DOCCS - Diagnostic & Clinical Care Services
2100 N. Wickham Rd., Melbourne FL 32935
Ph: (321) 259-6007 Fax: (321) 752-7105

TYPE OF VISIT: ☐ INSURANCE ☐ SELF-PAY DATE: ____________________

NEW PATIENT REGISTRATION FORM

PATIENT NAME		DOB	SS#
STREET ADDRESS		PHONE *(H)* *(C)*	
CITY		STATE	ZIP
SEX **(M) (F)**	MARITAL STATUS **(M) (S) (D) (W)**	EMAIL ADDRESS	EMPLOYER
EMPLOYER ADDRESS		EMPLOYER PH#	
EMPLOYER CITY		EMPLOYER STATE	EMPLOYER ZIP
(IF UNDER 18) GUARDIAN NAME		RELATIONSHIP	SS#
STREET ADDRESS		PHONE *(C)* *(W)*	
CITY		STATE	ZIP
DOB	SS#	EMAIL ADDRESS	

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER:	
MEMBER ID	GROUP ID
SECONDARY INSURANCE CARRIER:	
MEMBER ID	GROUP ID

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

HEALTH HISTORY & ADDITIONAL INFORMATION

HEALTH CARE PROVIDER	**PHONE**	**HEALTH CARE PROVIDER**	**PHONE**

HAVE YOU COMPLETED HEALTH CARE DIRECTIVES? ☐ YES ☐ NO If yes, please provide a copy as soon as possible.

IF YES, NAME/CONTACT FOR HEALTH CARE POWER OF ATTORNEY:
IF NO, WHO WOULD YOU PREFER AS A SURROGATE DECISION MAKE SHOULD YOU NEED ONE:

DO YOU HAVE ANY RELIGIOUS OR CULTURAL BELIEFS THAT MAY AFFECT YOUR HEALTH CARE?

DESCRIBE THE MEANS BY WHICH YOU PREFER TO LEARN NEW INFORMATION:
☐ VERBAL INSTRUCTION ☐ WRITTEN INSTRUCTION ☐ HANDOUTS ☐ VISUAL (PICTURES, VIDEOS, ETC.)

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (include OTC medications, herbs and vitamins):

Medication & Dose	**Frequency**	**Medication & Dose**	**Frequency**

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PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (continued from page 1):

Medication & Dose	Frequency	Medication & Dose	Frequency

HAVE YOU TRAVELED IN THE PAST 12 MONTHS? ☐ **YES** ☐ **NO** If yes, please list locations and time spent traveling.

Within the U.S.	Duration	Outside the U.S.	Duration

DO YOU EXERCISE? ☐ **YES** ☐ **NO** If yes, please describe activities, frequency and duration of each activity.

Activity & Duration	Time/Week	Activity & Duration	Times/Week

SUBSTANCE USE AND PERSONAL RISK HISTORY

Have you ever smoked tobacco as cigarettes, cigars, or pipe?	☐ **YES** ☐ **NO**	#Pack/Years:
Have you quit? If yes, when?	☐ **YES** ☐ **NO**	
Have you ever chewed tobacco?	☐ **YES** ☐ **NO**	#Pouches/Years:
Have you quit? If yes, when?	☐ **YES** ☐ **NO**	
Have you considered quitting?	☐ **YES** ☐ **NO**	
Have you tried quitting? If yes, for how long did you quit?	☐ **YES** ☐ **NO**	
Do you drink alcohol?	☐ **YES** ☐ **NO**	#Drinks________ ☐ Day ☐ Week

Have you ever lost consciousness as a result of drinking alcohol?	☐ **YES** ☐ **NO**
Have you ever had a "drink" to prevent tremors, sweats, or irritability?	☐ **YES** ☐ **NO**
Have you ever been ticketed or arrested for a DUI?	☐ **YES** ☐ **NO**
Have you been involved in a motor vehicle accident in the past 12 months?	☐ **YES** ☐ **NO**

Have you ever used drugs for recreational purposes? ☐ **YES** ☐ **NO** If yes, check all that apply below:
☐ Amphetamines ☐ Cocaine ☐ Heroin ☐ Inhalants ☐ LSD ☐ Marijuana ☐ PCP ☐ Other:

Method of drug delivery you use: ☐ Ingestion ☐ Injection ☐ Inhalation	Amount/Frequency
Have you ever been dependent on prescription drugs?	☐ **YES** ☐ **NO** If yes, which Rx:

Are you sexually active? ☐ **YES** ☐ **NO**

If yes, do you use contraception of any kind? Check all that apply:
☐ Condoms ☐ Diaphragm ☐ Intrauterine Device IUD ☐ Pills, Implants, Patches

How many sexual partners have you had in the past 12 months?	#:
Do you feel safe in your relationship?	☐ YES ☐ NO
Have you been in a relationship where you feel threatened, hurt or afraid?	☐ YES ☐ NO
Do you have a place to go and the resources to leave if you feel threatened?	☐ YES ☐ NO
Have you ever had sex with a person who is the same gender as yourself, bisexual, or anyone who performs sexual favors in exchange for money or drugs?	☐ YES ☐ NO

Have you ever been diagnosed with an STD? If yes, list STD(s) here:

Do you have any body piercings or tattoos?	☐ YES ☐ NO
Have you ever received transfusions of blood or blood products?	☐ YES ☐ NO

Describe your seatbelt use whether you are driving or a passenger in a vehicle:
☐ All the time ☐ Most of the time ☐ About half the time ☐ Rarely ☐ Never

Can you perform your own hygiene, dressing, cooking, and shopping needs?	☐ YES ☐ NO

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Prior Diagnostic Exam History Have you ever had the following exams? If so, list where and when.

Exam		Location & Month/Year	Results (Neg/Pos)
PAP Smear	☐ YES ☐ NO		
Prostate Biopsy	☐ YES ☐ NO		
Mammogram	☐ YES ☐ NO		
Colonoscopy	☐ YES ☐ NO		
EGD (Esophageal endoscopy)	☐ YES ☐ NO		
EKG	☐ YES ☐ NO		
Cardiac Stress Test	☐ YES ☐ NO		
ECHO (Echocardiogram)	☐ YES ☐ NO		
Chest X-ray	☐ YES ☐ NO		
CT "Cat" Scan of Chest	☐ YES ☐ NO		
Pulmonary Function Test	☐ YES ☐ NO		
EEG (Electroencephalography)	☐ YES ☐ NO		
Bone Density Test	☐ YES ☐ NO		

Vaccinations Have you ever had the following vaccines? Check all that apply and state date last received.

Vaccine		Date Received
Influenze	☐ YES ☐ NO	
Pneumonia	☐ YES ☐ NO	
Tetanus	☐ YES ☐ NO	
BCG	☐ YES ☐ NO	
Varicella	☐ YES ☐ NO	
Human Papilloma Virus (HPV)	☐ YES ☐ NO	

Gynecologic History This section to be completed by females. Males skip to the next section.

Have you ever been pregnant? ☐ YES ☐ NO	Are you planning on becoming pregnant? ☐ YES ☐ NO
How old were you when you started menstruating?	Date of last period:
How old were you when you started menopause?	Date of last breast exam:

Have you ever used birth control pills, patches or implants?	☐ YES ☐ NO If yes, when?
Have you ever taken hormone replacement therapy?	☐ YES ☐ NO If yes, when?
Have you ever had an Intrauterine Device (IUD)?	☐ YES ☐ NO If yes, when?
If yes, was your IUD removed?	☐ YES ☐ NO If yes, when?
Have you ever had a tubal ligation?	☐ YES ☐ NO If yes, when?
Have you had your ovaries surgically removed?	☐ YES ☐ NO If yes, when?

Surgical History Please list all surgical procedures you have had. Include physician's name and the date of the procedure.

Surgical Procedure	Physician	Date

Family Medical History Please list all known medical problems in your family.
(Specify M=Mother, F=Father, B=Brother, S=Sister, So=Son, D=Daughter, GM=Grandmother, GF=Grandfather)

Medical problem	Relative	Medical Problem	Relative

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REASON FOR TODAY'S VISIT:		
SYMPTOMS (Check all that apply):		
General:	☐ FEVER	☐ CHILLS
Eyes:	☐ EYE PAIN	☐ LOSS OF VISION
ENT:	☐ EAR PAIN	☐ SORE THROAT
Lung:	☐ COUGH	☐ BREATHING DIFFICULTY
Cardiac:	☐ CHEST PAIN/PRESSURE	☐ IRREGULAR HEART BEAT
Abdomen:	☐ STOMACH PAIN	☐ VOMITING
Urinary:	☐ PAINFUL URINATION	☐ FREQUENT URINATION
Musc/Skel:	☐ JOINT SWELLING	☐ MUSCLE/JOINT PAIN
Endocrine:	☐ EXCESSIVE THIRST	☐ WEIGHT CHANGE
Heme:	☐ ABNORMAL BLEEDING	☐ EASY BRUSING
Skin:	☐ RASH	☐ ITCHING
Neuro:	☐ HEADACHE	☐ ARM/LEG WEAKNEDD
Psych:	☐ DEPRESSION	☐ ANXIETY
☐ OTHER:		

Health Care Provider Notes

Referral Information – We would appreciate learning how you heard about us? Check one, please.

☐ Another physician, nurse practitioner, or physician assistant. If yes, who?
☐ Family member or friend who is not a patient of this clinic.
☐ Family member or friend who is a patient of this clinic.
☐ Sign outside of our office.
☐ TV Ad ☐ Radio Ad ☐ Magazine or Newspaper Ad
☐ Phone Book
☐ Internet
☐ Other, please specify:

I (print your name) ______________________ consent to and authorize to treatment by DOCCS Urgent Care. The provider has explained all information to me in language that I understand including the nature of the diagnosis/treatment and/or procedures as well as the expected outcome, benefits, effects, or risks. I understand that no guarantees have been made to me concerning the results of treatment or other procedures. I authorize the physician/provider to proceed as he/she considers advisable and in my best interest.

I have read the above information and I completely understand it. Any questions that may have occurred have been answered to my satisfaction.

✗ ____________________________________ ____________________________________
Patient Signature/Date Provider Signature/Date

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AUTHORIZATION AND ASSIGNMENT OF BENEFITS FOR COMMERCIAL INSURANCE SERVICES

I authorize release of any information necessary to secure the payment of insurance benefits for services I receive to diagnostic and Clinical Care Services, all insurance benefits payable for the medical services rendered by physicians or staff. I authorize the use of this signature on all insurance submissions.

✗____________________________________ ___________________

SIGNATURE *DATE*

AUTHORIZATION AND ASSIGNMENT OF BENEFITS FOR MEDICARE SERVICES

I request that payment of authorized Medicare benefits be made to Diagnostic and Clinical Care Services for any services furnished to me by physicians and staff. I authorize any holder of medical information about me to release to the Healthy Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for needed services. My signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If I have insurance that is a supplement to Medicare, my signature authorizes release of information to such insurer or agent for the purpose of paying Diagnostic and Clinical Care Services any benefits payable by such insurance.

✗____________________________________ ___________________

SIGNATURE *DATE*