

New Patient Registration

Office		Date	
Last Name		First Name	Nickname
DOB	Sex	SSN	Address
Apt/Suite	City	State	Home Phone
Email		Mobile Phone	
Primary Provider		Referring Provider	
Employer		Work Phone	Marital Status
Is your spouse working or retired?		Spouse Name	Spouse DOB
Spouse SSN	Spouse Phone	Alternative Address	
Apt/Suite	City	State	ZIP

Insurance Information

Primary	Plan ID	Group#
Phone Number	Policy Holder	Policy Holder DOB
Secondary	Plan ID	Group#
Phone Number	Policy Holder	Policy Holder DOB
Guarantor		Guarantor Relationship

Emergency Contact Information

Name	Phone Number	Relationship		
Address	Apt/Suite	City	State	ZIP

Are you currently admitted to a hospital or enrolled in a hospice or skilled nursing facility?

Yes No If yes, please fill out the following:

Facility Name		Phone Number		
Address	Apt/Suite	City	State	ZIP

Are you receiving benefits from the Veterans Administration?

Yes No If yes, please fill out the following:

VA Name		Phone Number		
Address	Apt/Suite	City	State	ZIP



Sex Assigned at Birth (Choose 1)		Gender Identity			
Male	Female	Male	Female	Non-Binary	Decline to Disclose
Intersex	Decline to Disclose	Trans-Male	Trans-Female	Other	

Which of the following best describes your race and/or ethnicity (Select all that apply)?

Asian	Caucasian	Black/African American	Middle Eastern/ North African
Hispanic	Native Hawaiian/Pacific Islander	American Indian/Alaskan Native	Choose Not to Disclose

What language do you feel most comfortable using when discussing your healthcare?

English	Spanish	German	French	Italian	Russian
Portuguese	Chinese	Creole	Other	Decline	

Social History

Have you ever smoked? Yes No

Have you quit smoking? Yes No

Have you ever chewed tobacco? Yes No

Have you quit chewing tobacco? Yes No

Have you ever attended tobacco cessation classes? Yes No

Do you drink alcohol? Yes No

Have you quit drinking? Yes No

Do you use any street drugs? Yes No If so, which? Marijuana Cocaine Methamphetamine

Do you have a medical marijuana card? Yes No

Do you need any help with any of the following: coping, financial assistance, nutrition, social work, transportation, home assistance? Yes No

Marital Status: Single Married Partnered Separated Divorced Widowed

Do you have a strong social support system? Yes No

Do you adhere to any religious beliefs that would like us to know about? Yes No

Are you still working? Yes No If yes, Full-Time Part-Time
If no, Retired Disabled Unemployed

What is or was your primary occupation?

Did you ever work in an occupation that involved exposure to asbestos or any other carcinogens, hazardous chemicals, or toxic fumes? Yes No

Have you ever served in the military? Yes No

Mobility-Fall Risk Assessment

Do you need assistance walking? Yes No

If so, do you use any of the following? Cane Walker Wheelchair

Have you fallen before or been injured because of a fall? Yes No

Do you have foot ulcers, bunions, hammertoes, or calluses that are painful or cause you to adjust your steps while walking? Yes No

Do you feel unsteady on your feet or shuffle when you walk? Yes No

Do you feel dizzy/lightheaded when you stand up? Yes No

How many falls have you had in the past 12 months? Any injuries?

We screen all patients for domestic violence or abuse.

Does anyone at home hurt, hit, or threaten you? Yes No

Social Geographic History

In which state (or country) were you born?

In what area did you live most of your life?

How long have you lived in your current state of residence?

Do you live in this state all year round? Yes No

If no, what is your alternate address and phone number?

Allergies

Are you allergic to latex? Yes No

Are you allergic to IV Contrast? Yes No

Are you allergic to any medications? Yes No

Other allergies (drug, food, tape, etc.)?

Do you have a history of any of the following? (Check all that apply)

Constitutional

- Fever/Chills
- Increased Fatigue
- Night Sweats
- Unexplained Weight Loss

If so, how much?

Weight Gain

If so, how much?

Current Height

Current Weight

Pulmonary

- Persistent Cough
- Coughing Up Blood
- Shortness of Breath
- Inability to Lie Flat

Positive TB Test

Influenza Vaccine Yes No

Date

Pneumonia Vaccine Yes No

Date

COVID-19 Vaccine Yes No

Date

Rheumatological

- Systemic Lupus Erythematosus
- Rheumatoid Arthritis
- Osteoarthritis/Arthritis
- Scleroderma/CREST Syndrome
- Gout
- Bone Pain
- Broken Bones

List

Psychiatric

- Anxiety
- Depression
- Psychosis
- Bipolar Disorder

Gastrointestinal

- Difficulty Swallowing
- Decreased Appetite
- Frequent Vomiting
- Hiatal Hernia
- Gastric Reflux
- Bowel Polyps
- Dark/Black Stool
- Diverticulosis
- Diverticulitis
- Blood in Stool
- Frequent Diarrhea
- Inflammatory Bowel Disease (Ulcerative Colitis/Crohn's)
- Constipation
- Hemorrhoids Colonoscopy/Sigmoidoscopy

Yes No

Date

Genitourinary

- Difficulty Starting Stream
- Stopping and Starting Stream
- Blood in Urine
- Pain or Burning on Urination
- Frequent Urination
- Getting Up at Night to Urinate
- Urinary Urgency
- Leakage of Urine
- Kidney Stone
- Elevated PSA
- Urinary Tract Infections
- Difficulty with Erections

Are you sexually active? Yes No

Neurological

- Frequent Headaches
- Dizziness/Lightheadedness
- Tremors
- Paralysis
- Numbness
- Polio
- Weakness in Limbs
- Seizures

Eyes/Ears/Nose/Throat

- Cataracts
- Glaucoma
- Diminished Eyesight
- Experienced Hearing Loss
- Sinus Problems
- Hoarseness
- Dentures

Cardiac

- Angina (chest pain)
- Irregular Heartbeat

Past Surgical History (Please list year in the box)

- Eye Surgery
- Tonsillectomy
- Thyroid Surgery
- Lung Surgery
- Breast Surgery

- Appendectomy
- Cholecystectomy
- Hernia Surgery
- D & C
- Heart Surgery

- Coronary Artery By-Pass
- Heart Valve Replace/Repair
- Coronary Artery Stent
- Defibrillator Placement
- Pacemaker Placement

Type/Model

- Colon or Rectal Surgery
- Bladder Surgery
- Prostate Surgery
- Hysterectomy or Gynecological Surgery
- Joint Replacement
- Other

Female History

Please complete the following information if you are female.

Age 1st Menstrual Period	<input type="text"/>	Number of Deliveries	<input type="text"/>	If yes, how long?	<input type="text"/>	Vaginal Discharge	<input type="text"/>
Last Menstrual Period	<input type="text"/>	Age 1st Child Was Born	<input type="text"/>	Bra Cup Size	<input type="text"/>	History of Sexually Transmitted Diseases	Yes <input type="checkbox"/> No <input type="checkbox"/>
Age of Menopause	<input type="text"/>	Did you breastfeed?	<input type="text"/>	Nipple Discharge	<input type="text"/>	Date of Last PAP Smear	<input type="text"/>
Any chance you could be pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Did you ever take hormones (estrogen, birth control pills, androgens, etc.)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Vaginal Bleeding	<input type="text"/>	Date of Last Mammogram	<input type="text"/>
Number of Pregnancies	<input type="text"/>						

Male History

Please complete the following information if you are male.

Date of Last PSA	<input type="text"/>	Score of last PSA	<input type="text"/>	Where	<input type="text"/>	History of Sexually Transmitted Diseases	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Pain

Pain Measurement Scale

NO PAIN MILD MODERATE SEVERE VERY SEVERE WORST

0 1 2 3 4 5 6 7 8 9 10

Pain Level Number

Pain Management Questions

Are you in pain now?	Yes <input type="checkbox"/> No <input type="checkbox"/>	How is your pain being managed?	<input type="text"/>
When did your pain start?	<input type="text"/>	Anything making it better?	<input type="text"/>
Location of Pain	<input type="text"/>	Anything making it worse?	<input type="text"/>
Pain Quality			
Sharp	Dull		
Constant	Intermittent		
Cramping	Aching		
Stabbing			
How long have you been in pain?	<input type="text"/>		

Family History of Cancer or Blood Diseases

Father	Mother	Siblings	Children
If living, age <input type="text"/>	If living, age <input type="text"/>	How many sisters? <input type="text"/>	How many daughters? <input type="text"/>
If deceased, age of death <input type="text"/>	If deceased, age of death <input type="text"/>	How many brothers? <input type="text"/>	How many sons? <input type="text"/>
Any history of cancer? <input type="text"/>	Any history of cancer? <input type="text"/>	Any history of cancer? <input type="text"/>	Any history of cancer? <input type="text"/>
Type <input type="text"/>	Type <input type="text"/>	Type <input type="text"/>	Type <input type="text"/>

Is there any history of cancer or blood diseases in other family members such as grandparents, aunts, uncles, cousins, etc.?

Yes No If yes, please explain

Conditions of Service for SunState Medical Specialists

In this document, “**Patient**” means the person receiving treatment. “**Patient Representative**” means any person acting on behalf of the Patient and signing as the Patient’s representative. Use of the word “I,” “you,” “your” or “me” may in context include both the Patient and the Patient Representative. With respect to financial obligations “I” or “me” may also, depending on the context, mean financial guarantor “Guarantor.”

“**Provider**” means the practice and may include SunState Medical Specialists’ physicians and/or staff, which may include but are not limited to: Oncologists, Radiologists, Radiation Oncologists, Physician Assistants, Nurse Practitioners, Social Workers, Behavioral Health Practitioners, as well as certain other licensed independent practitioners and any authorized agents, contractors, affiliates, successors, or assignees acting on their behalf.

1. **Consent to Treatment.** I consent to medical care and procedures recommended by my Provider, including emergency care, lab tests, x-rays, imaging, diagnostics, and other treatments. I also allow residents and supervised trainees to participate in or observe my care as part of their training. I consent to blood-borne disease testing, such as hepatitis, HIV, or AIDS, if ordered by my Provider or protocol, and understand that side effects are usually minor, like brief pain, burning, bleeding, or soreness at the needle site. Test results will be kept confidential in my medical record.
2. **Consent to Treatment Using Telemedicine.** I consent to the use of Telemedicine, which allows my healthcare providers to share my medical information for diagnosis, treatment, follow-up, or education. My information may be shared with third parties as needed, and confidentiality protections still apply. I understand there are risks, such as technical problems or delays, and results cannot be guaranteed. I may withhold or withdraw consent at any time without affecting my care or benefits.
3. **Financial Agreement.** I understand the practice may bill my insurance. I (the Patient or Guarantor) agree to pay any remaining balance not covered by insurance, including coinsurance, deductibles, non-covered services, or unpaid amounts due to policy limits or exclusions. If I overpay, the extra may be applied to other outstanding balances before a refund. I can request a free, itemized billing statement. For patients with government or certain private insurance coverage, payments may be adjusted according to the program or plan rules.
4. **Professional services rendered by independent contractors and practitioners are not part of the practice bill.** I understand and acknowledge that the independent contractors and advanced practice professionals providing services to me at the practice are not agents or employees of the practice. I understand that I may not actually see or be examined by all physicians or other advanced practice professionals participating in my care; for example, I may not see the radiologists or pathologists participating in my care. I understand that, in most instances, there will be a separate charge for professional services rendered by these providers and that I will receive a bill for these professional services that is separate from the bill for practice services.
5. **Legal Relationship between Practice and Physicians and Advanced Practice Professionals.** Independent physicians and advanced practice professionals are responsible for their own actions and the practice shall not be liable for the acts or omissions of any such independent physicians and/or advanced practice professionals. To the extent that any duty to perform any care, procedure, service, and/or treatment is imposed upon the practice, the responsibility for the performance of such care, procedure, service, and/or treatment is delegated to the applicable healthcare professionals.
6. **Assignment of Benefits.** I assign my insurance benefits to the Provider and authorize direct payment to the Provider for services, including emergency care. I understand that my insurance may be supplemental to other coverage, and accepting insurance payment does not prevent the Provider from collecting any remaining balance from other sources. I agree to help the Provider collect payment from any responsible party, including allowing the Provider to act on my behalf if needed. If I receive payment directly for my care, I will promptly forward it to the Provider. I also authorize the Provider to pursue claims, appeals, or legal remedies for any unpaid or underpaid benefits on my behalf and to access necessary documents or information from insurers or other parties. This assignment is full and unconditional, but it does not take away my right to recover payment from my insurer or health plan.
7. **Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide in applying for payment under Title XVIII (“Medicare”) or Title XIX (“Medicaid”) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the practice or physician by the Medicare or Medicaid program.



8. **Outpatient Medicare Patients.** Medicare does not provide coverage for “self-administered drugs” or drugs that you normally take on your own, with only a few limited exceptions. If you get self-administered drugs that are not covered by Medicare Part B, we may bill you for the drug. However, if you are enrolled in a Medicare Part D Drug Plan, these drugs may be covered in accordance with Medicare Part D Drug Plan enrollment materials. If you pay for these self-administered drugs, you can submit a claim to your Medicare Part D Drug Plan for a possible refund.
9. **Consent to Photographs, Video, Digital, and Audio Recordings.** I acknowledge that the practice’s security, quality improvement, patient care, healthcare operations, and/or risk management activities may involve photographs, video, digital or audio recordings, and/or other images of me, including telephone calls, being recorded, and I consent to such images and recording. I understand that the practice retains the ownership rights to the images and/or recordings. Images and/or recordings in which I am identified will only be used and disclosed as permitted by law.
10. **Consent to Telephone Calls, Email or Text Message.** I authorize the use of any email address or telephone number I provide (including email addresses or telephone numbers that I provide for my family or designated representatives) (whether wireless or a landline and including email addresses and telephone numbers forwarded or transferred from provided information) for receiving information relating to my healthcare services and financial obligations, including healthcare-related information and financial communications. I expressly agree and consent that you or your customer service personnel and collection agents may contact me by telephone, on a recorded line and/or using automated dialing technology, at any telephone number I have provided or obtained, or any number forwarded or transferred from that number, regarding the services rendered or my related financial obligations. I represent (if I am not the patient) that I am authorized by the patient to receive calls, text messages, or email messages on their behalf and that I am involved in assisting in the patient’s care and/or payment. Methods of contact may include pre-recorded/artificial voice messages and/or automated dialing devices. I represent that I am the account holder for any telephone number(s) provided and am responsible for notifying the Provider of any changes or updates.

I understand that emails and text messaging are unencrypted and that there is some risk that information included in unencrypted messages may be intercepted or received by unintended third parties and/or stored or archived by service providers and system operators. Information included in such messages may include name, date/time of appointments, physician/practice name or specialty, patient account number, or other information related to financial obligation or services. Message and data rates may apply. Message frequency may vary. Additional text messaging terms may be located on the Practice’s website and may be updated. To stop receiving a certain text message type, I understand that I can opt out by notifying SunState Medical Specialists in writing but may continue receiving text messages of other types subject to separate opt-out notification. For assistance or questions, contact SunState Medical Specialists at

11. **Use and Disclosure of Information.** I consent to Providers using and disclosing health information about me for purposes of treatment, payment, healthcare operations, public health, and other purposes permitted by applicable law. Information covered by this consent includes history and physical records, emergency records, laboratory reports, pharmacy claims and prescription history, physician office notes, nurse notes, discharge summaries, genetic, psychological, psychiatric, intellectual disability, and substance abuse disorder information, and information about infectious diseases including blood borne diseases such as HIV and AIDS. This consent applies to uses and disclosures for coordinated care or case management purposes; to any person or entity involved in payment on the Patient’s behalf, including to verify coverage; and to my employer’s designee when services are related to a workers’ compensation claim. If I am covered by Medicare or Medicaid, I authorize the release of my healthcare information to the Social Security Administration or appropriate state agency for payment of a claim. Providers participate, or may participate, in Health Information Exchanges (HIEs) to share health information for purposes permitted by law. Unless I notify Provider in writing that I desire to opt-out, I consent to my health information being shared as described above.

12. **Other Acknowledgments.**

- **Weapons/Explosives/Drugs.** I understand and agree that if the practice at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage on my person or with my belongings, the practice may terminate the practice/patient relationship.

Acknowledgment of Notice of Patient Rights and Responsibilities. I have been furnished with a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law. I understand that I can provide an advance directive to the Provider, and I can request information about formulating an advance directive at registration or thereafter.

Acknowledge (Initial)

Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the Provider may use and disclose my health information. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. I understand that I may contact the practice Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge (Initial)

Acknowledgment: I have been given the opportunity to read and ask questions about the information contained in this form, specifically including but not limited to the financial obligation's provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than the rendition of services by the Providers.

Acknowledge (Initial)

I, the undersigned, as the Patient or Patient Representative, or, for a minor/incapacitated Patient, as the legal guardian, certify I have read and understand these Conditions of Physician Practice Services and have signed knowingly, freely, voluntarily, and agree to be bound by its terms. I have received no promises, assurances, or guarantees as to the results of any medical treatment or services. If insurance coverage is insufficient, denied, or unavailable, the undersigned agrees to pay all charges not paid by the insurer.

Date Time

Patient/Patient Representative Signature Witness Signature and Title

Additional Witness Signature and Title:

(required for Patients unable to sign without a representative or Patients who refuse to sign)

Additional Signature and Title

If you are not the Patient, please identify your relationship to the Patient. **(Mark relationship(s) from list below):**

Spouse Parent Legal Guardian Healthcare Power of Attorney Guarantor Other (Please specify)

Authorization of Release of Information

Section A: This section must be completed for all Authorizations.

Patient's Name		Patient's Phone		
DOB		Last 4 Digits of SSN (Optional)		
Recipient's Name		Recipient's Address		
Recipient's Phone		City	State	ZIP
Recipient's Fax (Only to physician/medical office)		Recipient's Email		
Purpose of Disclosure	At the request of the individual; or		Other 3rd party recipient (Please specify purpose)	
Request Dates of Service		Facility Name(s) and Addresses		

Request Delivery (If left blank, a paper copy will be provided) Paper Copy Electronic Media (If available) Encrypted Email Unencrypted Email

There is some level of risk that a third party could see your information without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Note: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy).

This authorization will expire after 180 days or on the following (Please choose only one)

Exp. Date	Exp. Event
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Is this request for psychotherapy notes? No, then you may check as many items below as you need. Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

Description of Information to be Used or Disclosed

All Pertinent Records includes those listed below

Other Records

Consultation	Discharge Summary	ER Report	EKG Report	History & Physical	Clinical/Lab Report	Discharge Instructions	Labor & Delivery Record	Specialty Test/Therapy
Medication List	Operative Report	Pathology Report	Problem List	Radiology Report		Progress Notes	Physician Orders	Other

For USCDI Release Requests: To include all elements as defined in the United States Core Data for Interoperability. Requires Direct Address or National Provider Identifier.

All types of information found in the records selected above will be provided (if applicable), including information that may be viewed as sensitive, such as alcohol, drug abuse, genetic information, psychiatric, HIV testing, or AIDS information. Specify any information below that you want to exclude:

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I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the recipient is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
- I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI?

Yes No If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the Provider receive financial remuneration in exchange for using or disclosing this information?	Yes	No	If yes, describe
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May the recipient of the PHI further exchange the information for financial remuneration? Yes No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative	Date
Print Name of Patient's Representative	Relationship to Patient
ID Verified by (Initials)	



HIPAA Disclosure Release & Communication Preferences Form

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I wish to be contacted in the following manner(s) (Check all that apply):

Cell Phone

Leave message with detailed information

Only leave message with callback details

Home Telephone

Leave message with detailed information

Only leave message with callback details

Work Telephone

Leave message with detailed information

Only leave message with callback details

Written Correspondence

Mail to my home address on file

Mail to the address listed below:

I hereby authorize one or all of the designated individuals below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or any information in my medical records. I understand the identity of the designated individual must be verified before release of PHI.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

This authorization shall remain in effect from the date signed below until revoked.

You have the right to revoke this authorization in writing.

- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand information disclosed to any of the individuals authorized above, is no longer protected by federal or state law and may be subject to redisclosure by the above individual.

Patient/Legal Representative Print Name	
Patient/Legal Representative Signature	Date

Lee/Collier Counties, Florida Market

Patient Protection and Affordable Care Act of 2010. Patient Disclosure for Diagnostic MRI, PET, or CT Services.

Dear Patient,

If your physician determines that a referral for diagnostic MRI, PET, or CT services is appropriate as a part of your medical evaluation and treatment; we may have these services available at one of our locations. We will provide you information about those options.

You, however, have the freedom to choose the supplier for this service. To the best of our knowledge, the following providers furnish these services in the area:

Name: Radiology Regional Centers
Address: 6100 Winkler Road, Fort Myers, FL 33919
Phone: (239) 936-4068

Name: Radiology Regional Centers
Address: 700 Goodlette Road, Naples, FL 34102
Phone: (239) 936-4068

Name: Advanced Radiology Imaging Associates
Address: 2721 Del Prado Blvd., Ste 110, Cape Coral, FL 33904
Phone: (239) 454-2742

Name: SimonMed Imaging
Address: 730 Goodlette Road, Naples, FL 34102
Phone: (239) 307-0234

Name: Florida Radiology Consultants
Address: 8791 Conference Drive, Fort Myers, FL 33919
Phone: (239) 331-5566

Name: ProScan Open MRI & CT
Address: 260 Tamiami Trail N, Naples, FL 34102
Phone: (239) 261-1227

Name: Naples Diagnostic Imaging Center
Address: 311 North Tamiami Trail, Ste 104, Naples, FL 34102
Phone: (239) 624-4443

