



5112 N. Habana Ave. Tampa, FL 33614 | Phone: (813)374-2406 | Fax: (813)374-2407
www.AccordMedicalGroup.com

PATIENT REGISTRATION FORM

Patient Name: _____
Last First Middle Initial

Date of Birth: _____ Gender : Male Female Transgender Social Security #: _____

Marital Status : Single Married Divorced/Separated

Address: _____ City: _____ State: _____ Zip: _____

Personal email: _____

Primary Phone: _____ Type: Home Cell Phone Work Phone

Ethnicity: Hispanic or Latino Not Hispanic or Latino Race: American Indian or Alaska Native Asian
 Black or African American Native Hawaiian or Other Pacific Islander White Other: _____

Employment Information

Company Name: _____

Phone: _____ Ext: _____

Insurance Information

Primary: _____ Secondary: _____

Policy holder ID: _____ Policy holder ID: _____

Policy holder name: _____ Policy holder name _____

Policy holder DOB: _____ Policy holder DOB: _____

Patient relationship to policy holder: _____ Patient relationship to policy holder: _____

Policy holder sex: Female Male Policy holder sex: Female Male

Pharmacy: _____ Location: _____

Pharmacy phone: _____

How did you hear about Accord Medical Group?

Doctor Family/Friend Insurance Event TV Radio Mail
Website / Internet Phonebook Building Sign Other (Otro): _____



5112 N. Habana Ave. Tampa, FL 33614 | Phone: (813)374-2406 | Fax: (813)374-2407
 www.AccordMedicalGroup.com

HEALTH INFORMATION QUESTIONNAIRE

This is a confidential record of your medical history and will be kept in the office. Information contained here will not be released to any person unless you have authorized us to do so.

Name: _____ Date: ____/____/____

DOB: _____ Age: _____ New patient Established patient

What medical/health concerns bring you to our office today? _____

Medications- List all medications you take on regular basis (include over-the-counter, herbal or natural remedies).

Medication Name	Strength	Daily Frequency	Medication Name	Strength	Daily Frequency

Medical History- Have you ever had or been diagnosed to have (check all that apply)?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colon polyps | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes/prediabetes | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fracture | <input type="checkbox"/> Jaundice/liver disease | <input type="checkbox"/> TB/lung disease |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Migraines/headache | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Cancer: What kind?
_____ | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other Conditions:
_____ |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pneumonia | _____ |
| | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Prostate problems | _____ |



5112 N. Habana Ave. Tampa, FL 33614 | Phone: (813)374-2406 | Fax: (813)374-2407
 www.AccordMedicalGroup.com

HEALTH INFORMATION QUESTIONNAIRE

Allergies- Do you have any known allergies to medications or food? Yes No

If yes, please list: _____

OB/GYN History (females only):

Age of menses: _____ Age of menopause: _____ Method of birth control: _____

How many pregnancies: _____ How many children: _____ Vaginal or C-section _____

Hospitalizations and Surgeries - List any hospitalizations, surgeries or procedures you have had performed.

What	Date	What	Date

Family History- Please indicate if your blood relative(s) have had/currently have the following by placing an X in appropriate column:

Family Member	Health Problem(s)	General Health
Mother (age _____)		
Father (age _____)		
Brother(s) (age _____)		
Sister(s) (age _____)		
Grandparents (age _____)		



5112 N. Habana Ave. Tampa, FL 33614 | Phone: (813)374-2406 | Fax: (813)374-2407
 www.AccordMedicalGroup.com

HEALTH INFORMATION QUESTIONNAIRE

Social History

Smoking/ Tobacco Use? Current Past Never

If you answered yes, answer these additional questions:

Type: _____ Amount/day: _____ How long(years): _____

Alcohol Use? Current Past Never

If you answered yes, how many drinks/week: _____

Recreational Drug Use? Current Past Never

If you answered yes, type: _____

Are there any personal problems or concerns at home, work or school you would like to discuss? Yes No

If you answered yes, type: _____

Do you have any personal health goals? Yes No

If you answered yes, please list: _____

Occupation: _____ Full-time Part-time

If retired, what was your former occupation: _____

Health Screening Tests History- Please answer what screening tests you have had, the date of the last test and the results.

Screening Test	Yes/No/Date	Results
FLU Shot	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Dexa Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
EKG	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Fecal Test	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Mammogram	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Pap Smear-Females Only	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Prostate-specific Antigen- PSA- Males only	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Spirometry	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal



5112 N. Habana Ave. Tampa, FL 33614 | Phone: (813)374-2406 | Fax: (813)374-2407
www.AccordMedicalGroup.com

MEDICAL INFORMATION RELEASE FORM- (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse: _____

Child(ren): _____

Other: _____

Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call: my home my work my cell number

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

The best time to reach me is : (day) _____ Between (time) _____

RELEASE OF MEDICAL INFORMATION: I acknowledge that “protected health information” pertains to my diagnosis and/or treatment at Accord Medical Group including, but not limited to, information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases. I acknowledge that the “Notice of Privacy Practices” provides information about how this facility may use and/or disclose protected health information about me for treatment, payment, health care operations and as otherwise allowed by law. I understand that Accord Medical Group cannot be responsible for use or re-disclosure of information by third-parties.

Signed: _____ Date: _____



5112 N. Habana Ave. Tampa, FL 33614 | Phone: (813)374-2406 | Fax: (813)374-2407
www.AccordMedicalGroup.com

Medical Records Release/Request Form

Patient Authorization for Use or Disclosure of Protected Health Information

As required by the Health Portability and Accountability Act of 1996 (HIPAA), a practice may not use or disclose your identifiable health information without your authorization except as provided in our Notice of Privacy. Your Completion of this form means that you give permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete those sections detailing the information to be released, and the purposes for the disclosure.

Your Name (Print) _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone _____

Date(s) of Service For Release _____ OR the entire Medical Record

I hereby authorize this medical practice, _____ to release my health information to:

___ Accord Medical Group | 5112 N. Habana Avenue, Tampa, FL 33614 | T: 813-374-2406 | F: 813-374-2407

OR ___ Other practice (include name, address, phone number): _____

Reason for release: _____

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the expressed purpose identified above, unless another authorization is obtained from me, or such use or disclosure is specifically required or permitted by law.

I understand that any medical record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral/mental health services; and/or treatment for alcohol and/or drug abuse. Initial all requested exclusions:

EXCLUSION(S):

Alcohol/Drug _____ Behavior/Mental/Psychiatric _____ Sexually Transmitted Disease _____
HIV/AIDS _____ Other _____ specify other exclusion _____.

I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan. This authorization is effective _____ through _____ (dates must be specified).

Signature _____ Address: _____

Guardian: _____ Parent: _____

Patient Representative and Relationship: _____



5112 N. Habana Ave. Tampa, FL 33614 | Phone: (813)374-2406 | Fax: (813)374-2407
www.AccordMedicalGroup.com

Awareness of Controlled Medication

Patient's Name: _____

Date of Birth: _____

The following is to make awareness of controlled medication requirements. All controlled medications will not be called in to your pharmacy and will not be written without a face-to-face visit. All controlled substances are required to be followed up by a primary care physician. If you are in need of a controlled substance, you must contact our office at 813-374-2406 and schedule an appointment for further treatment.

By signing this form, you are giving acknowledgement to the above-mentioned statement.

Patient Signature

Date