James J. Macool, MD
765 Douglas Ave.
Altamonte Springs, FL 32714-2919
(407)774-7781
(407) 774-7743 – fax

Please complete all sections and sign the yellow highlighted area. Please give me your Insurance card and Driver's License so I can obtain a copy.

Patient Registration

Parent/Guardian Name: _____ Date: __ /___/_____

Name: _____ Date of Birth: __ /___/_____ Sex: _____

Address: _____ Age: _____

_____, _____, _____ Cell Phone: (___) ___-_____

Marital Status: ☐Married ☐Divorced ☐Widow ☐Single ☐Domestic Partner ☐Other

Home Phone: (___) ___-_____ Work Phone: (___) ___-_____ **Email**: _____

Name of Primary Insured/Policy Holder: _____ **Date of Birth:** ___/___/_____

Primary Insurance: **Secondary Insurance**

Ins. Company: _____ Ins. Company: _____

Insurance Policy # _____ Insurance Policy # _____

GOVERNMENT MANDATED QUESTIONS

Ethnicity (circle 1): Hispanic / Non-Hispanic / Decline Preferred Language: _____

Race (circle 1): American Indian /Alaska Native Asian Black/African-America Unknown

Native Hawaiian/Other Pacific Islander White/Caucasian Other Decline

Guarantor Name: _____ Guarantor Name: _____

Pharmacy name, telephone & address: _____, (___) ___-_____, _____

Allergies to Medications, Dyes, or Other Substances: ☐No ☐Yes (if Yes, please list names and type of reaction):

_____

Emergency Contact: _____ Phone #: (___) ___-_____ Relationship: _____

What is your preferred method of contact for appointment reminders (circle one): Home Cell Work Leave Message? YES NO

What is your preferred method of contact for medical information (circle one): Home Cell Work Leave Message? YES NO

Smoking Status

☐ Unknown if ever smoked ☐Never Smoked ☐Former Smoker ☐Current Some Day Smoker

☐Current Every Day Smoker ☐Smoker, Current Status Unknown

Alcohol Use

☐Denies Alcohol Use ☐Past Alcohol Use ☐Recovering Alcoholic ☐Rare Alcohol Use

☐Social Alcohol Use ☐Daily Alcohol Use

Drug Use

☐ Yes ☐No Additional Information: _____

ALL PROFESSIONAL SERVICES RENDERED ARE THE RESPONSIBILITY OF THE PATIENT. THE PATIENT IS RESPONSIBLE FOR THE FEES, REGARDLESS OF INSURANCE COVERAGE. ALL DEDUCTIBLES, CO-PAYS, ETC. ARE TO BE PAID AT THE TIME OF SERVICE.

I HEREBY AUTHORIZE JAMES J. MACOOL, M.D. TO RELEASE INFORMATION TO ANOTHER DOCTOR/PROVIDER/INSURANCE COMPANY AND HEREBY AUTHORIZE ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO BE PAID DIRECTLY TO JAMES J. MACOOL, M.D.

Responsible Party Signature/*Firma* Signature of Patient/Guardian: _____Date/*Fecha*: __ /___/_____

I ACKNOWLEDGE RECEIVING A COPY OF JAMES J. MACOOL, M.D. PRIVACY ACT.