculty:** I understand that at the time of the treatment, unforeseen circumstances may require changing which individual clinical faculty member and/or student(s) or resident(s) actually are involved in performing the care and treatment. In addition, I understand at the Student Medical Center that at the time of the treatment, unforeseen circumstances may require changing which individual clinical faculty member is involved in performing the care and treatment.

12. **Information for Female Patients:** I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing conception and pregnancy. I have been advised that in addition to using my regular birth control pills that I will need to use and an additional alternative method of birth control while taking medications prescribed during my care and treatment.

Patient/Representative's Initials: _____

13. **Medical History and Follow up:** I acknowledge that I have provided an accurate and complete medical and personal history, including antibiotics, drugs or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays.

14. **Assignment of Benefits:** I hereby irrevocably assign and transfer to NSU all right, title and interest in any benefits payable to which I may be entitled from all insurance companies, employee benefit plans, third party administrators and/or other person or entities financially responsible for my medical care and treatment rendered to me, my dependent or the insured by NSU. Where Medicare benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct and request that said payment of authorized benefits be made on my behalf to NSU. Where Medicaid benefits are applicable, I certify that I am a recipient of Medicaid benefits and request that said payment of authorized benefits be made on my behalf to NSU Health.

RELEASE OF INFORMATION FOR TREATMENT AND HEALTH CARE OPERATIONS

By signing this form, I am consenting to the use and disclosure of my Protected Health Information ("PHI") for treatment and Nova Southeastern University's Health Care operations purposes for myself or for the patient for whom I am the parent or legally authorized representative. I understand that the Nova Southeastern University Medicine Health Care Centers ("NSU") will share patient PHI according to the federal and state law for treatment, payment and operations, as well as in accordance with its Notice of Privacy Practices.

NSU's Notice of Privacy provides a more complete description of these uses and disclosures. I agree that I have the right to review the Notice of Privacy Practices prior to signing this consent. I acknowledge that I have done so. NSU reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy may be obtain at NSU Health.

I acknowledge and agree that the PHI that may disclosed for treatment and health care operations purposes may include any or all of the following information concerning the patient:

i. Any psychiatric or psychological information related to treatment of physical and/or mental illness;
ii. Any information regarding drug abuse, chemical dependency or alcohol abuse; or
iii. Any information regarding testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome ("AIDS"); human immunodeficiency virus ("HIV"); Sexually Transmitted Disease ("STD"); Tuberculosis; Hepatitis; or other information as may be required for my treatment and health care operations.

I also consent to the release of any information to any and all business associates, regulatory and/or accrediting organizations as necessary to maintain licensure and accredited status. In addition, I consent to the release of any information to country, state or federal public health agencies, as required by law.

Patient/Representative's Initials: _____

I understand that I have the right to request that NSU restrict how it uses or discloses the patient's PHI to carry out treatment and health care operations. However, I understand that NSU is not required to agree to the requested restrictions, but if it does, it is bound by such agreement.

I understand that I may revoke this consent in writing except to the extent that NSU has already made disclosures in reliance upon it. If I do not sign this consent, or if I later revoke it, NSU may decline to provide treatment to the patient.

I certify that I have read and understand the preceding Consent and Agreement for Treatment, and/or have asked and had answered to my satisfaction, any and all questions that I may have about same, by my treating student/resident or clinical faculty physician.

CONSENT AND AGREEMENT FOR TREATMENT AND RELEASE OF INFORMATION FOR TREATMENT AND HEALTHCARE OPERATIONS

_____ _____

Patient or Patient Representative Signature **Date**

_____ _____

Print Name of Patient or Patient Representative **Patient's Date of Birth**

_____

Description of Patient Representative's Authority

Confirmation of interpretation to patient (if applicable)
If the patient does not read/understand English, it is the responsibility of the person who is authorized by him/her to ensure that the content of this consent form has been duly explained to him/her before he/she signs the form.

- The Patient does not read or understand English.
- I confirm that I understand the content of the consent form and I have interpreted and explained the content of the form to the patient so that he/she clearly understood what it meant before signing it.

_____ _____

Print Name of Interpreter **Relationship to Patient**

_____

Signature of Interpreter

FAMILY AND FRIENDS COMMUNICATION DESIGNATION FORM

We respect the privacy of your health information. If you wish to grant permission for us to share your medical and billing information with a family member or friend involved in your care, which is not otherwise authorized by law to act on your behalf (e.g., a minor patient's parent), please specify below.

The Family and Friends Communication Designation Form pertains to limited verbal disclosures of Protected Health Information ("PHI") to persons directly involved in your treatment, for purposes of notifying such persons of a patient's current location, and general condition. It also applies to limited disclosures of PHI, which may be in printed, or other written formats, to such persons for the purposes of making appointments, receiving appointment reminders, and making billing or paying inquiries on behalf of a patient.

The Family and Friends Communication Designation Form does not apply to disclosures of health care information unrelated to your current condition, nor does it apply to the provision of copies of health records; in both cases, a written authorization must be provided by you or your Personal Representative.

You are not required to grant this permission, and may revoke this permission by notifying the NSU Health in writing of any changes to this form by contacting the Medicine Health Care Center's HIPAA Liaison at:

Dr. Gina Foster-Moumoutjis, MD, MS
NSU Health
College of Osteopathic Medicine
3300 S. University Drive
Davie, FL 33328

You may also notify our Privacy Officer at:
NSU Health
Office of Compliance
3300 S. University Drive
Davie, FL 33328
Attention: Privacy Officer

I give my permission to the NSU Health to share the medical and billing information of:

_____ _____

Print Patient Name **Date of Birth**

Please provide the full names of these individuals, their relationship with you, and telephone number.

Individual's Full Name (Please Print)	Relationship to Patient	Telephone #

By my signature below, I hereby consent to and request that NSU Health communicate with the above listed individuals regarding my health care treatment and payment information as indicated. I agree to NSU Health may rely upon this information unless I change this form as set forth above.

_____ _____

Full Patient Name (Printed) **Personal Representative Name (Printed) (if applicable)**

_____ _____

Patient or Personal Representative Signature **Signature Date**

NSU Health

Date Received – Official Use Only

AUTHORIZATION FOR USE AND DISCLOSURE OF
INFORMATION FOR EDUCATIONAL AND RELATED PURPOSES
(OTHER THAN FOR TREATMENT AND PAYMENT PURPOSES)

Patient Name (last, first, middle initial): _____ Date of Birth: _____

Patient Address: _____ City: _____ State: _____ Zip Code: _____

Telephone No.: ( ) _____

SPECIFY THE INFORMATION TO BE DISCLOSED: When I sign this Authorization, I authorize NSU Health to use or disclose the following health information during the term of this Authorization:

Medical Record Information (including but not limited to description of injury or condition, clinical history, family history, patient demographics, test results, patient diagnosis and patient treatment)

I understand and agree that the information I am authorizing to be released may include:

(1) HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed, or reported, regardless of whether the results of such tests were positive or negative)
(2) Information about Substance (i.e., alcohol or drug) Abuse
(3) Information about Abuse of an Adult
(4) Information about Sexual Assault
(5) Information about Child Abuse and Neglect
(6) Information about a Mental Illness or Developmental Disability
(7) Information about Communicable Diseases
(8) Information about Venereal Disease(s)
(9) Information about Genetic Testing

PURPOSE: When I sign this Authorization, I authorize NSU Health to use and disclose the protected health information listed above for the following purpose:

- Uses/disclosures by NSU students or faculty for classroom activities within NSU for current and future teaching activities within NSU including disclosures by students to faculty for exam purposes;
- To create and present one or more presentation(s), seminars, conferences, and meetings;
- To create and publish one or more articles(s), textbooks, internet publications, or other publications; and
- Uses and disclosures by NSU students and faculty for marriage and family counseling clinical competency exams.

RECIPIENT: The following are the people to whom the NSU may disclose my protected health information:

- NSU students or faculty for classroom/exam activities within NSU;
- Attendees at a public conference(s), seminars, or other educational session(s);
- Publishers and readers of an article, textbook, internet publication or other publication(s); and
- NSU students or faculty for clinical competency exam activities.

EFFECTIVE DATE OF AUTHORIZATION:

This authorization shall be in force and effect until the end of the educational purpose at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to:

NSU Health

3300 S University Dr

Davie, FL 33328

I understand that a revocation is not effective to the extent that NSU has relied on the use or disclosure of health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state law.

I understand that NSU will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- **Inspect or copy my health information to be used or disclosed as permitted under state law.**
- **Refuse to sign this authorization.**

_____	_____
Signature of Patient or Personal Representative	Date
_____	_____
Print Name of Patient or Personal Representative	Description of Personal Representative's Authority

File in Patient Chart