PRINCE OF PEACE
Medical Center LLC

2964 NORTH STATE RD
7 SUITE 310, MARGATE FL 33063
(866) - 603 7505

PATIENT REGISTRATION FORM

Personal Details

Full Name: _____ **Date:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Date of Birth: _____ **Gender:** Male Female
Marital Status: Single Married Divorced Widowed **Spouse Name:**
_____

Contact Information

Mobile Number: _____ Can we leave a message? Yes No
Home Number: _____ Can we leave a message? Yes No
Work Number: _____ Can we leave a message? Yes No
Email Address: _____ Can we send appointment updates? Yes No
Employer/School: _____ **Occupation:**
_____
Emergency Contact Name: _____ **Relationship:**
_____
Emergency Contact Phone: _____ **Primary Language:**
_____
How did you hear about us?
_____

Insurance Details

Policy Holder's Name: _____ **SSN (Last 4):** _____
Date of Birth: _____ **Insurance Company:** _____
Policy Number: _____ **Group Number:**
_____
Insurance Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Insurance Phone: _____ **Effective Date:**
_____

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Advance Directives

A. **Health Care Surrogate**

Do you have one? ☐ Yes ☐ No

If yes, **Name:** _____ **Relationship:** _____

Phone: _____

B. **Living Will**

Do you have a Living Will? ☐ Yes ☐ No

If yes, please provide the name of the person authorized to discuss your medical condition:

Authorization and Consent

I certify that the information I have provided above is accurate to the best of my knowledge. I authorize my healthcare provider and its physicians to provide treatment and to release medical information necessary for claim processing. I assign insurance benefits directly to the provider and agree to be responsible for any charges not covered by my insurance or government program.

Signature: _____ **Date:** _____

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MEDICAL HISTORY QUESTIONNAIRE

All information provided is strictly confidential and will become part of your medical record.

Patient Information

Full Name: _____ **Date of Birth:** _____

Referring or Previous Doctor: _____

Date of Last Physical Exam: _____

Childhood Illnesses

Please check all that apply:

☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

---

Vaccinations & Screenings

Vaccine / Test	Year of Last	Vaccine / Test	Year of Last
Pneumonia	_____	Tuberculosis	_____
Flu	_____	CXR (Chest X-Ray)	_____
Tetanus	_____	Cholesterol	_____
MMR	_____	Stress Test	_____
Hepatitis B	_____	Echocardiogram	_____
Rectal / Stool	_____	Mammogram	_____
Pap Test	_____	Prostate Exam	_____
Bone Density	_____		

Diagnosed Medical Conditions

Please list any medical problems that other physicians have diagnosed:

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Health Conditions

Please check **Yes** or **No** for each condition:

Condition	Yes	No	Condition	Yes	No
Heart Disease	☐	☐	Hypertension	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	Diabetes	☐	☐
Lung Disease	☐	☐	Cancer	☐	☐
Coronary Artery Disease	☐	☐	Depression	☐	☐
GERD (Acid Reflux)	☐	☐	Thyroid Disease	☐	☐
Kidney Disease	☐	☐	Anxiety	☐	☐
Migraines	☐	☐	Osteoporosis	☐	☐
Arthritis	☐	☐			

Surgical History

Year	Reason / Type of Surgery	Hospital / Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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SUPPLEMENTAL MEDICAL HISTORY FORM

Other Hospitalizations

Year Reason Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Pharmacy Name: _____ **Phone #:** _____
Fax #: _____

Current Medications

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

Name of Drug Strength Frequency Taken

Drug Allergies & Reactions

Allergies

Please indicate if you are allergic to any of the following:

Allergen			**Allergen**		
Food	☐ Yes	☐ No	Peanuts	☐ Yes	☐ No
Iodine	☐ Yes	☐ No	Pollen	☐ Yes	☐ No
Adhesive Tape	☐ Yes	☐ No	Animal Dander	☐ Yes	☐ No

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Allergen			**Allergen**		
Shellfish	☐ Yes	☐ No	Latex	☐ Yes	☐ No

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LIFESTYLE & FAMILY HEALTH HISTORY FORM

All questions in this questionnaire are optional and will be kept strictly confidential.

Exercise

☐ Sedentary (No exercise)
☐ Mild exercise (e.g., climb stairs, walk 3 blocks, golf)
☐ Occasional vigorous exercise (e.g., work or recreation less than 4×/week for 30 minutes)
☐ Regular vigorous exercise (e.g., work or recreation 4×/week for 30 minutes)

Diet

Are you dieting? ☐ Yes ☐ No
If yes, are you on a physician-prescribed medical diet? ☐ Yes ☐ No
Number of meals you eat per day: _____

Caffeine

☐ None ☐ Coffee ☐ Tea ☐ Cola

of cups/cans per day: _____

Alcohol

Do you drink alcohol? ☐ Yes ☐ No
If yes, what kind? _____
How many drinks per week? _____
Are you concerned about the amount you drink? ☐ Yes ☐ No

Tobacco

Do you use tobacco? ☐ Yes ☐ No
☐ Cigarettes – _____ packs/day ☐ Chew/day ☐ Pipe/day ☐ Cigars/day

of years: _____ ☐ **Year quit: _____**

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Drugs

Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, please list: _____
Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

---

Sex

Are you sexually active? ☐ Yes ☐ No
Illnesses associated with **HIV/AIDS** and other **sexually transmitted infections (STIs)** remain a significant public health concern.
Common **risk factors** include **intravenous drug use** and **unprotected sexual activity**.
Would you like to speak with your provider about these risks? ☐ Yes ☐ No

---

Personal Safety

Do you live alone? ☐ Yes ☐ No
Do you have frequent falls? ☐ Yes ☐ No
Do you have vision or hearing loss? ☐ Yes ☐ No

Note: Physical or emotional abuse is a major health issue in this country.
It may include verbal threats, physical assault, or sexual abuse.
Would you like to discuss this issue with your provider? ☐ Yes ☐ No

---

FAMILY HEALTH HISTORY

Relation	Age	Significant Health Problems	Relation	Age	Significant Health Problems
Father			Children		
Mother			☐ M ☐ F		
Sibling			☐ M ☐ F		
☐ M ☐ F			☐ M ☐ F		

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Relation **Age** **Significant Health Problems** **Relation** **Age** **Significant Health Problems**

☐ M ☐ F ☐ M ☐ F

Grandparents:

- Paternal Grandmother: _____ **Health Problems:** _____
- Paternal Grandfather: _____ **Health Problems:** _____
- Maternal Grandmother: _____ **Health Problems:** _____
- Maternal Grandfather: _____ **Health Problems:** _____

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MENTAL HEALTH & GENERAL HEALTH FORM

Mental Health

Question	Yes	No
Is stress a problem for you?	☐	☐
Do you feel depressed?	☐	☐
Do you panic when stressed?	☐	☐
Do you have problems with eating or appetite?	☐	☐
Do you cry frequently?	☐	☐
Have you ever attempted suicide?	☐	☐
Have you ever seriously thought about hurting yourself?	☐	☐
Do you have trouble sleeping?	☐	☐
Have you ever been to a counselor?	☐	☐

Women Only

Age at onset of menstruation: _____ **Date of last menstruation:** _____

Period every: _____ Days

Heavy periods, irregularity, spotting, pain or discharge? ☐ Yes ☐ No

Number of pregnancies: _____ **Number of live births:** _____

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Any urinary tract, bladder, or kidney infections within a year? ☐ Yes ☐ No

Any blood in your urine? ☐ Yes ☐ No

Any problems with control of urination? ☐ Yes ☐ No

Any hot flashes or sweating at night? ☐ Yes ☐ No

Do you have menstrual tension, pain, bloating, or irritability? ☐ Yes ☐ No

Any recent breast tenderness, lumps, or nipple discharge? ☐ Yes ☐ No

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Men Only

Do you usually get up to urinate during the night? ☐ Yes ☐ No If yes, how many times? _____

Do you feel pain or burning with urination? ☐ Yes ☐ No

Any blood in your urine? ☐ Yes ☐ No

Do you feel burning discharge from your penis? ☐ Yes ☐ No

Has the force of your urination decreased? ☐ Yes ☐ No

Have you had kidney, bladder, or prostate infections in the last 12 months? ☐ Yes ☐ No

Any problems emptying your bladder completely? ☐ Yes ☐ No

Any difficulty with erections or ejaculation? ☐ Yes ☐ No

Any testicle pain or swelling? ☐ Yes ☐ No

Other Problems

Check if you have or have had any symptoms in the following areas to a significant degree and briefly explain:

☐ Skin ☐ Chest/Heart ☐ Head/Neck ☐ Back

☐ Ears ☐ Intestinal ☐ Nose ☐ Bladder

☐ Throat ☐ Bowel ☐ Lungs ☐ Circulation

Recent changes in:

☐ Weight ☐ Energy level ☐ Ability to sleep

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NOTICE – LABORATORY BILLING INFORMATION

We are pleased to offer **In-House Lab Draw Services** for the convenience of our patients.

Please note that laboratory tests ordered by your provider **may not be covered** by your insurance carrier. Depending on your plan, you may be responsible for **out-of-pocket expenses**, including deductibles, co-payments, co-insurance, or charges for non-covered services.

Our office cannot guarantee reimbursement from your insurance provider and is **not responsible** for any costs related to uncovered testing. You may also receive a **separate bill directly from the laboratory** (such as Quest Diagnostics or LabCorp) for any remaining balance not covered by your insurance.

Consent for Lab Services

Choose One:

☐ **NO:** I have decided **not** to receive these services.

☐ **YES:** I want to receive these services.

Patient or Guardian Signature: _____

Print Name: _____

Regarding Test Results

Lab results are posted on our patient portal once reviewed.
Before leaving the office, please ensure you receive access to your patient portal.

NO-SHOW NOTICE

Please contact our office at least **24 hours in advance** if you are unable to keep your appointment.

Patient or Guardian Signature: _____

Print Name: _____

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Referral Process

This policy applies to all insurance plans that require referrals.
Our office has provided you with the necessary information to schedule your appointments.
Due to the high volume of referral requests, please allow **3–5 business days** for processing.

Same-day referrals are **not available**. If your need is urgent, please contact our **referral coordinator** directly.

If you do not receive a reply to your e-mail or voicemail within **24 hours**, please call the office and request to speak with the referral coordinator for assistance.

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Notice of Privacy Acknowledgment

I understand that, under the Health Insurance Portability and Accountability Act (HIPAA), I am entitled to specific rights concerning the privacy and protection of my health information.

I acknowledge that I have received, or have been given the opportunity to receive, a copy of the Provider's *Notice of Privacy Practices.* I further understand that this practice reserves the right to revise its Notice of Privacy Practices at any time and that I may request the most recent version from the office whenever needed.

Patient Name or Legal Guardian (print): _____
Date: _____

Signature: _____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **ID Number:** _____

Date of Birth: _____

By signing below, I authorize the use and disclosure of my individually identifiable health information as outlined in this document. I understand that providing this authorization is entirely voluntary. I also acknowledge that if the recipient of this information is not a health care provider, health plan, or entity otherwise subject to federal privacy regulations, the disclosed information may no longer be protected under those regulations.

Disclosure Information

Persons/Organizations Providing Information Persons/Organizations Receiving Information

---

Details of Disclosure

Specific Description of Information (Including Dates) Purpose of Requested Use or Disclosure

---

Patient Authorization Statements

The patient or their representative must read and initial each statement below:

Statement **Initials**

1. I understand that this authorization will expire on ____ / ____ / _____ (DD/MM/YY). If no expiration date is specified, this authorization will expire in **six months**.

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Revocation will not apply to information already released prior to the revocation and does not apply to my insurance company when law allows my insurer the right to contest a claim.

3. I understand that my healthcare and payment for healthcare will not be affected if I choose **not** to sign this form.

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Statement	Initials

4. I understand that I may view, copy, and receive a copy of this form after it is signed.

5. If I have questions about disclosure of my health information, I can contact the office staff or physician.

Signatures

Signature of Patient or Legal Representative: _____
Date: _____

If Signed by Legal Representative, Relationship to Patient:

_____

Signature of Witness: _____

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E-Mail Consent Form

Patient Name: _____ **Date:** _____

Patient E-mail Address: _____ **Patient Phone Number:** _____

Throughout this form, "Provider" refers to the clinic, its staff, and agents.

---

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER

Your Provider offers the option to communicate through e-mail. While e-mail can be a convenient and efficient way to exchange information, it also presents certain privacy and security risks. Before consenting to e-mail communication, patients should be aware of the following potential risks, which include but are not limited to:

a. E-mails may be forwarded, copied, or stored electronically or in print, potentially at multiple locations.
b. E-mails can be transmitted across global networks and may be inadvertently accessed by unintended recipients.
c. E-mail addresses can be entered incorrectly, resulting in messages being sent to the wrong individual.
d. E-mails are easier to falsify or alter than handwritten or officially signed documents.
e. Deleted e-mails may still exist as backup copies on servers or personal devices.
f. Employers or internet service providers may monitor or review e-mails transmitted through their systems.
g. E-mails can be intercepted, modified, or forwarded without authorization during transmission.
h. E-mails may contain viruses, malware, or other harmful software.
i. E-mails may be subject to disclosure or use as evidence in legal or administrative proceedings.

---

2. CONDITIONS FOR THE USE OF E-MAIL

The Provider will take reasonable measures to maintain the privacy and confidentiality of all e-mail communications. However, given the inherent limitations of electronic communication, absolute security cannot be guaranteed. By signing this form, you consent to the use of e-mail under the following terms and conditions:

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a. Any e-mails exchanged between the patient and the Provider that relate to diagnosis, treatment, or care may be printed and included in the patient's official medical record. Individuals authorized to access the record may also review these communications.

b. The Provider may share or forward e-mails internally with authorized staff and agents involved in patient care, scheduling, billing, or insurance processing. No e-mails will be shared with external parties without the patient's written consent, except where disclosure is required by law.

c. The patient is responsible for maintaining the security of their e-mail account, passwords, and access devices. The Provider shall not be held liable for any loss of confidentiality or data resulting from actions or negligence of the patient or third parties.

d. The Provider will not engage in any unlawful activity through e-mail communication, including but not limited to the unauthorized practice of medicine across jurisdictional boundaries.

Patient (Print Name): _____ **Signature:** _____ **Date:** _____

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3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS

To ensure secure and effective e-mail communication, the patient agrees to:
a. Refrain from using an employer's computer or shared systems for e-mail correspondence whenever possible.
b. Notify the Provider promptly of any changes to their e-mail address.
c. Acknowledge receipt of e-mails and confirm that the message has been read when requested.
d. Include their full legal name within the body of each e-mail.
e. Clearly identify the purpose of the communication in the subject line (e.g., billing, general inquiries, appointments).
f. Maintain the confidentiality of e-mail correspondence by using security measures such as password protection and screen savers.
g. Submit any withdrawal of consent for e-mail communication in writing or via e-mail notification to the Provider.

---

4. TERMINATION OF THE E-MAIL RELATIONSHIP

The Provider retains the right to discontinue e-mail communication at any time if, in their professional judgment, it is determined that:

- The patient has breached any terms or conditions outlined in this agreement; or
- The patient's conduct or manner of communication is considered inappropriate or unacceptable by the Provider.

PATIENT ACKNOWLEDGEMENT, AGREEMENT, AND HOLD HARMLESS

I confirm that I have reviewed and discussed this consent with the Provider or an authorized representative and have had the opportunity to ask any questions. I acknowledge and understand the potential risks involved in using e-mail as a form of communication and voluntarily agree to proceed under these terms.

I agree to follow all guidelines outlined in this consent form, along with any additional e-mail communication policies established by the Provider.

Furthermore, I agree to release, indemnify, and hold harmless the Provider, including its employees, officers, directors, agents, contractors, and service partners, from any claims, damages, losses, expenses, or reasonable attorney fees arising from technical issues, data loss, or breaches related to the use of e-mail communication.

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Patient Name (Print): _____

Patient Signature: _____ **Date:** _____

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RECORD RELEASE AUTHORIZATION

To: _____

I hereby authorize and request the release of copies of the following information:

☐ Complete Medical Record ☐ X-Rays ☐ Laboratory
☐ Procedure Reports ☐ Other: _____

(Including current and previous medical records from other practices, practitioners, hospitals, and/or clinics that form part of my complete medical record.)

Release To:

Phone: _____ **Fax:** _____

Patient Information

Patient Name: _____ **Date of Birth:** _____

Phone #: _____

Signature: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____

☐ **Single Disclosure** ☐ **Continuing Disclosure for 120 Days** **Expiration Date:** _____

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Authorization Statement

I hereby release the disclosing facility and its employees from any liability arising from the release or use of the information contained in the records provided under this authorization.

Signature: _____