BROWARD MEDICAL & URGENT CARE, INC.

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

Social Security:_____**Birth Date**: _____/____/_____**Age**_____
Month/Day/Year

Home Address: _____**City**:._____**State**: _____**Zip**:_____

Mobile Phone _____**Home** _____**Work** _____

Email _____**Other Phone/email** _____

Marital Status: _____Married _____Single _____Divorced _____Widowed

Spouse's/Partner's Name: _____

Spouse's/Partner's Phone _____ **Email** _____

REFERRED BY: Person _____

FOUND BY: Search Engine/Website _____
Google/Yelp/Bing/Web MD/Etc.

EMPLOYER:_____ **Occupation**:_____

Work Address: _____**City**:._____**State**: _____**Zip**:_____

Emergency Contact: _____ **Relationship:** _____

Phone: _____ **Email** _____

PHARMACY: _____ **Pharmacy Phone** _____

Pharmacy Address: _____**City**:._____**State**: _____**Zip**:_____

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 for Medicare and a limited number of PPO insurance. We accept Workers Comp and PIP with a reimbursable payment of $120.** 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. **DR. 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 _____ _____(enter the name of your medical insurance policies) and assign directly to BROWARD MEDICAL & URGENT CARE, INC., or MARTIN M. 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.

Signature: _____ **Date:** _____

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

THANK YOU

BROWARD MEDICAL & URGENT CARE, INC.

DRUG ALLERGIES	

PREVIOUS HOSPITALIZATION OR SURGERY	
Date	Reason

YEAR OF LAST VACCINE OR TEST				MEDICATIONS YOU ARE CURRENTLY TAKING
Tetanus		Tuberculosis		
Pneumonia		Rectal/Stool		
Flu		Cholesterol Test		

MEDICAL HISTORY

	Abdominal Pain - Chronic		Epilepsy		Osteoporosis
	ADD/ADHD		Eyesight Failing		Phobias
	Adenoids Removed		Fen-Fen Use		Pneumonia
	AIDS/HIV Positive		Fever Blisters		Polio
	Alcoholism		Fibromyalgia		Prostate Disease
	Allergies/Hayfever		Foot Pain/Cold Numb Feet		Psoriasis/Eczema
	Anaphylaxis		Gall Bladder Problems		Psychiatric Care
	Anemia		Glaucoma		Radiation Treatment
	Angina Pectoris		Gout		Rapid Weight Gain/loss
	Anxiety		Headaches - Frequent		Rheumatic Fever
	Appetite Loss/Weight Loss		Heart Attack		Rheumatic Heart Disease
	Arthritis/Rheumatism		Heart Disease		Rubella
	Artificial Heart Valves		Heart Murmur/Chest Pain		Scarlet Fever
	Artificial Joint (Hip/Knee)		Heart Pacemaker		Sexual/Menstrual Dysfunction
	Asthma/Wheezing		Heart Surgery		Shingles
	Back Problems - Recurrent		Hemophilia		Shortness Of Breath
	Bipolar Disorder		Hemorrhoids		Sinus Trouble
	Blood Disease		Hernia		Skin Rash/Hives
	Blood Transfusion		Herpes		Sleep Apnea
	Bronchitis/Cronic Cough		High Blood Pressure		Smoking
	Bruises Easily		High Cholesterol		Snoring
	Cancer		Indigestion/Heartburn		Stools - Bloody or Tarry
	Cerebral Palsy		Infection		Stroke
	Chemotherapy		Irritable Bowel Syndrome		Surgical Implant
	Chicken Pox		Jaundice/Hepatitis		Swallowing Difficulty
	Chronic Ear Problems		Jaw Pain		Swelling Of Feet/Ankles
	Chronic Fatigue Syndrome		Kidney Stones/Disease		Systemic Lupus Eryth
	Chronic Sinus Problems		Latex Allergy		Tetanus
	Circulatory Problems		Leg Pain		Throat Soreness - Frequent
	Cochlear Implant		Liver Disease		Thyroid Disease
	Congenital Heart Defect		Low Blood Pressure		Tobacco Use
	Convulsions/Seizures		Measles		Tonsilitis
	Cortisone Treatments		Memory Loss		Tonsils Removed
	Cosmetic Surgery		Mental Illness		Tremor
	Cough Up Blood		Mitral Valve Prolapse		Tuberculosis
	Crohn's Disease		Moodiness - Excessive		Ulcerative Colitis
	Diabetes		Multiple Sclerosis		Ulcers - Peptic
	Diarrhea/Constipation		Mumps		Urethral Discharge
	Diphtheria		Muscle Weakness		Urination - Overnight More than 2x
	Diverticulosis/Chron's/Colitis		Nausea/Vomiting - Persistent		Urine - Blood Present
	Dizziness/Fainting		Nervousness/Depression		Varicose Veins/Phlebitis
	Drug Addiction		Nose Bleeds		Venereal Disease
	Emphysema/COPD		Numbness/Tingling Sensation		

FAMILY HISTORY

	Father	Mother	Child	Sibling	Father's Parents	Mother's Parents
Alcoholism						
Asthma						
Bleeding Disorder						
Cancer						
Diabetes						
Glaucoma						
Epilepsy						
Convulsions						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Mental Illness						
Migraine						
Osteoporosis						
Stroke						
Thyroid Disease						
Other						

OTHER HABITS

Alcohol: Type	
Amount	
Diet: Salt Intake	
Fat Intake	
Smoke: Packs Daily	
How Long	
Interested In Stopping	
Exercise Routine	
Other	
Sleep: Difficulty Falling Asleep	
Continuity Disturbances	
Early Morning Awakening	
Daytime Drowsiness	
Other	
Coffee: Cup Daily	
Other Caffeine	

FEMALES- PLEASE COMPLETE

Pregnant	
Planning Pregnancy	
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	
Live Births	
Miscarriages	
Abortions	
Birth Control Method	
Birth Control Pill Name	
Flushing/Menopause	
Date of Last PAP Test	
Normal/Abnormal	
Date of Last Mammogram	
Normal/ Abnormal	