Peter R. Bendetson, M.D.

Patient Social/Medical History

Name_____ Age_____ Female____ Male___ Weight _____ Height_____

Do you smoke _____ If yes, how much _____ How many years _____ When did you quit _____

Do you drink _____ How much _____ How many times in the last year did you have 5 or more drinks (men) or 4 or more drinks (women)_____

Allergies _____ Occupation _____

Medications_____

_____

List any surgeries and what year they occurred _____

_____

List any hospitalizations and what year they occurred _____

Do you have or have you ever been treated for:

_____Epilepsy	_____ Nerve Disorders	_____ High Blood Pressure
_____Depression	_____ Stomach Ulcer	_____ Heart Disease
_____Glaucoma	_____Rheumatic Fever	_____ Liver Disease
_____Stroke	_____Heart Attack	_____ Kidney Disease
_____Trauma	_____Phlebitis	_____ Arthritis
_____Diabetes	_____Hepatitis	_____ Cancer
_____Anemia	_____ Anxiety	_____ Psychiatric Disorders
_____Asthma	_____Lung disease	_____ Skin cancer
_____ High cholesterol	_____ Pacemaker	_____ HIV/AIDS

Any family history of any of the above? (If yes, list the relationship and problem)_____

_____

Are your parents still living? _____ If not what was the cause of death and age _____

13005 Southern Blvd. Suite 231, Loxahatchee, FL 33470 (561)328-9434 Fax: (561)469-2496

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Patient Registration Form

Last Name_____ First Name _____ Middle Initial____ Male Female

Address_____
City_____ State_____ Zip code _____

Date of Birth ____-____-_____ e-mail _____

Home phone _____ Cell Phone _____ Work Phone _____

Social Security Number _____ Employer _____

Primary Language _____ Ethnicity _____

Marital status _____ Living Will: Yes No

Emergency contact Name _____ Phone _____ Relation_____

Pharmacy name and number _____

What is your relationship to primary cardholder of your insurance: SELF SPOUSE CHILD OTHER _____ Primary cardholder name _____

Social Security number of primary cardholder:_____

Date of Birth of Primary Cardholder:_____

Who may we thank for referring you? _____

Primary Physicians Name _____ Number _____

Do we have permission to:

Leave a message on your answering machine at home? Yes No

Leave a message at your place of employment? Yes No

Discuss your medical condition with a member of your household? Yes No

If yes, whom: _____ Relationship _____

Signature:_____ Date: _____

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STATEMENT OF FINANCIAL RESPONSIBILITY

I _____ understand that services provided me by Dr. Bendetson are my responsibility to pay.
Insurance is a contract between my insurance company and me. Dr. Bendetson is only a third party to this arrangement. I understand that as a courtesy, Dr. Bendetson will file claims for me. If payment is denied, suspended, below community standards, or is not provided directly to us within 45 days of the date of treatment, I am responsible for immediate payment in full on my account. I understand that it is my responsibility to verify that my account is current. My account will be considered past due if it is not paid in full within 15 days of the closing date listed on the billing statement.
Patients who are covered under an HMO plan are only responsible for any applicable co-payment or non-covered services. You will be notified prior to any non-covered services being rendered. Patients who are not covered under insurance plans are responsible for payment in full at the time the services are rendered.
Payments may be made with any valid Visa, Mastercard, American Express, or debit card. We also accept local checks with a current driver license, money orders, cashiers' checks, or cash. A bank charge plus the amount of the check will be accessed for returned checks.
I understand the failure to comply with the above may result in my account being sent to a collection agency. I understand that I will assume all collection fees associated with the collection of my unpaid balance, in addition to my balance. I also understand that if these measures are necessary, they may damage my personal credit rating.
By signing below, I am attesting to my understanding of my financial responsibility to this office for services rendered.

X_____ _____
Signature of patient, parent or guardian Date

HIPPA
Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Pratices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____

We strive to schedule appointments in a timely manner to accommodate our patients. Unfortunately, this can be very difficult due to patients who do not show up for their appointments. We understand that there are events that are unforeseen and occasionally not keeping a scheduled appointment is unavoidable. However, habitually not showing up for your appointments creates a problem for our office and most importantly for patients who need an appointment.
After 4 missed appointments without calling to cancel or reschedule you will be dismissed as a patient.

_____ _____ _____
Print name Signature Date

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