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## NEW PATIENT REGISTRATION

Patient Last Name: \_\_\_\_\_ Patient First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_  
Gender: M ( ) F ( )  
Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated  
Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Responsible Party Name/Relationship: \_\_\_\_\_ Address/Phone #: \_\_\_\_\_

**WHOM MAY WE THANK FOR REFERRING YOU?** \_\_\_\_\_

**How will you be paying today?** ( ) Cash ( ) Check ( ) VISA ( ) MC ( ) DISC

### ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information in relation to all claims, including Medicare for benefits submitted on my behalf and/or my dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each claim form to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed each claim.

I hereby authorize my insurance carrier to pay and assign all medical and/or surgery benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to **Dr. Mickel Anglin/Anglin Medical**. I authorize the release of any medical records for treatment, payment or healthcare operations.

**INSURANCE COVERAGE IS NOT A GUARANTEE OF PAYMENT FOR ANY CLAIM, FURTHER I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED REGARDLESS OF INSURANCE COVERAGE.**

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Past Medical History (please circle all that apply)**

Asthma	HTN	High cholesterol	COPD	Arthritis
GERD	Gout	Depression	Migraine	Tendonitis
Allergies	Seizures	Sleep apnea	Palpitations	DVT
Heart murmur	HIV	Respiratory disease	Osteoporosis	Drug abuse
Diabetes, type I	Diabetes, type II	Stroke	Abnormal pap	

**Medications**

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**Surgical History**

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**Social History (please circle all that apply)**

Working	Alcohol	Smoking
Exercise	Caffeine	Drug use

**Family History (please circle all that apply)**

<b>Father have a history of</b>	High blood pressure	Diabetes	High cholesterol
	Cancer	Heart Disease	
<b>Mother have a history of</b>	High blood pressure	Diabetes	High cholesterol
	Cancer	Heart Disease	
<b>Siblings have a history of</b>	High blood pressure	Diabetes	High cholesterol
	Cancer	Heart Disease	
<b>Paternal Grand Father have a history of</b>	Heart Disease	Diabetes	Cancer
	High cholesterol	High blood pressure	
<b>Paternal Grand Mother have a history of</b>	Heart Disease	Diabetes	Cancer
	High cholesterol	High blood pressure	
<b>Maternal Grand Father have a history of</b>	Heart Disease	Diabetes	Cancer
	High cholesterol	High blood pressure	
<b>Maternal Grand Mother have a history of</b>	Heart Disease	Diabetes	Cancer
	High cholesterol	High blood pressure	



**Patient Consent Form**

*(Please Read and Sign)*

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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/tests and cultures
- 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 in full force until revoked in writing.

I understand that **Anglin Medical/Dr. Anglin** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **Anglin Medical/Dr. Anglin** will 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 the consent shall be considered as valid as the original.

**MEDICARE PATIENTS:** I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Anglin Medical/Dr. Anglin**.

I acknowledge that I have been given the **Anglin Medical/Dr. Anglin** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

Patient Initial: \_\_\_\_\_

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
*Patient (or Responsible Party) Signature*

\_\_\_\_\_  
*Date*

I, the undersigned certify that I (or my dependent) has insurance coverage as listed above and assign directly to Anglin Medical. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Anglin Medical to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

Are you the Guarantor? Yes \_\_\_ No \_\_\_ If not please see receptionist.



**Anglin Medical, Dr. Mickel Anglin, MD**  
**Authorization to Release Health Information**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Social Security

\_\_\_\_\_  
Other Names Patient has Used

Send Records to:

Anglin Medical  
13045 Summerfield Square Dr.  
Riverview, FL 33569  
813-672-1385

From: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I  do  do not (check applicable box) authorize this information to be faxed.  
If yes, fax number: 813-672-8904

This information is being disclosed for the purpose of Continuing Health Care.

For Healthcare Covering:

**\*Last 3 progress notes**

**\*Most recent consultation notes**

**\*Most recent labs**

**\*All Imaging**

I understand that specific information to be released may include AIDS or HIV, Alcohol and/or Drug Abuse, and Mental Health.

I understand that if I request copies of records for myself or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

Unless otherwise indicated, this authorization will expire ninety (90) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be evoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

I understand that there may a fee for preparing and furnishing thus information.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date



## Notice of Privacy Practices

Effective Date: April 1, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

### Uses and Disclosures:

#### How we may use and disclose Health Information about you.

**Treatment:** We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other medical office personnel who are involved in taking care of you at the medical office. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the medical office also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

**Payment:** We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

**Health Care Operations:** Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may also combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and students for educational purposes. And we may combine health information we have with that of other medical offices to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

**As required by law,** we may also use and disclose health information for the following types of entities, including but not limited to: Food and Drug Administration, Public Health or Legal authorities charged with preventing or controlling disease, injury or disability, Correctional Institutions, Workers Compensation Agents, Organ and Tissue Donation Organizations, Military Command Authorities, Health Oversight Agencies, Funeral Directors, Coroners and Medical Directors, National Security and Intelligence Agencies, Protective Services for the President and Others, Law Enforcement/Legal Proceedings, State Specific Requirements.

**Your Rights** - Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to:**

**Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by the medical office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the medical office. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

**Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

**Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. The facility will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services.

**A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

**Changes to this notice:** We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the medical office and include the effective date.

**Complaints:** *If you believe your privacy rights have been violated, you may file a complaint with the medical office by contacting the main number and asking for the Facility Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with the medical office, contact the Privacy Official. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.***

**Other Uses of Health Information**

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time.

If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented in the doctor's office or clinic.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices.

Print Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_



Please Review and Sign:

- There will be a \$25.00 returned check fee.
- All appointment changes require at least a 24 hour notice.
- As of September 1, 2011 the first time missed /no show/ cancelled appointments the day of the scheduled appointment will be charged a fee of \$35. Appointments thereafter after will be charged a fee of \$50.
- All Co-Pays are due at time of appointment.
- All outstanding balances are due before services are rendered.

Print Name \_\_\_\_\_

Sign \_\_\_\_\_

Date \_\_\_\_\_



**New Symptoms**  
**(please circle all that apply)**

ENT/RESPIRATORY

Ear pain. Ear drainage. Hearing loss. Tinnitus (ear ringing)

ENDOCRINOLOGY

Polyphagia.(increased eating) Polyuria (painful urination)  
Polydypsia (increased drinking) Heat intolerance. Cold intolerance.

GASTROENTEROLOGY

Nausea:. Vomiting. Constipation. Diarrhea.

DEMATOLOGY

Rash. Itching.

HEME/LYMPH

Bleeding. Bruising.

OPHTHALMOLOGY

Eye drainage. Eye redness. Eye pain. Vision change.

PULMONOLOGY

Shortness of breath. Wheezing. Chest congestion.

RHEUMATOLOGY

Joint pain. Joint stiffness. Joint swelling.

NEUROLOGY

Dizziness. Headache. Memory loss. Seizures. Tremor.  
Weakness.

PSYCHOLOGY

Panic attacks. Sleep disturbance. Suicidal ideations.  
Hallucinations. Paranoia.

CONSTITUTIONAL

Fatigue. Night sweats. Fever.

ALLERGIC RHINITIS

Cough. Nasal congestion. Postnasal drip. Sinus pain. Sore throat. Sneezing.

CARDIOLOGY

Chest pain. Dizziness. Orthopnea. Palpitations.

**Health Maintenance**

**Last Mammogram** \_\_\_\_\_

**Last Pap Smear** \_\_\_\_\_

**Last Colonoscopy** \_\_\_\_\_

**Last Bone Scan** \_\_\_\_\_

**General Symptoms**  
**(please circle all that apply)**

CONSTITUTIONAL

Ill contacts. Weight change. Fever. Night sweats.  
Weakness. Fatigue.

ALLERGY

Itchy eyes. Cough. Sore throat. Nasal congestion.  
Nasal drip. Sneezing. Facial pressure.

CARDIOLOGY

Diaphoresis (sweating) Chest pain. Palpitations.

DERMATOLOGY

Rash. Itching.

ENT

Ear pain. Hearing loss. Teeth pain. Change in voice.

ENDOCRINOLOGY

Heat intolerance. Cold intolerance. Sleep disturbance.  
Polyuria. Polydipsia.

GASTROENTEROLOGY

Nausea. Vomiting. Constipation. Diarrhea. Stomach pain.

HEMATOLOGY/LYMPH

Swollen glands. Easy bruising. Easy bleeding.

MUSCULOSKELETAL

Joint pain.or stiffness. Tingling/numbness. Muscle aches.

OPHTHALMOLOGY

Blurring of vision. Diminished vision. Eye redness. Eye drainage.

RESPIRATORY

Wheezing. Orthopnea. Pain in the calves. Shortness of breath. Chest congestion.

UROLOGY

Pain with urination. Discharge. Dysuria. Urinary frequency. Blood in urine.

NEUROLOGY

Confusion. Weakness. Speech abnormality. Dizziness.  
Memory loss.

PSYCHOLOGY

Mood swings. Anxiety. Suicidal ideation.  
Hallucinations. Mental or physical abuse.