Registration Form

Date: _____ PRIMARY CARE PROVIDER: _____
Patient Information:
Name: _____
(Last) (First) (Mi)
Responsible Party (if a minor): _____
Home Phone: (___) _____ Cell Phone: (___) _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Sex: Male/Female Age: _____ DOB: _____ SS#: _____
_____Married _____Widowed _____Single _____Divorced _____Separated _____Other ____Minor
Race_____Ethnicity_____Language_____

Employer/School: _____
Occupation: _____ Business Phone: (____) _____

Email address: _____ May we contact you by email: yes/ no

In case of an emergency notify: _____ Relationship _____
DOB: _____ SS#: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____
Primary
Insurance Company Name: _____
Name of Policy Holder: _____
Policy #_____ Group #_____
Policy holder's date of birth: _____ SS#: _____
Secondary
Insurance Company Name: _____
Name of Policy Holder: _____
Policy #_____ Group #_____
Policy holder's date of birth: _____ SS#: _____

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to ER Physicians Group at Jackson Hospital all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid for by my insurance. I authorize the use of my signature on all insurance submissions. The ER Physicians Group at Jackson Hospital may use my health care information and may disclose such information to the above insurance company(ies) and their agents for the purpose of obtaining payment for the services and determine insurance benefits or the benefits payable for related services.

Signature of Patient, Guardian, or Personal Representative Date

Print the name of Patient, Guardian, or Personal Representative Date

General Health Questionnaire

Name: _____DOB:_____ DATE: _____

REASON FOR TODAY'S VISIT:

☐ Establish with Physician ☐ Specialist Referral from My Doctor ☐ Auto Accident ☐ Work Injury
☐ Surgery ☐ Annual Wellness ☐ Work Physical Visit ☐ Sports Physical
☐ Medical Weight Loss ☐ Sleep Study ☐ Other: _____

Referring Provider: _____

PERSONAL PAST MEDICAL HISTORY

(Check ALL that apply)

- ☐ Anorexia
- ☐ Anemia
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Lupus
- ☐ Obesity
- ☐ Sickle Cell
- ☐ Cancer (Type): _____
- ☐ Glaucoma
- ☐ Tinnitus
- ☐ Seasonal Allergies
- ☐ Environmental Allergies
- ☐ Stroke
- ☐ TIA
- ☐ Migraines
- ☐ Neuropathy
- ☐ Seizures
- ☐ Dementia
- ☐ Hypertension
- ☐ Hypotension
- ☐ Hyperlipidemia
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Stents
- ☐ Blood Clots
- ☐ Pacemaker
- ☐ Angina
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Pneumonia
- ☐ GERD
- ☐ Peptic Ulcer Disease
- ☐ Gallbladder Disease
- ☐ Liver Failure
- ☐ Chronic Hepatitis
- ☐ Back Pain
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Attention Deficit Disorder
- ☐ Schizophrenia
- ☐ Other: _____ _____ _____

Female GU:

- ☐ Recurrent UTI
- ☐ Endometriosis
- ☐ Ovarian Cysts
- ☐ Incontinence
- ☐ Other:_____

Menopause: __YES __NO
Previous Breast Biopsy or Aspiration:___ YES ___NO
Hormone Replacement Therapy: ___ YES ___NO
What kind:_____
Form of Contraception: _____

LMP:_____
Age at first period:___
# of pregnancies: ___
# of live births: ___
# of abortions: ___
# of miscarriages: ___
Age at first child:___

GU (Male):

- ☐ Benign Prostate Hypertrophy (BPH)
- ☐ Incontinence
- ☐ Recurrent UTI
- ☐ Other: _____

ALLERGIES

Are you allergic to any medication: ___YES ___NO Food Allergies: ___YES ___NO Environmental Allergies: ___YES ___NO

Allergy	Reaction

FAMILY HISTORY

Condition	NO	What Kind?	Mother	Father	Siblings	Grandparents Maternal/Paternal
Heart Disease						
Lung Disease						
High Blood Pressure						
Stroke						
Diabetes						
Kidney Disease						
Liver Disease						
Cancer						
Thyroid Disease						
Other						
Other						

SOCIAL

Marital Status: _____
Do you currently smoke/use smokeless tobacco?
___NO ___YES
#of packs a day: ___ # years: ___
Have you ever smoked/use smokeless tobacco? ___NO ___YES
#of packs a day: ___ # years: ___
Do you exercise? ___ NO ___ YES

Do you have pets in the home?
___NO ___YES
Do you consume caffeine? __NO __YES
Occupation: _____
Do you drink alcoholic beverages?
___never ___rarely ___ daily amount
Drug Use: ___ NO ___ YES
If yes, drug type: _____

MEDICATION LIST

List ALL medication below, please include over the counter medications, contraceptives, and vitamins.

Please bring any and all medication to all appointments.

Medication Name	Dosage	Frequency

Name Pharmacies you use, please list city/state

List any past Specialist/Physicians

Name Physician Specialty

Please list all surgical procedures performed if any (Date if possible)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Have you had any problems with general anesthesia: _____ NO _____ YES

HEALTH MAINTENANCE

(Please provide the date of your most recent screening if applicable)

Mammogram: _____ Flu: Vaccine: _____
Bone Density Study: _____ Pneumovax: _____
Colonoscopy: _____ Annual Eye Exam: _____
Pap Smear: _____ ColoGuard:_____

IMPAIRMENTS

Have you fallen within the last 30 days? ___NO ___YES
Do you have a vision or hearing impairment? ___ NO ___ YES; If yes, explain: _____

REVIEW OF SYSTEMS

Check ALL that CURRENTLY apply

GENERAL	✓
Appetite Loss	
Chills	
Chronic pain	
Fatigue	
Fever	
Weakness	
Weight Gain	
Weight Loss	
Unable to sleep lying flat	

SKIN	✓
Abscess	
Hair Loss	
Jaundice	
Mass/Lump	
Nail Changes	
New Lesions	
Varicose Veins	
Surgical Wound	

ENDOCRINE	✓
Cold Intolerance	
Decreased Sweating	
Excessive Sweating	
Excessive Urination	
Heat Intolerance	
Polydipsia	
Polyuria	

NECK	✓
Neck Mass	
Neck Pain	
Neck Stiffness	
Neck Swelling	
Swollen Glands	

MUSCULOSKELETAL	✓
Arthritis	
Back Pain	
Decrease Range of Motion	
Hot/Red/Swollen Joints	
Joint Pain	
Muscle Cramps	

RESPIRATORY	✓
Bloody Sputum	
Cough	
Decrease Exercise Tolerance	
Difficulty Breathing	
Sputum Production	
TB Exposure	
Wheezing	

REVIEW OF SYSTEMS (Continued)

Check ALL that CURRENTLY apply

CARDIOVASCULAR	✓
Abnormal Blood Pressure	
Bradycardia	
Calf Cramps	
Chest Pain	
Difficulty Breathing	
Edema	
Fainting	
Irregular Heart Beat	
Murmur	
Palpitations	
Shortness of Breath	
Syncope	

HEENT	✓
Hearing Loss	
Ear Pain	
Ear Discharge	
Ringing in the Ears	
Runny Nose	
Nasal Congestion	
Nose Bleed	
Sneezing	
Seasonal Allergies	
Environmental Allergies	
Sinus Pain	
Snoring	
Sore Throat	
Trouble Swallowing	
Hoarseness	
Bleeding Gums	
Oral Ulcers	
Choking Sensation	
Blurred Vision	
Double Vision	
Excessive Tearing	
Eye Pain	
Eye Redness	
Periorbital Puffiness	
Visual Disturbances	
Visual Loss	
Head Injury	
Facial Numbness	

GASTROINTESTINAL	✓
Abdominal Pain	
Belching	
Black, Tarry Stool	
Change in Bowel Habit	
Constipation	
Diarrhea	
Hemorrhoids	
Heartburn	
Nausea	
Pain with Bowel Movement	
Rectal Bleeding	

NEURO	✓
Attention Deficit	
Difficulty Speaking	
Dizziness	
Headaches	
Hyperactivity	
Loss of Consciousness	
Memory Problems	
Numbness	
Tremor	
Trouble Walking	

Psychiatric	✓
Stress	
Delusions	
Hallucinations	
Suicidal Ideation	
Suicidal Planning	

HEMATOLOGY	✓
Abnormal Bleeding	
Easy Bruising	

BREAST	✓
Breast Mass	
Breast Pain	
Breast Swelling	
Nipple Discharge	
Skin Changes	

FEMALE GU	✓
Absence of Menstruation	
Blood in Urine	
Change in Bladder Habits	
Discharge	
Excessive Menstrual Bleeding	
Painful Intercourse	
Painful Urination	
Pelvic Pain	
Vaginal Dryness	

MALE GU	✓
Blood in Urine	
Change in Bladder habits	
Difficulty with Erection	
Discharge	
Painful Urination	
Penile Lesions	
Testicular Mass	
Other:	

HEPATITIS B VACCINATION	✓
I have never had Hep B vaccines	
Completed entire series of 3 doses	
I started the series but did not get all 3 doses	

List any condition not covered above:

_____

_____

_____

_____

Provider signature: _____

Request for Release of Medical Records

Send to: _____ Fax number_____

Patient Name: _____DOB: ___/_____/_____SSN: _____-_____-_____

Address: _____

____ I grant permission for my Medical Records to be shared with the group physicians shown below as medically necessary for my care and treatment.

☐ General Surgery
4295 Third Avenue, Marianna, FL 32446
Phone (850) 482-0017/**Fax (850) 526-5002**
- Vechai Arunakul, MD, FACS
  - Holly Sims, APRN

☐ Family & Internal Medicine
4230 Hospital Drive, Suite 210, Marianna, FL 32446
Phone (850) 526-6735/**Fax (850) 633-5912**
- John Brunner, DO
- Robin Albritton, MD
  - Gerald Trotman, APRN
  - JD Tyler, APRN

☐ Hematology/Medical Oncology
4230 Hospital Drive Suite 101, Marianna, FL 32446
Phone (850) 526-6707/**Fax (850)718-2887**
- Thomas Brown, MD
  - April Cooper, APRN
- Toby Murray, APRN

☐ Sneads Clinic
7999 Hwy 90, Sneads, FL 32460
Phone (850) 593-1155/**Fax (850) 593-6042**
- Abby Strickland, APRN

☐ Chipola Quick Care & Primary Care – Alford 1798 Georgia Street, Alford, FL 32420 Phone – 850-526-6727/Fax 850-526-1027
- Kristin Fenton, APRN

☐ OB/GYN
4230 Hospital Drive Suite 209, Marianna, FL 32446
Phone (850) 526-6711/**Fax (850) 526-5021**
- Toby Marshall, MD, FACOG, NCMP
- Orlando Muniz, MD, FACOG
  - Jacquelyn Bard, APRN

☐ Panhandle Family Care
4284 Kelson Avenue, Marianna, FL 32446
Phone (850) 482-2910/**Fax (850) 526-2138**
- Mark Akerson, MD
  - Kristin Owens, APRN
- John Spence, MD
  - Jennifer Brogan Palmberg APRN

☐ ENT/Sinus & Allergy
4306 Third Avenue Suite B, Marianna, FL 32446
Phone (850) 372-4070/**Fax (850) 633-5909**
- Angelo Consiglio, MD, FAAOA
- Christy Peeler, APRN

☐ Pediatrics
3028 4th Street, Suite A & B, Marianna, FL 32446
Phone (850) 718-2886/**Fax (850) 633-5908**
- Melissa Caraballo, DO
- Holli Jemsion, APRN
- MaryBeth Melvin, MD

☐ Internal Medicine Associates of Jackson Hospital
4318 Fifth Avenue, Marianna, FL 32446
Phone (850) 526-5300/**Fax (850) 526-5001**
- Richard Christopher, MD
  - Julie Smith, APRN
- Steven Spence, MD
  - Anna Brunner, APRN
  - Megan Tyler, APRN
  - Tucker Retherford, MD

☐ Quick Care/General Surgery
4896 Hwy 90 Suite A, Marianna, FL 32446
Phone (850) 526-6700/**Fax (850)526-6701**
- Richard Brunner, MD, FACS
  - D. Michelle Baber, APRN
  - Anastasia Horne, APRN
  - Ashley Wester, APRN
  - Pam Hill, APRN

☐ Wound Healing Center
4896 Hwy 90 Suite B, Marianna, FL 32446
Phone (850) 526-6730/**Fax (850)526-6701**
- Richard Brunner, MD, FACS

___ X-ray or MRI reports___Surgical Records ___Hospital Records/Reports ___Progress Notes ___ All OB ___Other ___Labs/Pathology
I further authorize the release of information which may be included in the PHI: ____ Behavioral Health ____ Substance Use Disorder ____ STD/HIV/AIDS/ Treatment or Tests
Reason for release: ___Further care/treatment ___Legal ___Per my Request ___Other (specify): _____

This authorization will expire on _____. If no date specified, authorization will expire one year after the date it is signed by the patient or patent's representative.
I understand that:

- The PHI (protected health information) disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Federal Privacy Standards of the Health Insurance Portability and Accountability act of 1996 (HIPPA)
- I may revoke this authorization, at any time, upon written request, except to the extent that action has been taken in reliance of the authorization.
- I have the right to receive a copy of this authorization.
- Treatment may not be conditioned on the signing of this authorization, and its signing is voluntary.
- A photocopy of this consent shall be considered as valid as the original.

I HEREBY AUTHORIZE BY MY SIGNATURE THE RELEASE OF ANY AND ALL OF MY MEDICAL RECORDS TO ER Physicians Group at Jackson Hospital or specific practice as checked above.

Patient, Guardian or Legal Signature: _____ Date_____
Relationship to Patient: _____
Witness: _____Date_____

Patient Consent Form

Patient Name/DOB_____

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures and/or tests
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain valid until revoked in writing.

I, the undersigned, authorize __Chipola Surgical & Medical Specialties; Internal Medicine Associates of Jackson Hospital___to use and disclose my information for the purposes of treatment, payment and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statements and consents.

Signature of Patient, Guardian, or Legal Representative Date

Relationship to Patient

Witness Date

Receipt of Notice of Privacy Practices

ER Physicians Group at Jackson Hospital Notice of Privacy Practices describe how medical information about you may be used or related. It also explains your rights regarding your medical information. ER Physicians Group at Jackson Hospital are required by federal law to obtain your acknowledgment that you have received this notice. Due to the HIPAA Policy we are unable to disclose any of your healthcare information to anyone other than those people listed on this form with the exception of your referring physician or physician we may refer you to:

Name: Relationship:

I acknowledge that I have received ER Physicians Group at Jackson Hospital Notice of Privacy Practices and the names listed above are the people who are allowed to be told of my healthcare information.

Patient Name

Signature of Patient, Guardian, or Legal Representative Date

Relationship to Patient

Financial Policy of ER Physicians Group at Jackson Hospital

Patient Name/DOB_____

I have read, understand, and agree to the financial policy of ER Physicians Group at Jackson Hospital. I understand that charges not covered by my insurance company, as well as, applicable co-payments and deductibles are my responsibility.

I authorize my insurance benefits to be paid directly to ER Physicians Group at Jackson Hospital.

I understand that any patient overpayment on my account may be transferred to an outstanding account balance with another employed physician of Jackson Hospital or an account balance for Jackson Hospital.

I authorize ER Physicians Group at Jackson Hospital to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Print Name	Date
Signature of Patient, Guardian, or Legal Representative	Date
Relationship to Patient	

Patient Portal

Date: _____

I, _____, patient, legal representative, or guardian of _____, have received information on the patient portal, Follow My Health, and I acknowledge that the office will register me.

Check one:

___Yes I would like to have access to my medical records, email is provided below.

___No thank you not at this time.

Email Address: _____

Please print

Patient, Guardian, or Legal Signature: _____

DOB: _____

Relationship to patient: _____

USER NAME: email address provided above

PASSWORD: __jackson111#

Please change password at: https://jacksonhosp.followmyhealth.com input: _____

Jackson Hospital
Growing a Healthier Community.

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Jackson Hospital and its affiliated clinics, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state, and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing, or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Jackson Hospital and its affiliated clinics to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____	_____
Signature of Patient	Signature of Witness
_____	_____
Printed Name of Patient	Printed Name of Witness
_____	_____
Date	Date