John Michael Thomassen, MD, PA

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Patient's First Name:	Middle:	Last:		Single / Mar / Div / Sep / Wid	
Local Address:		Birth date: / /	Age:	Sex: ❑ M ❑ F	
		Home phone no.: ( )	Cell Phone no: ( )		
City:	State:	Zip Code:	Email Address:		
Out of State Address:					
Name of Spouse /Partner:			Contact Phone: ( )		
Occupation:	Employer:		Employer phone no.: ( )		
Chose clinic because/Referred to clinic by (please check boxes applic):	❑ Dr.	❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Internet web page or Search Engine	
Please describe referral source detail:					
Reason for Consultation with Dr. Thomassen: (please provide detailed response)					

CONTACT PERSON IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

HEALTH INFORMATION PRIVACY PROTECTION	
I hereby acknowledge that I have been provided the opportunity to read the practice's NOTICE OF PRIVACY PRACTICES, which describes how my private health information may be used or disclosed. I understand that I have the right to request a copy of such, at any time.	
Patient/Guardian signature	*Date*

STATEMENT OF LIABILITY INSURANCE COVERAGE	
Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.	
Patient/Guardian signature	*Date*

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME *(Last, First, M.I.):*	

List Medical Problems:

Surgeries:

Mo/Year	Reason	Hospital

Have you or a family member ever had an adverse reaction to anesthesia:	☐	Yes	☐	No

If yes, please describe:

Medications (include herbal remedies):

Name the Drug	Strength	Frequency Taken

Allergies:

Name the Drug	Reaction You Had

Health Habits:

Exercise	☐ Sedentary (No exercise) ☐ Mild exercise ☐ Occasional vigorous exercise ☐ Regular vigorous exercise				
Diet	Are you dieting? Describe:	☐	Yes	☐	No
Alcohol	Describe Consumption:			☐	None
Tobacco	Do you use tobacco?	☐	Yes	☐	No
	☐ Cigarettes – pks./day	☐ # of years		☐ Year quit	
Drugs	Do you currently use recreational or street drugs?	☐	Yes	☐	No
	Have you ever given yourself street drugs with a needle?	☐	Yes	☐	No

Family History:						
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS
FATHER			**CHILDREN**	☐ M ☐ F		
MOTHER				☐ M ☐ F		
SIBLINGS	☐ M ☐ F			☐ M ☐ F		
	☐ M ☐ F			☐ M ☐ F		

Women's Health:				
Number of pregnancies _____ Number of live births _____				
Are you pregnant or breastfeeding?	☐	Yes	☐	No
Date of last mammogram screening mammogram?				

REVIEW OF SYSTEMS						
Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain on the rightmost column.						
General Health (Please Complete Height and Weight)						*Explanation*
☐	Current Weight:	☐	Current Height:	☐	Adverse Anesthesia Reaction	
☐	Recent Changes in Weight	☐	Hx of Cancer			
Dermatologic ☐ None						
☐	Rashes	☐	Changing lesions	☐	Hx of Skin Cancer	
☐	Pigmented lesions	☐	Keloid formation	☐	Hx of Melanoma	
Breast ☐ None						
☐	Masses or Lumps	☐	Nipple discharge	☐	Tenderness	
Head and Neck ☐ None						
☐	Headaches	☐	Vertigo	☐	Vision deficits	
☐	Glaucoma	☐	Tearing	☐	Dry Eyes	
☐	Nosebleeds	☐	Nasal trauma	☐	Nasal obstruction/discharge	
☐	Colds/Congestion	☐	Dental Pain	☐	Denture use	
☐	Neck Stiffness/Pain	☐	Neck masses	☐	Other pain/discomfort:	
Cardiovascular ☐ None						
☐	Chest pain	☐	Fast or irregular heart rate	☐	Heart Murmur	
☐	Leg swelling	☐	Difficulty breathing on exertion	☐	Heart Disease	
Pulmonary ☐ None						
☐	Shortness of breath	☐	Asthma	☐	Lung disease	
☐	Lung disease	☐	Wheezing			
Gastrointestinal ☐ None						
☐	Poor Appetite	☐	Peptic ulcer disease/Heartburn	☐	Nausea/Vomiting	
☐	Constipation	☐	Abdominal Pain	☐	Liver disease	
☐	Diarrhea	☐	Irritable bowel syndrome			

Genitourinary ☐ None					
☐	Pain with urination	☐	Urinary tract infections	☐	Kidney disease
Musculoskeletal ☐ None					
☐	Fibromyalgia	☐	Arthritis	☐	Back Pain
Neurological /Psych ☐ None					
☐	Seizures	☐	Stroke	☐	Head trauma
☐	Depression	☐	Anxiety	☐	
Endocrine/Hematologic ☐ None					
☐	Lymph nodes palpable	☐	Bleeding tendency	☐	Steroid use
☐	Diabetes	☐	Blood clots/DVT	☐	Anemia
☐	Immune disorders	☐	Thyroid disease		
Infectious ☐ None					
☐	Herpes simplex/fever blisters	☐	HIV	☐	Hepatitis

STATEMENT OF FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED.

I accept financial responsibility for charges incurred on my behalf including costs of collection (if applicable). In the event that insurance is filed for surgery or other services rendered to me, I hereby authorize John Michael Thomassen, MD, PA to release information to my insurance company and assign benefits directly to John Michael Thomassen, MD, PA. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the Doctor, not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance. A photocopy of this assignment is to be considered as valid as an original.

Patient/Guardian signature	*Date*

FOR MEDICARE PATIENTS ONLY

Medicare will only pay for services that it determines are reasonable and necessary" under Section 1862 (a) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary, Medicare will deny payment for that service. If Medicare denies payment, I agree to be personally and fully responsible for payment. I understand that there is a $100 Medicare deductible every year.

Patient/Guardian signature	*Date*

AUTHORIZATION AND CONSENT TO PHOTOGRAPH AND PUBLISH

I authorize John Michael Thomassen, MD, to obtain pre-operative, operative and post-operative photographs as deemed necessary for the complete documentation and illustration of the case involved. I understand that these photographs may appear in marketing materials including brochures or internet publications. These photographs may also appear in medical publications or conferences in the interest of medical education, knowledge or research. Although permission is given for the publication of details and pertinent photographs concerning my case, I understand that I will not be identified by name. I further understand that no form of compensation shall become payable to me for the use of these photographs. I hereby release John Michael Thomassen, MD and its agents from any and all claims and demands arising out of or in conjunction with the use of these photographs.

Patient/Guardian signature	*Date*

All the information filled in these forms is accurate to the best of my knowledge	
Patient Signature (Parent or Guardian if applicable):	*Date*