



NASA PRIMARY CARE

1555 W NASA Blvd, Unit B1
Melbourne FL 32901
Ph: 321-341-1700 Fax: 321-622-6295
www.nasaprimarycare.com

New Patient Registration Page 1 of 2

Insurance Information

Primary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ____/____/____ SS# _____

Secondary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ____/____/____ SS# _____

Complete below if patient is a minor

Father's Name (or Guardian) _____

DOB ____/____/____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

☐ Check if same as patient's address

Employer _____

Mother's Name (or Guardian) _____

DOB ____/____/____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

☐ Check if same as patient's address

Employer _____

Patient Information

Patient Name

First _____ MI _____ Last _____

DOB ____/____/____ SS# _____

Marital Status _____ ☐ MALE ☐ FEMALE

Address _____

Home Phone _____ Cell _____

Email _____

Work Phone _____

Employer _____

Occupation _____

Race

- ☐ American Indian or Alaska Native ☐ Asian
☐ Native Hawaiian ☐ Black or African American ☐ White
☐ Other Pacific Islander ☐ Prefer not to answer

Ethnicity

- ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
☐ Prefer not to answer

Preferred Language

- ☐ English ☐ Spanish ☐ French ☐ Indian (includes Hindu & Tamil) ☐ Other _____

Preferred Pharmacy _____

Location _____



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New Patient Registration

HIPAA Release

Patient Name

First MI Last

Emergency Contact:

Name

Relationship

Phone #

Do you have a Living Will? ☐ Yes ☐ No

Do you have an Advance Directive? ☐ Yes ☐ No

If you answered yes to either, please provide us a copy.

I authorize Medical Associates of Brevard LLC to discuss my healthcare information with the below:

Name

Relationship

Phone #

Name

Relationship

Phone #

Preferred appointment reminder notification:

- ☐ Home Phone ☐ Cell ☐ Cell Text ☐ Work phone
☐ Mail ☐ E-Mail ☐ None
☐ With the person(s) authorized above

Preferred medical information notification:

I authorize Medical Associates of Brevard LLC to leave a detailed message which may contain personal health information via:

- ☐ Home Phone ☐ Cell ☐ Cell Text ☐ Work phone
☐ Mail ☐ E-Mail ☐ None
☐ With the person(s) authorized above

Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine.

Your HIPAA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.



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YOU MUST READ BELOW FOR IMPORTANT INFORMATION AND NOTICES

Financial Policy

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of-pocket, deductibles and noncovered services.

I authorize the payments from my insurance company(s) according to my medical benefits be made payable to **Medical Associates of Brevard LLC** for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Medical Associates of Brevard as well as to my insurance company(s).

LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

NOTE: You will electronically sign for this Financial Policy agreement on the signature pad in your doctors' office to be stored in your electronic medical chart.

Notice of Privacy Practices

I acknowledge that I have received a copy of the **Provider Notice of Privacy Practices** for Medical Associates of Brevard LLC. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

NOTE: You will electronically sign for this Notice of Privacy Practices on the signature pad in your doctors' office to be stored in your electronic medical chart.

Consent to Obtain External Prescription History

I authorize Medical Associates of Brevard LLC and its physicians and staff to view my external prescription history via the electronic medical records system Medent, and the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

NOTE: You will electronically sign for this Consent to Obtain External Prescription History on the signature pad in your doctors' office to be stored in your electronic medical chart. You will have the option to give consent or deny this access upon electronically signing.

Community Chart Consent

I give consent to Medical Associates of Brevard LLC to access the Community Chart in order to access and share my medical records if available through other entities operating under the Carequality Interoperability Framework, including Surescripts. This includes demographic information as well as other relevant clinical documentation.

NOTE: You will electronically sign for this Community Chart Consent on the signature pad in your doctors' office to be stored in your electronic medical chart. You will have the option to give consent or deny this access upon electronically signing.



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Patient Authorization for Release of Medical Records

Patient's Name:

DOB:

Address:

Please check all information that applies:

Chart Notes: ☐

Imaging: ☐

Lab results: ☐

Other: ☐ _____

I give my authorization to release the above protected information to MEDICAL ASSOCIATES OF BREVARD, LLC.

Select one of the following choices:

This authorization will end on the following date: _____

This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use/or disclosure. Describe the event below:

Signature of Patient: _____

Today's Date: _____

Name of Patient: _____



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NO SHOW POLICY

Thank you for trusting NASA PRIMARY CARE with your healthcare. When you schedule an appointment, we set aside enough time to provide you with the highest quality of care. If you need to cancel or re-schedule an appointment, please contact us at least 24 hours prior to the scheduled appointment. This gives us time to offer that slot to other patients who need to be seen.

Missed, no-showed or cancelled appointments with less than 24 hours' notice may be subject to \$25 fee. Multiple missed appointments or late cancellations may result in discharge from the practice.

I have read and understand the medical appointment cancellation / no show policy and agree to its terms.

Signature (Patient or legal guardian)

Date

Name

CONSENT TO AI SCRIBE

During your visit, the Physician/APRN/PA may use AI scribe to assist with documentation. AI scribe helps to capture accurate and timely documentation of the visit in the electronic health record, so the Physician/APRN/PA can focus on you, instead of the computer and provide the highest quality of care.

I agree to the use of AI scribe by the Physician/APRN/PA.

Signature (Patient or legal guardian)

Date

Name



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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.)

☐ M
☐ F

DOB:

Today's Date:

Previous Doctor:

How did you hear about us?

PERSONAL HEALTH HISTORY

**Immunizations
and dates:**

☐ Tetanus

☐ Pneumonia

☐ Hepatitis

☐ Shingrix

☐ Influenza

☐ COVID-19

Medical History

Surgeries

Year	Reason	Hospital

Hospitalization

Year	Reason	Hospital

Have you ever had a blood transfusion?

☐ Yes ☐ No

Please turn to next page

Name <i>(Last, First, M.I.):</i>		DOB:		Today's Date:	
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers					
Name the Drug		Strength		Frequency Taken	
Allergies to medications					
Name the Drug		Reaction You Had			
HEALTH HABITS AND PERSONAL SAFETY					
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you following a specific diet plan?				☐ Yes ☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?				☐ Yes ☐ No
	How many drinks per week?				
Tobacco	Do you use tobacco?				☐ Yes ☐ No
	☐ Cigarettes – pks. /day	☐ Chew - #/day	☐ e-cigarettes?	☐ Cigars - #/day	
	☐ # of years	☐ Or 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
Occupation					
Sexually Active	With Men/ Women / N/A (Circle all that apply)				
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				

Please turn to next page

Page 2 of 3

Name (Last, First, M.I.):

DOB:

Today's Date:

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children		
Mother					
Sibling					
			Grandmother <i>Maternal</i>		
			Grandfather <i>Maternal</i>		
			Grandmother <i>Paternal</i>		
			Grandfather <i>Paternal</i>		

When did you have the following investigations?

Mammogram

Pap

Colonoscopy

DEXA/Bone Density

OTHER PROBLEMS

Check if you have any symptoms in the following areas.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Please list the names of the Specialists you currently see:

Signature: _____ Date: _____