

HARMONY IN MOTION
Restoring Movement, Revitalizing Lives

Fax: (561) 740.4755

Kenneth E. Bresky, D.O.,P.A.
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NEW PATIENT INFORMATION SHEET

Patient Name (PLEASE PRINT) _____
Date of Birth: ____/____/____ SEX: Male / Female
Marital Status: Single Married Divorced Widow
Patient Address: (PLEASE PRINT) _____
City: _____, State: _____, Zip: _____
Home Phone #: _____
Cell Phone #: _____
Email Address: _____
Name of Physician who referred you _____
Employment Status: Retired / Employed / Not Employed / Student
Employer Name: _____ Phone Number: _____
Name of Primary Insurance: _____ ID# _____
Primary Physician Name: _____ Phone #: _____
Emergency Contact: _____ Phone #: _____
Relationship to Patient: _____

For all patients: I understand and agree that I am financially responsible for all charges incurred on my behalf. I authorize the release of any medical information necessary to process my claims. I also authorize payment of medical benefits to the physician or supplier of service as indicated on claim. In the event it is necessary to refer my account to a collection agency or any attorney, I agree to pay all collection costs, including attorney fee's and court costs.

Whom may we share your medical billing information with:

Name: _____ Relationship: _____
Patient signature: _____ Today's Date: ____/____/____

Acknowledgment of Receipt of Notice of Privacy Practices

Notice to Patient: We are required to provide you with a copy of the Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of notice. I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Today's date: ____/____/____

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NEW PATIENT INFORMATION FORM**NAME:** _____ **DATE OF BIRTH:** _____**FAMILY HISTORY:**

	YES	NO	RELATION
HEART ATTACK	☐	☐	_____
HEART DISEASE	☐	☐	_____
DIABETES	☐	☐	_____
HYPERTENSION	☐	☐	_____
STROKE	☐	☐	_____
CANCER	☐	☐	_____
EMPHYSEMA	☐	☐	_____
THYROID	☐	☐	_____

FATHER: Alive ☐ Deceased ☐ Age: _____
Cause: _____**MOTHER:** Alive ☐ Deceased ☐ Age: _____
Cause: _____

SIBLINGS:		M	F	Age	Illness
☐	☐	☐	☐	_____	_____
☐	☐	☐	☐	_____	_____
☐	☐	☐	☐	_____	_____
☐	☐	☐	☐	_____	_____

SOCIAL HISTORY:Married: ☐ Divorced: ☐ Widow: ☐ Single: ☐

In Florida Since: _____ Originally From: _____

Local Residence: _____ Children: _____

Other Residence: _____

Occupation: _____ Retired: YES ☐ NO ☐

PAST MEDICAL HISTORY	ILLNESS/SURGERY	MEDICATIONS	NAME/DOSE/FREQUENCY

ALLERGIES: (List NONE if No Allergies)

HABITS:

Smoking: Packs Per Day: _____ How Long: _____ Other: _____

Drinking: How Much: _____ How Long: _____

Dr. Signature: _____ Reviewed ☐ Revised ☐ Date: ____/____/____

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Pharmacy Information

Today's date: _____

Patient's Name: _____ DOB: _____

Retail Pharmacy:

• Pharmacy's Name: _____
• Pharmacy Address: _____
• Phone: _____ Fax: _____

Mail Order Pharmacy:

• Pharmacy's Name: _____
• Pharmacy Address: _____
• Phone: _____ Fax: _____

Specialty Pharmacy:

• Pharmacy's Name: _____
• Pharmacy Address: _____
• Phone: _____ Fax: _____

Print Patient's Name: _____ Signature: _____

Internal use ONLY:

Prescription Insurance's:

Name: _____ Member ID: _____

Phone: _____ Fax: _____ Website: _____

Prior Authorization Dept:

Phone: _____ Fax: _____ Website: _____

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Medical Record Release Form

Today's Date: _____

Patient Name: _____ DOB: _____

- I hereby authorize Dr. Kenneth E. Bresky DO, PA the use/ access/ disclosure of my protected health Information as described below.
- I understand that authorizing the disclosure of this health Information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Dr. Kenneth E. Bresky DO, PA office staff.
- I understand that the revocation will not apply to Information that has already been released in response to this authorization.
- I understand that the revocation will not apply to my Insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that I may inspect or obtain a copy of the Information to be used or disclosed, as provided in CFR 164.524.
- I understand the information in my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease, psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations.
- I understand that unless otherwise revoked, this authorization will expire upon the following date, event or condition: _____. If no expiration date, event or condition is noted this authorization will expire in 1 year from the date signed.
- I understand that Dr. Kenneth E. Bresky is released from any legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.
- I authorize to have my medical records to be released to and/or from the following facility listed below:

_____ Phone: _____ Fax: _____

Information to be released or disclosed (check all that apply):

☐ Office Visit: Notes, Consultation Reports, Discharged Reports	DOS: _____
☐ Laboratory Reports	DOS: _____
☐ Radiology Reports (Including but not limited to X-Ray, MRI, Scans, U/S, Dexa)	DOS: _____
☐ EKG's and Holter Reports	DOS: _____
☐ Complete Chart	DOS: _____

Other: _____

Other: _____

Patient Signature: _____ Print Name: _____