Colleen Campbell, M.D.

5503 East Busch Blvd	3105 North 22nd Street
Temple Terrace, FL 33617	Tampa, FL 33605
(813) 200-7717 Phone	(813) 200-7717 Phone
(813) 985-8500 Fax	(813) 985-8500 Fax

PATIENT REGISTRATION FORM

General:

Name: First_____________________________Middle ______________________Last______________________

SSN:_________________________D.O.B.______________Gender________AKA_________________________

Permanent Home Address & Phone:

Street____Zip:__________________

Ph (H):_______________________________(W):___________________________(Cell)____________________

Specify Your Preferred Phone #:_________________ Email:____

Mailing Address (If same as above, put "Same"):

____Zip:__________________

Race:_________________________Sex: (Male/Female) Marital Status:______________________________

Highest Education Level Achieved:___________________Place Of Employment:___________________________

Driver's License # & State Issued:____

Pharmacy Name:________________________Pharmacy Address:____

Pharmacy Ph #:_________________________Fax #:__________________Who Referred You:_________________

Emergency Contact:

Contact Name:____Relationship:___________________

Address of Contact:____

Phone: (H)________________________(W)____________________(Cell)___________________________

Do you have Medical Insurance? ______________If No, then stop here.*************

Health Insurance Information:

Primary Person Insured:____________________________________Relationship to Patient:__________________

Address & Ph # of Insured:____

SS # of Insured:______________________DOB______________Place of Employment:_______________________

Name of Insurance:____

Claims Address:____

Policy ID#: ___________________________Group Name:____________________Group #:_________________

If Medicare is Your Primary:

Write your Medicare # (Include the letters):____

If you are employed, State Where:_________________________________Ph#:_____________________________

Primary Insurance is:____

Secondary Insurance:____

Tertiary Insurance:____

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PERMISSION FOR TREATMENT

I hereby give Dr. Campbell, and all associated healthcare personnel, permission to provide medical treatment as necessary.

STATEMENT OF FINANCIAL RESPONSIBILITY

Dr. Campbell may bill my insurance company and/Medicare for services provided to me; and as such, Dr. Campbell may release my personal health information for processing of such claims. Therefore, I will provide complete, correct and current insurance information at every office visit or when any changes occur.

It is my responsibility to be familiar with all the services covered by my insurance plan and I will pay to Dr. Campbell the fees and costs, including deductibles and co-payments, not covered by the plan.

I understand that Dr. Campbell will make every effort to bill and recover payment on my behalf; however, the ultimate responsibility for payment of rendered services is mine. Any unpaid balance is due within thirty (30) days of receiving statement.

I HAVE RECEIVED THE PATIENT RIGHTS AND RESPONSIBILITIES FORM (see form)

NOTICE OF PRIVACY PRACTICES

Representatives of Dr. Campbell have provided me with its Notice of Privacy Practices which describes how she utilizes and discloses "Protected Health Information". I understand that I may review this document before signing this form. The terms of The Notice of Privacy Practices may be changed at any time but patient may obtain a copy of the revised notice from the office manager upon request.

I give my consent to release my Protected Health Information to the following individual(s):

(1) ____

(2) ____

Print Patient's Name: ______________________________ D.O.B: __________

Patient's or Guardian's Signature: ____

Relationship to Patient: ____

Date: _____________________________

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Patient Rights and Responsibilities

Dr. Campbell is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

1. A personal clinician who will see you on an on-going, regular basis.
2. Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
3. A second medical opinion from the clinician of your choice, at your expense.
4. A complete, easily understandable explanation of your condition, treatment and chances for recovery.
5. The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
6. Confidential management of communication and records pertaining to your medical care.
7. Information about the medical consequences of exercising your right to refuse treatment.
8. The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
9. Be free from mental, physical and sexual abuse.
10. Humane treatment in the least restrictive manner appropriate for treatment needs.
11. An individualized treatment plan.
12. An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
13. The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
14. The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for :

1. Knowing your health care clinician's name and title.
2. Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
3. Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
4. Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
5. Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.

Name: ______________________________ Date: _______________

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Patient Rights and Responsibilities Cont.

6. Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
7. Telling your clinician about any changes in your condition or reactions to medications or treatment.

8. Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.

9. Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.

10. Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
11. Paying co-payments at the time of the visit or other bills upon receipt.
12. Following the office's rules about patient conduct; for example, there is no smoking in our office.
13. Respecting the rights and property of our staff and other persons in the office.

PLEASE SIGN THAT YOU HAVE READ & UNDERSTAND THE ABOVE:

NAME: ___________________________ D.O.B: __________

SIGNATURE: ______________________

DATE: ________

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NEW PATIENT QUESTIONNAIRE

DATE: ___________

NAME: ____ **D.O.B.**____________**AGE**____

Sex: M F Marital Status: Single Married Divorced Widowed Other
Occupation:______________________ Disabled: No, Yes---Explain______________________

Please complete the attached medication form as completely as possible. Also, list all your medication allergy and the type of reactions on that form

State the approximate date of the following **screening tests**:
1. Eye exam____________ 2. EKG____________ 3. Mammogram______________________

4. Bone density__________5. Colonoscopy______ 6. Pelvic exam/Pap-smear_______________

7. Prostate exam_________ 8. Foot Exam________ 9. Blood Work_______________________

State the approximate date of the following **vaccinations/immunizations:**
1. Flu __________________2. Pneumonia________3. Tetanus__________________________

4. Shingles______________5. Hepatitis B________6. Others___________________________

Blood Transfusion: No, Yes
Give Details____

Family Member	Age	Medical History	Age at time of Death, if applicable	Cause of Death, if applicable	Comments
Father					
Mother					
Brothers or Sisters					

List all **Surgeries & Hospitalizations** (include approximate dates)**:**
____
____
____

Females Only: Are you currently pregnant, planning a pregnancy, or nursing a child? **[Yes]/[No]**
Date of Last regular menstrual period____

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Patient Medication Sheet

Name: ______________________ D.O.B: __________ Date: ___________

Please list all your medication allergies (use additional paper if necessary):

Name of Medication to which you are Allergic	Type of Reaction (rash, swelling etc.)

List all Medications you are **presently** using (use additional paper if necessary):

Name of *Medication* as spelled on prescription bottle	**Dose in mg**	**Instructions**/How often do you take it	Check if you need **Refills**

Past Medical History – Do you have or have had any of these illnesses?

- ☐ 1 Glaucoma or Cataracts
- ☐ 2 Macular degeneration
- ☐ 3 Frequent ear Infection
- ☐ 4 Hay fever? Sinus allergies
- ☐ 5 Chronic sinusitis
- ☐ 6 Asthma or Emphysema (COPD)
- ☐ 7 Chronic bronchitis
- ☐ 8 Pneumonia
- ☐ 9 Heart Murmur
- ☐ 10 High Blood Pressure
- ☐ 11 Heart attack or heart disease
- ☐ 12 Irregular heartbeat / Pacemaker
- ☐ 13 High cholesterol
- ☐ 14 Acid Reflux or GERD
- ☐ 15 Hepatitis
- ☐ 16 Peptic or Stomach Ulcers
- ☐ 17 Irritable Bowel Syndrome (IBS)
- ☐ 18 Diverticulosis or Diverticulitis
- ☐ 19 Hemorrhoids
- ☐ 20 Gall Bladder Disease
- ☐ 21 Colitis
- ☐ 22 Frequent Urine infections
- ☐ 23 Kidney Stone
- ☐ 24 Enlarged Prostate
- ☐ 25 Chronic Kidney Disease
- ☐ 26 Sexually Transmitted Disease
- ☐ 27 Diabetes or Pre-Disease
- ☐ 28 Thyroid disease
- ☐ 29 Varicose Veins/Phlebitis
- ☐ 30 Tuberculosis
- ☐ 31 Stroke
- ☐ 32 Epilepsy
- ☐ 33 Migraine headaches
- ☐ 34 Anemia
- ☐ 35 Gout
- ☐ 36 Rheumatoid Arthritis
- ☐ 37 Osteoarthritis
- ☐ 38 Lupus
- ☐ 39 Psonasis or Eczema
- ☐ 40 Anxiety or Depression
- ☐ 41 Schizophrenia
- ☐ 42 Bipolar disorder
- ☐ 43 German Measles/Rubella
- ☐ 44 Chicken Pox
- ☐ 45 Measles
- ☐ 46 Scarlet Fever
- ☐ 47 Mumps
- ☐ 48 Polio
- ☐ 49 Rheumatic fever
- ☐ 50 Cancer
  Which ____________
- ☐ 51 Other __________

Review of Symptoms –Do you HAVE or RECENTLY has any of these symptoms?

- ☐ 1 Unusual fatigue or weakness
- ☐ 2 Fever or chills
- ☐ 3 Recent weight loss or gain
- ☐ 4 decreased hearing
- ☐ 5 Ringing in ear
- ☐ 6 Dizzy Spells
- ☐ 7 Earache
- ☐ 8 Failing Vision
- ☐ 9 Double or Blurred Vision
- ☐ 10 Eye pain
- ☐ 11 Eye Infection
- ☐ 12 Nose Bleeds
- ☐ 13 Sinus congestion or pain
- ☐ 14 Sore Throat
- ☐ 15 Hoarseness
- ☐ 16 Wheezing
- ☐ 17 Shortness of breath
- ☐ 18 Chronic cough
- ☐ 19 Chest Pain or tightness
- ☐ 20 Palpitations or tachycardia
- ☐ 21 Swelling of feet or legs
- ☐ 22 Fainting spells
- ☐ 23 leg pain when walking
- ☐ 24 Loss of appetite
- ☐ 25 Difficulty swallowing
- ☐ 26 Indigestion / Heartburn
- ☐ 27 Persistent nausea / Vomiting
- ☐ 28 Abdominal pain
- ☐ 29 Change in bowel habits
- ☐ 30 Diarrhea or Constipation
- ☐ 31 Bloody or Tarry Stools
- ☐ 32 Jaundice (Yellowing of skin)
- ☐ 33 Hernia
- ☐ 34 Painful urination
- ☐ 35 Blood in urine
- ☐ 36 Overnight urination – more than 2
- ☐ 37 Incontinence or dribbling of urine
- ☐ 38 Decrease in force or urination
- ☐ 39 Urethral Discharge
- ☐ 40 Bruise or bleed easily
- ☐ 41 Convulsions/Seizures
- ☐ 42 Tremor/hands shaking
- ☐ 43 Numbness/Tingling Sensation
- ☐ 44 Frequent headaches
- ☐ 45 Memory loss
- ☐ 46 Muscle weakness
- ☐ 47 Back Pain - Recurrent
- ☐ 48 Bone Fracture/Joint Injury
- ☐ 49 Joint Pain
  Which ___________
- ☐ 50 Cold hands or feet
- ☐ 51 Rashes or itching
- ☐ 52 Hives
- ☐ 53 Moodiness - Excessive
- ☐ 54 Nervousness
- ☐ 55 Depression
- ☐ 56 Phobias
- ☐ 57 Other_________________

Do you wear or use? ☐ Eyeglasses or contact lenses ☐ Dentures ☐ Hearing aides

Do you wear seat belts? Yes No

Do you drink alcohol? Yes No
Type _________ How many __________ How often ____________

Do you drink beverages with caffeine Yes No

Do you use drugs? (Marijuana, Cocaine, Crack Etc...) Yes No

Do you smoke cigarettes? Yes No Quit Packs per day________ How long ______

Name____ **D.O.B**________________ **Date**___________________

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Authorization to Release Medical Information

I, **(patient name)**____,D.O.B.______________,authorize

Name & Address of Organization:____

Ph:_____________________________________Fax:______________________________________

To **Release to** (Name & Contact Information) : **DR. CAMPBELL**

Dates of Service: From:______________________To:____________________________________

Information to be released: (check which one): ______Complete Record

______Medication List

______Diagnostic Studies

______Labs

______(ECG)

______Consultation/Progress Notes

______Other (please specify)____________________

Purpose of Release (circle one) : Continued Treatment, Personal, Payment of Insurance Claim, Legal

Other & Explain____

This authorization will expire either on the following date, event, condition:_________________________

or one year from signed consent.

I understand that a reasonable fee may be charged for duplication of records and the estimated costs may be obtained upon request prior to duplication.

Signature of Patient ____Ph#:_________________

or Legally Authorized Representative_______________________________Ph#:__________________

Date:_________________________

Circle any Special Authorization you want released : Alcohol, Drug Abuse, Mental Health, Genetic testing, STD, HIV/AIDS

Note that a general authorization for release of medical records does not include those for alcohol, drug abuse, mental health, genetic testing, sexual transmitted disease, HIV/AIDS. This information is protected by federal confidentiality rules (42 CFR part 2). By signing this portion of the written consent, you are authorizing Dr. Campbell to obtain, or share, this information. Federal rules restrict use of this disclosure to criminally investigate or prosecute any patient with history of alcohol or drug abuse.

Patient Signature for Special Authorization: ___________________________________***Date:***_______