Broward Medical & Urgent Care, Inc. Martin M. Roche, Sr., M.D.
103 S.E. 20th Street • Ft. Lauderdale, FL 33316

WELCOME TO OUR OFFICE

PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT)

NAME ❑ Mr. ❑ Mrs. ❑ Miss _____ (LAST) _____ (FIRST) _____ (MIDDLE INITIAL)

MARITAL STATUS: M S D W **REFERRED BY:** _____

SOCIAL SECURITY # _____ - _____ - _____ **BIRTH DATE** _____ (MONTH) / _____ (DAY) / _____ (YEAR) **AGE** _____

HOME ADDRESS: _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

OTHER PHONE _____ EMAIL _____

EMPLOYER: _____ **OCCUPATION** _____

WORK ADDRESS: _____

CITY _____ STATE _____ ZIP _____

SPOUSE'S NAME: _____

WORK PHONE _____ OTHER PHONE _____

WHO TO NOTIFY IN AN EMERGENCY: _____ RELATIONSHIP _____

PHONE _____ OTHER PHONE _____

ACKNOWLEDGMENT OF NOTICE

By signing this I understand that I am financially responsible for all charges including medication, laboratory test and/or procedure(s) received and/or performed.

PERSONAL HEALTH INSURANCE: Our office currently accepts assignment on AETNA, BC/BS, CIGNA, HUMANA, MEDICARE, UNITED, TRICARE, WORKERS COMP, and PIP.
Your insurance carrier will determine your eventual reimbursement. Our office will not accept responsibility for negotiating a settlement on a disputed claim. You are responsible for knowing and following through on your insurance claim if it is denied.

PRIVACY PRACTICES: I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

MALPRACTICE INSURANCE: Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. MARTIN M. ROCHE, SR. MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

PLEASE SIGN AND RETURN TO RECEPTIONIST (ALL PATIENTS MUST SIGN BELOW)
I, the undersigned, have insurance coverage with the above noted insurance company and assign directly to MARTIN ROCHE, MD all surgical and/or medical benefits, if any otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Date _____ Signature _____

*PLEASE COMPLETE THIS ENTIRE FORM BEFORE RETURNING IT TO OUR STAFF - THANK YOU

Martin M. Roche, Sr., M.D.
Broward Medical & Urgent Care, Inc.
103 S.E. 20th Street • Ft. Lauderale, FL 33316
Telephone: 954-462-7558 Fax: 954-525-5820

DRUG ALLERGIES

PREVIOUS HOSPITALIZATION OR SURGERY

DATE	REASON	DATE	REASON

YEAR OF LAST

VACCINE	VACCINE	TEST/EXAM	TEST/EXAM
TETANUS	PNEUMONIA	RECTAL/STOOL	TUBERCULOSIS
FLU	OTHER	CHOLESTEROL	OTHER

MEDICATIONS YOU ARE CURRENTLY TAKING

MEDICAL HISTORY

- ❑ Abdominal Pain - Chronic _____
- ❑ Allergies/Hayfever _____
- ❑ Anemia _____
- ❑ Ankle Swelling _____
- ❑ Appetite Loss _____
- ❑ Arthritis/Rheumatism _____
- ❑ Asthma/Wheezing _____
- ❑ Back Pain - Recurrent _____
- ❑ Bronchitis/Chronic Cough _____
- ❑ Cancer _____
- ❑ Chicken Pox ❑ Polio ❑ Mumps _____
- ❑ Convulsions/Seizures _____
- ❑ Diabetes _____
- ❑ Diarrhea ❑ Constipation _____
- ❑ Change in Bowel Habits _____
- ❑ Diphtheria _____
- ❑ Diverticulosis ❑ Crohn's/Colitis _____
- ❑ Dizziness/Fainting _____
- ❑ Ear Infections - Frequent _____
- ❑ Ear Ringing _____
- ❑ Eyesight - Failing _____
- ❑ Fatigue - Chronic _____
- ❑ Foot Pain ❑ Cold Numb Feet _____
- ❑ Gall Bladder Trouble _____
- ❑ Gout _____
- ❑ Heart Murmur ❑ Chest Pain _____
- ❑ Headaches - Frequent _____
- ❑ Hemorrhoids _____
- ❑ Hernia _____
- ❑ High Blood Pressure _____
- ❑ Indigestion or Heartburn _____
- ❑ Infection _____
- ❑ Jaundice/Hepatitis _____
- ❑ Kidney Stones _____
- ❑ Leg Pain _____
- ❑ Measles ❑ Rubella ❑ Rheumatic Fever
- ❑ Memory Loss _____
- ❑ Mental Illness _____
- ❑ Moodiness - Excessive _____
- ❑ Muscle Weakness _____
- ❑ Nausea/Vomiting - Persistent _____
- ❑ Nervousness ❑ Depression _____
- ❑ Nose Bleeds _____
- ❑ Numbness/Tingling Sensation _____
- ❑ Osteoporosis _____
- ❑ Phobias _____
- ❑ Pneumonia _____
- ❑ Prostate Disease _____
- ❑ Psoriasis ❑ Eczema _____
- ❑ Rashes ❑ Hives _____
- ❑ Scarlet Fever ❑ Tuberculosis ❑ Herpes
- ❑ Sexual/Menstrual Dysfunction _____
- ❑ Sinus Trouble _____
- ❑ Stools - Bloody or Tarry _____
- ❑ Stroke _____
- ❑ Swallowing Difficulty _____
- ❑ Swollen Ankles _____
- ❑ Tetanus _____
- ❑ Throat Soreness - Frequent _____
- ❑ Thyroid _____
- ❑ Tremor _____
- ❑ Ulcers - Peptic _____
- ❑ Urethral Discharge _____
- ❑ Urine - Blood Present _____
- ❑ Urination - Overnight More than Twice
- ❑ Varicose Veins/Phlebitis _____
- ❑ Venereal Disease _____
- ❑ Weight Loss _____
- ❑ Other _____
- ❑ Other _____
- ❑ Other _____
- ❑ Other _____

Females - *Please Complete*

Pregnant? ❑ Yes ❑ No

Planning Pregnancy? ❑ Yes ❑ No

Menstrual Flow:

❑ Regular ❑ Irregular ❑ Pain/Cramps

____Days of Flow ____Length of Cycle

Date-1st day of last period_____

❑ Pain/Bleeding during or after sex

Number of:

____Pregnancies ____Abortions

____Miscarriages ____Live Births

Birth Control Method_____

B.C. Pill (Name) _____

❑ Flushing/Menopause

Date of Last PAP Test _____

❑ Normal ❑ Abnormal

Date of Last Mammogram _____

❑ Normal ❑ Abnormal

FAMILY HISTORY

	FATHER	MOTHER	CHILDREN	SIBLINGS	FATHER'S PARENTS	MOTHER'S PARENTS
ALCOHOLISM	☐	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐	☐
BLEEDING DISORDER	☐	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐
GLAUCOMA	☐	☐	☐	☐	☐	☐
EPILEPSY/CONVULSIONS	☐	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐	☐

	FATHER	MOTHER	CHILDREN	SIBLINGS	FATHER'S PARENTS	MOTHER'S PARENTS
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐	☐	☐	☐
MENTAL ILLNESS	☐	☐	☐	☐	☐	☐
MIGRAINE	☐	☐	☐	☐	☐	☐
OSTEOPOROSIS	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐
THYROID DISEASE	☐	☐	☐	☐	☐	☐

OTHER _____

HABITS

- ☐ ALCHOHOL: TYPE _____
  AMOUNT: _____
- ☐ DIET: SALT INTAKE _____
  FAT INTAKE: _____
  OTHER _____
- ☐ SLEEP: DIFFICULTY FALLING ASLEEP _____
  CONTINUITY DISTURBANCES _____
  EARLY MORNING AWAKENING _____
  DAYTIME DROWSINESS _____
  OTHER: _____
- ☐ SMOKE: PACKS DAILY _____
  HOW LONG? _____
  INTERESTED IN STOPPING? _____
  EXERCISE ROUTINE: _____
- ☐ COFFEE: CUPS DAILY _____
  OTHER CAFFEINE: _____