

John Michael Thomassen, MD, PA

NEW PATIENT REGISTRATION FORM

(Please Print Legibly)

(Please Print Legibly)						
Today's date:			Primary Care Physician:			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name?	If not, what is your legal name?		(Former name):	Birth date:	Age:	Sex:
<input type="checkbox"/> Yes <input type="checkbox"/> No				/ /		<input type="checkbox"/> M <input type="checkbox"/> F
Local Address:			Home phone no.:	Cell Phone no.:		
			()	()		
City:		State:	Zip Code:	Email Address:		
Out of State Address:						
Primary Language Spoken:		Name of Spouse /Partner:		Contact Phone:		
				()		
Occupation:		Employer:		Employer phone no.:		
				()		
Chose clinic because/Referred to clinic by (please check boxes applic):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Internet web page or Search Engine		
Please describe:						
Reason for Consultation with Dr. Thomassen:						
INSURANCE INFORMATION						
(Please give your insurance card and driver's license to the receptionist.)						
Person responsible for bill:		Birth date:	Address (only add information if different from above):		Home phone no.:	
		/ /			()	
Is this person a patient here?		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Occupation:		Employer:	Employer address:		Employer phone no.:	
					()	
Is this patient covered by insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance information below not required for Cosmetic Consultations			
Please indicate primary insurance		<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Workers Comp	<input type="checkbox"/> Out of State <input type="checkbox"/> Out of Country	
<input type="checkbox"/> PPO	<input type="checkbox"/> HMO	<input type="checkbox"/> BC/BS	<input type="checkbox"/> Cigna	<input type="checkbox"/> Humana	<input type="checkbox"/> Other:	
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
			/ /			\$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
All the information filled herein is accurate to the best of my knowledge						
Parent/Guardian Signature				Date		

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CONTACT PERSON IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		()	()

STATEMENT OF FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED.

I accept financial responsibility for charges incurred on my behalf including costs of collection (if applicable). In the event that insurance is filed for surgery or other services rendered to me, I hereby authorize John Michael Thomassen, MD, PA to release information to my insurance company and assign benefits directly to John Michael Thomassen, MD, PA. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the Doctor, not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance. A photocopy of this assignment is to be considered as valid as an original.

Patient/Guardian signature

Date

STATEMENT OF LIABILITY INSURANCE COVERAGE

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice.

This notice is provided pursuant to Florida law.

Patient/Guardian signature

Date

HEALTH INFORMATION PRIVACY PROTECTION

I hereby acknowledge that I have been provided the opportunity to read the practice's NOTICE OF PRIVACY PRACTICES, which describes how my private health information may be used or disclosed. I understand that I have the right to request a copy of such, at any time.

Patient/Guardian signature

Date

FOR MEDICARE PATIENTS ONLY

Medicare will only pay for services that it determines are reasonable and necessary" under Section 1862 (a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary, Medicare will deny payment for that service. If Medicare denies payment, I agree to be personally and fully responsible for payment. I understand that there is a \$100 Medicare deductible every year.

Patient/Guardian signature

Date

John Michael Thomassen, MD, PA

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

NAME <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:	
PREVIOUS OR REFERRING DOCTOR:		DATE OF LAST PHYSICAL EXAM:			

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio				
Immunizations:	<input type="checkbox"/> Tetanus		<input type="checkbox"/> Pneumonia		
	<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Chickenpox		
	<input type="checkbox"/> Influenza		<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>		

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

SURGERIES

Mo/Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Mo/Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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Please turn to next page

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LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<u>Exercise</u>	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
<u>Diet</u>	Are you dieting?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Describe diet:			
<u>Caffeine</u>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
<u>Alcohol</u>	Do you drink alcohol?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Tobacco</u>	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
<u>Drugs</u>	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Sex</u>	Are you sexually active?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy?			<input type="checkbox"/> Yes <input type="checkbox"/> No

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FAMILY HEALTH HISTORY					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			CHILDREN	<input type="checkbox"/> M <input type="checkbox"/> F	
MOTHER				<input type="checkbox"/> M <input type="checkbox"/> F	
SIBLINGS	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		GRANDMOTHER <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		GRANDFATHER <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		GRANDMOTHER <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		GRANDFATHER <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F				

MENTAL HEALTH				
Is stress a major problem for you?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you feel depressed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have problems with eating or your appetite?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

WOMEN ONLY				
Number of pregnancies ____ Number of live births ____				
Are you pregnant or breastfeeding?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Date of last mammogram?				

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REVIEW OF SYSTEMS			
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.			
General Health			
<input type="checkbox"/> Current Weight:	<input type="checkbox"/> Current Height:	<input type="checkbox"/> BMI:	
<input type="checkbox"/> Recent Changes in Weight:	<input type="checkbox"/> Exercise Tolerance:	<input type="checkbox"/> Hx of Cancer	
Skin			
<input type="checkbox"/> Rashes	<input type="checkbox"/> Changing lesions		
<input type="checkbox"/> Pigmented lesions	<input type="checkbox"/> Keloid formation		
Breast			
<input type="checkbox"/> Masses or Lumps	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Tenderness	
Eyes/Ears/Nose/Mouth/Throat			
<input type="checkbox"/> Headaches/Migraine	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Vision deficits	
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tearing	<input type="checkbox"/> Dry Eyes	
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Nasal trauma	<input type="checkbox"/> Nasal obstruction/discharge	
<input type="checkbox"/> Colds/Congestion	<input type="checkbox"/> Dental Pain	<input type="checkbox"/> Denture use	
<input type="checkbox"/> Neck Stiffness/Pain	<input type="checkbox"/> Neck masses	<input type="checkbox"/> Other pain/discomfort:	
Cardiovascular			
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Fast or irregular heart rate	<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> Leg swelling	<input type="checkbox"/> Difficulty breathing on exertion	<input type="checkbox"/> Heart Disease	
Lungs			
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Asthma	<input type="checkbox"/> Lung disease	
<input type="checkbox"/> Lung disease	<input type="checkbox"/> Wheezing		
Gastrointestinal			
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Peptic ulcer disease/Heartburn	<input type="checkbox"/> Nausea/Vomiting	
<input type="checkbox"/> Constipation/Diarrhea	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Hepatitis/Liver disease	
Genitourinary			
<input type="checkbox"/> Pain with urination	<input type="checkbox"/> Urinary tract infections	<input type="checkbox"/> Kidney disease	
Musculoskeletal			
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Back Pain	
Neurologic/Psychiatric			
<input type="checkbox"/> Seizures	<input type="checkbox"/> Stroke	<input type="checkbox"/> Head trauma	
<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety		
Allergic/Immunologic/Lymphatic/Endocrine/Hematologic			
<input type="checkbox"/> Lymph nodes palpable	<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Steroid use	
<input type="checkbox"/> Anesthesia Reaction	<input type="checkbox"/> Blood clots/DVT	<input type="checkbox"/> Anemia	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Immune disorders	<input type="checkbox"/> Thyroid disease	
Infectious			
<input type="checkbox"/> Herpes simplex/fever blisters	<input type="checkbox"/> HIV	<input type="checkbox"/> Anemia	

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AUTHORIZATION AND CONSENT TO PHOTOGRAPH AND PUBLISH

I authorize John Michael Thomassen, MD, to obtain pre-operative, operative and post-operative photographs as deemed necessary for the complete documentation and illustration of the case involved. I understand that these photographs may appear in marketing materials including brochures or internet publications. These photographs may also appear in medical publications or conferences in the interest of medical education, knowledge or research. Although permission is given for the publication of details and pertinent photographs concerning my case, I understand that I will not be identified by name. I further understand that no form of compensation shall become payable to me for the use of these photographs. I hereby release John Michael Thomassen, MD and its agents from any and all claims and demands arising out of or in conjunction with the use of these photographs.

Patient/Guardian signature

Date