WOODLANDS
Medical Specialists

New Patient Paperwork

Name *(Last, First, M.I.):* ☐ M ☐ F			**Today's Date:**
Email Address:			**DOB:**
Primary Phone:		**Alternate Phone:**	**Emergency Contact:**
Race:	☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ Caucasian ☐ Nat Hawaiian/Pacific Islander ☐ Unknown ☐ Decline to Answer		
Address:	**City:**	**State:**	**Zip:**
Previous Primary Care Physician:		**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Please list any other physicians that contribute to your health care:		
NAME & CONTACT NUMBER	SPECIALITY	DATE OF LAST VISIT

CURRENT MEDICAL PROBLEMS
Please list any concerns or problems you would like to address with your physician

MEDICAL HISTORY

Current and past medical diagnoses (check all that apply)

☐ Hypertension	☐ Kidney stones	☐ HIV / AIDS	☐ Insomnia	☐ Hypogonadism (low testosterone)
☐ Diabetes	☐ Enlarged prostate	☐ Hepatitis C	☐ Depression	☐ Bladder Cancer
☐ High cholesterol	☐ Urinary incontinence	☐ Cirrhosis	☐ Osteoporosis	☐ Kidney Cancer
☐ Heart disease	☐ Chronic pain	☐ Stomach ulcer	☐ Osteopenia	☐ Prostate Cancer
☐ Heart attack	☐ Arthritis, degenerative	☐ GERD / reflux	☐ Blood Clots(legs/lung)	☐ Cancer (Specify)
☐ Abnormal heart valve	☐ Arthritis, rheumatoid	☐ Irritable bowel disease	☐ Crohn's Disease	☐ Cancer (Specify)
☐ Heart failure	☐ Arthritis, gout	☐ Seizures	☐ Ulcerative Colitis	☐ Cancer (Specify)
☐ Stroke	☐ COPD	☐ Migraine headaches	☐ UTI	☐ Other (Specify)
☐ Kidney Disease	☐ Asthma	☐ Sleep apnea	☐ Erectile Dysfunction	☐ Other (Specify)
☐ Thyroid Problems	☐ Glaucoma	☐ Anxiety	☐ Pregnant #_____times	☐Congestive Heart Failure

Exposure to: ☐Asbestos ☐ Chemicals ☐Ionizing Radiation

IMMUNIZATIONS & DATES - If checked, please provide date(s)

☐ Influenza	☐ Hepatitis B	☐ MMR *Measles, Mumps, Rubella*
☐ Pneumonia	☐ Shingles / Zoster	☐ Tdap *Tetanus, diphtheria, pertussis*

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HEALTH SCREENING TESTS

Mammogram	☐ Normal ☐ Abnormal	Date:	Provider:
Colonoscopy	☐ Normal ☐ Abnormal	Date:	Provider:
Fecal occult blood	☐ Normal ☐ Abnormal	Date:	Provider:
Pap smear	☐ Normal ☐ Abnormal	Date:	Provider:
Bone density (DEXA)	☐ Normal ☐ Abnormal	Date:	Provider:
Prostate specific antigen (PSA)	☐ Normal ☐ Abnormal	Date:	Provider:
Lipid profile (cholesterol)	☐ Normal ☐ Abnormal	Date:	Provider:
Electrocardiogram (EKG)	☐ Normal ☐ Abnormal	Date:	Provider:
Cardiac stress test	☐ Normal ☐ Abnormal	Date:	Provider:

PAST HOSPITALIZATIONS

Year	Reason	Hospital

SURGICAL HISTORY

Year	Operation	Surgeon

SOCIAL HISTORY

Place of Birth:
Occupation:
Travel outside of USA: ☐ No ☐ Yes
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Sex	How many sexual partners have you had in the past six months?				
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness or other sexual transmitted diseases?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No

FAMILY HISTORY				
RELATIVE	**AGE (CURRENT OR DEATH)**	**HEART ATTACK OR STROKE**	**CANCER**	**OTHER HEALTH PROBLEMS**
Mother		☐ No ☐ Yes at age _____	☐ No ☐ Yes (type) _____	
Father		☐ No ☐ Yes at age _____	☐ No ☐ Yes (type) _____	
Sibling		☐ No ☐ Yes at age _____	☐ No ☐ Yes (type) _____	
Sibling		☐ No ☐ Yes at age _____	☐ No ☐ Yes (type) _____	
Sibling		☐ No ☐ Yes at age _____	☐ No ☐ Yes (type) _____	

ALLERGIES TO MEDICATIONS	
Name the Drug	Reaction You Had

MEDICATIONS **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**		
Name the Drug	Strength	Frequency Taken

WOODLANDS Medical Specialists

HIPAA/Consent/Policies

$25 CANCELLATION FEE POLICY

If you are unable to keep your scheduled doctor's appointment, we require a 24-hour notice (1-full business day) so that we may accommodate the needs of another patient. All doctor's appointments are reserved exclusively for you. In the event of a failed doctor's appointment, the patient is charged a $25 fee.

Patient Initials_____

PRESCRIPTION REFILL POLICY

I understand my doctor's refill policy:

1. Refills must be requested at least 24 - 48 hours ahead if I am not seeing the doctor.
2. Refills ARE NOT given at night or on weekends.
3. Refills are provided by my doctor only. I will not ask other physicians for refills.
4. Refills ARE NOT given for lost, stolen, spilled, misplaced or "used up early" medications. NO EMERCENCY REFILLS.
5. Some insurances may take 7-10 days for prior authorization to be complete.

Patient Initials_____

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION (HIPPA CONSENT)

I authorize Woodlands Medical Specialists to disclose my health care and billing information to those that I designate. I further provide authorization for these individuals to pick up prescriptions and/or medications on my behalf.

Patient Initials_____

I designate the following individuals for disclosure of patient health information as described above for my health care, billing and medications/prescriptions.

Patient Initials_____

Name_____ Relationship _____ Phone _____

Name_____ Relationship _____ Phone _____

Name_____ Relationship _____ Phone _____

NOTICE OF PRIVACY PRACTICES

I have the right to review the "Notice of Practices", prior to signing this consent and agree with these privacy policies.

Patient Initials_____

FINANCIAL POLICY

I hereby authorize Woodlands Medical Specialists to release any medical information required during the course of examination and treatment to my insurance company, and I permit payment to Woodlands Medical Specialists from my insurance for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services. I understand that I am responsible for all charges incurred regardless of insurance status. I agree to pay for services incurred after the patient has been charged for the office visit, such as labs, radiology, medical supplies, etc. I agree to pay my bill in full for services rendered by Woodlands Medical Specialists.

Patient Initials_____

I **do / do not (circle one)** authorize the release of information specific to laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions.

Patient Initials_____

Signature of Patient or Legal Guardian: _____ Date:_____

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Medical Records Request

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

First Name _____ Last Name _____

Date of Birth_____ Social Security #_____

I hereby authorize _____ (list name of healthcare facility/provider) to disclose the following specific information from my health record.

Release/Disclose to:
Woodlands Medical Specialists
4724 N Davis Hwy
Pensacola, Florida 32503
Phone: (850) 696-4000 Fax: (850) 435-9068

INFORMATION TO BE DISCLOSED (PLEASE INITIAL ALL THAT APPLY)

Entire Health Record ____ Lab Results ____ Radiology/Imaging Reports _____ Operative Report _____

Mammogram Report ____ Physician Consults ____ History/Physical ____ Other _____

REASON FOR DISCLOSURE (PLEASE INITIAL ALL THAT APPLY)

Continued Care ____ Insurance Claim _____ Legal Purposes _____

Personal Use ____ Other _____

I understand if I do not authorize the release of my entire health record, only a limited health record is provided per patient request.

I understand I may revoke this authorization in writing at any time, except to the extent that action has already been taken; forms are available. Woodlands Medical Specialists are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

I understand it *may take 7 to 10 business days* for this request to be processed. I further understand that I am entitled to a copy of the authorization.

Signature of Patient: _____ Date:_____

Signature of Representative: _____ Date:_____

Witness: _____ Date: _____