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:					
Occupation:	Employer		Contact Phone: ( )		
Spouse or Significant Other:			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 on the waiting area, which describe how my private health information may be used or disclosed. I understand that I have the right to request a copy of such, ant any time. In any matters in dispute after the fact or after services are rendered, we hereby waive any privacy consideration under the Health Information Portability and Accountability Act of 1996 (HIPAA).

STATEMENT OF LIABILITY INSURANCE COVERAGE AND CLINICAL PRIVILEGES

- 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.
- Dr. Thomassen has clinical privileges at the following hospitals: Holy Cross, Imperial Point, Broward General, Coral Springs and The Surgery Center of Fort Lauderdale.

Patient/Guardian signature	***Date***

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HEALTH HISTORY QUESTIONNAIRE

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

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
	Describe:				

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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 births _____ Plans for future pregnancy? _____				
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	☐	History of Cancer	☐	History of Chemotherapy	
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	☐	Pacemaker/Defibrillator	
☐	Leg swelling	☐	Stent/CABG/Other Cardiac Srg	☐	High Blood Pressure	
Pulmonary ☐ None						
☐	Shortness of breath	☐	Asthma	☐	COPD	
☐	Lung disease	☐	Wheezing	☐	Labored or Difficult Breathing	
Gastrointestinal ☐ None						
☐	Poor Appetite	☐	Peptic ulcer disease/Heartburn	☐	Nausea/Vomiting	
☐	Constipation	☐	Abdominal Pain	☐	Liver disease	
☐	Diarrhea	☐	Irritable bowel syndrome	☐	Pancreatitis	

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	☐	Facia Paresis
Endocrine/Hematologic ☐ None					
☐	Lymph nodes palpable	☐	Bleeding tendency	☐	Blood clots/DVT
☐	Diabetes mellitus	☐	Anemia/Thrombocytopenia	☐	Anticoagulant Use (Coumadin, ASA)
☐	Immune disorders	☐	Hemophilia	☐	Vitamin K Deficiency
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 or videos as deemed necessary for the complete documentation and illustration of the case involved. I understand that these photographs or video 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/Guardian signature	***Date***

John Michael Thomassen, MD, PA

DR. JOHN MICHAEL THOMASSEN HAS CLINICAL STAFF PRIVILEGES AT THE FOLLOWING HOSPITALS:
Broward General 1600 S. Andrews Avenue Fort Lauderdale, FL 33316 954-355-4400 Broward Health North 201 E. Sample Road Deerfield Beach, FL 33064 954-941-8300 Broward Health Coral Springs 3000 Coral Hills Drive Coral Springs, FL 33065 954-344-3000 Broward Health Imperial Point 6401 N. Federal Highway Fort Lauderdale, FL 33308 954-776-8500 Holy Cross Hospital 4725 North Federal Highway Fort Lauderdale, FL 33308 954-771-8000 The Surgery Center of Fort Lauderdale 4485 FL-7 Lauderdale Lakes, FL 33319 954-735-0096

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PROVIDED A LIST OF DR. JOHN MICHAEL THOMASSEN'S HOSPITAL PRIVILEGES.	
Patient Signature:	***Date:***