Health First

Aging SERVICES

NEW PATIENT FORM

In order to provide you with the very best care, please fill in as much information as possible. You can return the forms to us in person or via mail, email or fax. As soon as we have all of your completed paperwork, we will call to schedule your consult.

Phone: 321.434.7611

Fax: 321.727.3738

Address: 3661 S. Babcock St., Melbourne, FL 32901
We are located on the east side of Babcock St. between Florida Ave. and Pirate Ln./Eber Rd.

Please Bring a Family Member or Caregiver Along for Your Visit!

For your initial appointment, you should bring:

- All of your medications, including supplements
- Your insurance card(s) and picture ID
- Your co-pay depending on your insurance
- Legal documents (for example, a Living Will, Power of Attorney)
- A sweater or jacket (it can get chilly in the office)
- A snack – sometimes the initial visit can be a little longer than most
- Eyeglasses, hearing aids, cane or walker (wheelchairs are available if needed)

Health First Aging Services is a specialty office with a team of multi-disciplinary associates. These resources allow our team to provide quality care and support. Because of this, you may see two separate statements/bills for your visits. Physician fees will be billed by Health First Medical Group; charges from Holmes Regional Medical Center.

It is important that you also have a primary care physician for your general healthcare needs.

If you need to reschedule or cancel your appointment, please contact our office at least 48 hours in advance at 321.434.7611.

We look forward to meeting you.

PATIENT REGISTRATION

Patient Information:

Last Name_____First Name_____M.I._____Title _____

Street Address_____City_____State_____ZIP Code_____

Home Phone_____Mobile Phone_____Work Phone _____

EMERGENCY PHONE **EMERGENCY CONTACT'S NAME (FIRST, MIDDLE, LAST)** **EMERGENCY CONTACT'S RELATIONSHIP**

Patient's Email_____ Patient's Date of Birth _____

Sex: ☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ W ☐ D Social Security # _____

Primary Language_____ Employer _____

Responsible Information: *(If different from above)*

Last Name_____First Name_____M.I._____Date of Birth _____

Sex: ☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ W ☐ D Social Security # _____

Mailing Address_____City_____State_____ZIP Code _____

Secondary Billing Address *(if applicable)* _____

City_____State_____ ZIP Code_____

Home Phone_____Mobile Phone_____

Relationship to Patient _____

Primary Insurance:

Name of Insurance Company_____

Policy Number _____

Name of Insured_____ Group Number _____

Mailing Address of Insurance Company_____ Copay Amount $ _____

City_____State_____ ZIP Code_____

Secondary Insurance: *(if applicable)*

Name of Insurance Company_____Policy Number _____

Name of Insured_____ Group Number _____

Mailing Address of Insurance Company_____ Copay Amount $ _____

City_____State_____ Zip_____

Referral Information:

Referring Physician Name_____City_____State _____

How did you hear about us *(if not referred by another physician)*?

☐ Yellow Pages ☐ Media Advertisement ☐ Internet ☐ Insurance Referral ☐ Personal Referral

Other _____

Patient/Responsible Party *(print name)* _____

Signature of Patient/Responsible Party_____ Date _____

PATIENT REGISTRATION *(Page 2)*

Primary Care Physician_____

Local Pharmacy_____Address/Location _____

Pharmacy Phone _____

Secondary Pharmacy_____Address/Location _____

Pharmacy Phone_____ OK to send records? ☐ No ☐ Yes

Additional Physicians *(Example, Neurologist)* _____ _____

_____ _____ _____

Place of Birth_____Education Level _____

Military Experience: ☐ No ☐ Yes Branch_____Years Served_____

Religious Affiliation: ☐ No ☐ Yes Please list _____

Previous Occupation_____

Do you drive: ☐ No ☐ Yes How many miles per week_____Do you drive alone? ☐ No ☐ Yes

Seatbelt Use *(please check appropriate amount)*: ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ NEVER

Do you live alone? ☐ Yes ☐ No Who do you live with?_____

If you participate in any the following, please check:

☐ Adult Day Care ☐ Assisted Living Programs Private ☐ Caregiver Home ☐ Health Agency Hospice

Reason for today's visit _____

_____

Do you wear glasses? ☐ No ☐ Yes Last eye exam_____

Do you wear dentures? ☐ No ☐ Yes Last dental exam: _____

Do you wear hearing aids? ☐ No ☐ Yes Last Hearing exam: _____

Do you smoke tobacco products? ☐ No ☐ Yes Packs per day: _____ Quit date: _____

Do you chew tobacco products? ☐ No ☐ Yes Amount: _____ Quit date: _____

Does anyone in your home smoke? ☐ No ☐ Yes

Do you drink alcoholic beverages? ☐ No ☐ Yes How many per day?_____ What kind of alcohol? _____

Do you consume caffeinated beverages? ☐ No ☐ Yes How many per day?_____

Do you use drugs? ☐ No ☐ Yes_____ Do you participate in behavior considered to be at high risk for HIV? ☐ No ☐ Yes

Please explain _____

_____

Do you regularly exercise? ☐ No ☐ Yes How many times per week?_____

What is your sun exposure? *(please select one)* ☐ Frequent ☐ Occasional ☐ Rare

Advanced Directives *(Please circle all that you have in place)*:

☐ Living Will ☐ DNR *(Do Not Resuscitate order)* ☐ Power of Attorney ☐ Health Care Surrogate

PLEASE BRING ALL LEGAL DOCUMENTS WITH YOU TO YOUR APPOINTMENT
WE WILL MAKE COPIES FOR OUR RECORDS

PATIENT REGISTRATION *(Page 3)*

Medical History *(Please circle or check all that apply)*

General Symptoms

- ☐ Weight Loss - Pounds lost_____
- ☐ Weight Gain - Pounds gained_____
- ☐ Functional Decline
- ☐ Sleep Problems/Insomnia
- ☐ Fatigue

Ear/Nose/Throat/Mouth

- ☐ Trouble Hearing
- ☐ Hoarseness
- ☐ Problems Chewing
- ☐ Allergies

Eyes

- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Dry Eyes
- ☐ Legally Blind: ☐ Right ☐ Left ☐ Both Eyes

Brain/Nervous System

- ☐ Memory loss
- ☐ Dementia
- ☐ Alzheimer's Disease
- ☐ Parkinson's Disease
- ☐ Stroke/TIA *(Transient Ischemic Attack)*
- ☐ Seizures
- ☐ Frequent Headaches
- ☐ Vertigo/Dizziness
- ☐ Passing Out/Fainting
- ☐ Tingling Legs or Feet
- ☐ Head Injury

Mood

- ☐ Depression
- ☐ Anxiety
- ☐ Agitation
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Delusions

Skin Issues

- ☐ Dryness
- ☐ Sores
- ☐ Bruises Easily

Respiratory

- ☐ Sleep Apnea
- ☐ Trouble Breathing at Night
- ☐ Persistent Cough
- ☐ Asthma
- ☐ COPD

Kidney/Urinary

- ☐ Frequent Urination
- ☐ Frequent Infections
- ☐ Urination at Night
- ☐ Prostate Disease
- ☐ Erectile Dysfunction

Heart

- ☐ Pacemaker
- ☐ Hypertension
- ☐ Congestive Heart Failure
- ☐ Low Blood Pressure
- ☐ Shortness of Breath
- ☐ Irregular Heartbeat
- ☐ Swelling/Edema
- ☐ AICD *(Automated Implantable Cardioverter Defibrillator)*

Digestion

- ☐ Heartburn
- ☐ Difficulty Swallowing
- ☐ Nausea
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Constipation
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Hernia

Bones and Joints

- ☐ Loss of Balance
- ☐ Unsteady Gait
- ☐ Recent Falls
- ☐ Rheumatoid Arthritis
- ☐ Walking Device: ☐ Cane ☐ Walker

PATIENT REGISTRATION *(Page 4)*

Vaccinations

Include dates if possible: ☐ Flu Shot_____ ☐ Pneumonia Vaccine_____

☐ Last Tetanus Shot_____ ☐ Last Shingles Vaccination_____

Hospitalizations/Surgeries

Please include dates if possible _____

_____

_____

Please check family history of significant health conditions:

Unknown/Adopted	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Alcoholism	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Alzheimer's Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Anxiety	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Autoimmune Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Breast Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Cardiovascular Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Colon Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
COPD	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Dementia	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Diabetes	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Endometrial Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Epilepsy/Seizures	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Heart Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Hypertension	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Hypothyroidism	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Kidney Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Memory Loss	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Osteoporosis	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Parkinson's Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
Stroke	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____
TIA	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Other_____

Please review the following Activities and place a check in the appropriate box:

ACTIVITY	INDEPENDENT	NEED ASSISTANCE	DEPENDENT
Bathing			
Dressing			
Eating			
Toileting			
Transferring			
Continence			
Transportation			
Meal/Food Preparation			
Shopping/Errands			
Housekeeping/Chores			
Money Management			
Medication Management			
Telephone			
Laundry			

PATIENT REGISTRATION *(Page 5)*

Medications

Please list any prescriptions you are taking, as well as any over-the-counter medications and vitamins.

PLEASE BRING ALL MEDICATIONS WITH YOU.

CURRENT MEDICATION	DOSAGE/STRENGTH	HOW MANY TIMES A DAY
Example: TYLENOL	*500mg*	*2 pills every 4 hours as needed*

Are you allergic to any medications? ☐ No ☐ Yes Please specify:

NAME OF DRUG	TYPE OF REACTION	DATE OF ONSET

PLEASE BRING ALL MEDICATIONS WITH YOU.

Form completed by_____

Relationship _____