300 S Central Ave
Apopka, FL 32703
407-900-2747
321-559-2842

Registration Form

We look forward to your first visit in our office! Please find a quiet moment to complete this form.

Date: ______/______/______ **Date of Birth** ______/______/______ **SS#** ____________________

First Name ______________ **Middle** ____________________ **Last** ______________________

Email ____

Where can we leave a confidential message? (Circle one) Mobile _____ Home _____ Work _____

Phone (Mobile) ____________________ (Home) __________________ (Work) ________________

Work/School Name ____

Home Address _________________________ **Work/School Address** _______________________

_________________________________ _________________________________

Emergency Contact _____________________ Relationship ______________________________

Phone (Mobile) ________________ (Home) _________________ (Work) ____________________

Primary Insurance	Secondary Insurance
Name: ______________________	Name: ______________________
Policy Holder: ______________________	Policy Holder: ______________________
Relationship to Insured: ______________________	Relationship to Insured: ______________________
Birth Date of Insured: ______________________	Birth Date of Insured: ______________________
Policy # ___________ Group # ___________	Policy # ___________ Group # ___________

Ethnicity: __Latino __Asian/Pacific Islander __Black __White Other________ Preferred language________

Marital Status __Married __Domestic Partner Name: _______________ __Single __Divorced __Widowed

Children's Names & Location ________/________ ________/________ ________/________

________/________ ________/________ ________/________ ________/________

Do you have an **Advanced Directives:** Y / N If yes, what do you have? ______________________________

I hereby authorize payment of medical benefits billed to my insurance to MASRI MEDICAL, PA. I hereby accept responsibility for payment for any services(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the practice does not participate with my insurance.

I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

I will pay by (check one): ☐ Cash ☐ Check ☐ Credit Card X______________________ ____/____/____

Do you have any Medication, Food or Environmental **ALLERGIES**? What reaction did you experience?

Allergy	Reaction	Allergy	Reaction

Preferred Pharmacy:______________________________ Phone: ______________________________

Please list the **physicians, psychiatrists, psychologists, counselors** who have treated you in the past.

Name	Telephone #	Profession/Specialty	Dates of treatment

What **medications and remedies** are you currently taking? This includes over-the-counter medications, homeopathic and herbal remedies, and nutritional supplements.

Name	Dose or quantity per day	When did you start it?

Please list any **hospitalizations or surgeries** you have had:

Reason for hospitalization or surgery	Date

Last Tetanus Shot: ____/____/____ **Flu Shot**: ____/____/____ **Pneumonia Shot**: ____/____/____

Tobacco: __ Current Smoker __ Former Smoker __ Chewing Tobacco User __ Never Smoked

Age began smoking:_______ Age Quit Smoking: _______ Average # packs per day: _________

Alcohol: __No alcohol use __Past alcohol use __Current alcohol use Average Drinks per week _____ ___Recovering Alcoholic

Other substances that you use: ____

Are you satisfied with your **sleep**? ___________YES ____NO What is bedtime ________pm wakeup time? ________am

Do you have difficulty **falling** or **staying** asleep? Disturbances: ____________________________________

What are the greatest sources of **stress** in your life? ____________________________________

What are the greatest sources of **comfort** in your life? ____________________________________

Who are the people, including members of your family, **who play a very important role in your life?**

Name	Relationship to you	Age	Where do they live?

If sexually active, do you consider yourself ________heterosexual, ______homosexual, ______bisexual, or _____transgender?

What form of **birth control** or **protection from sexually transmitted infections**? ______________________

What concerns do you have about your **sexual relationships**? ______________________________

If you belong to an **organized religion or spiritual group**, please describe: ______________________

Are you currently a **student**? ________Yes ______No If yes, where? ____

How many **years of education** have you completed? __________ HS Graduate, __________Years of college

Do you have any **difficulties with learning**? _____Yes _____No If yes, please describe: ______________________________

What is your **job or occupation?**________________________________ Are you satisfied with your work? ___Yes ___No

Please describe any challenges: ____

What is your **household income**? _______<30K ____30-50K ____50-70K ____70-100K ____100-200K ____>200K

Describe any **FINANCIAL concerns**? ____

Women's Health:

Age of first menstrual period _____/_____/______ Date of last menstrual period _________/_____/______

Date of last: PAP/Pelvic_______/_______/_______ Mammogram______/_______/______ Breast exam______/_______/_______

Have you ever had an abnormal PAP? ___Yes ____No Explain: ____

Number of pregnancies____ Live births ______ Miscarriages ______ Abortions ______ Twins ______