

New Patient Paperwork

Name <i>(Last, First, M.I.):</i> _____		<input type="checkbox"/> M <input type="checkbox"/> F	Today's Date: _____
Patient Nickname <i>(if applicable)</i> _____			
Email Address: _____			DOB: _____
Primary Phone: _____		Cell Phone: _____	
Emergency Contact Information: Name: _____ Phone: _____		Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Nat Hawaiian/Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic or Latino	
Address: _____		City: _____	State: _____ Zip: _____
Previous or Current 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

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MEDICAL HISTORY

Current and past medical diagnoses (check all that apply)

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

Exposure to: Asbestos Chemicals Ionizing Radiation

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

<input type="checkbox"/> Influenza	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Shingles / Zoster	<input type="checkbox"/> Tdap <i>Tetanus, diphtheria, pertussis</i>

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HEALTH SCREENING TESTS

Mammogram	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Date:	Provider:
Colonoscopy	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Date:	Provider:
Fecal occult blood	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Date:	Provider:
Pap smear	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Date:	Provider:
Bone density (DEXA)	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Date:	Provider:
Prostate specific antigen (PSA)	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Date:	Provider:
Lipid profile (cholesterol)	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Date:	Provider:
Electrocardiogram (EKG)	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Date:	Provider:
Cardiac stress test	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Date:	Provider:

PAST HOSPITALIZATIONS

Reason	Year	Hospital

SURGICAL HISTORY

Operation	Year	Surgeon

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

MEDICATIONS
 List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

***Provide Your Local Pharmacy Name & Phone:**

Name the Drug	Strength	Frequency Taken

New Patient Paperwork

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SOCIAL HISTORY			
Place of Birth:			
Occupation:			
Travel outside of USA: <input type="checkbox"/> No <input type="checkbox"/> Yes			
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use or have you ever used tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Safety	Do you live alone?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision or hearing loss?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Would you like information on the preparation of these?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	In the past two weeks have you felt down, depressed or hopeless?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	In the past two weeks have you felt little interest or pleasure in doing things?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Domestic Violence	Over the last 12 months, has anyone close to you hurt, hit or threatened you?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Drugs	Do you currently use recreational or illicit drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No

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FAMILY HISTORY				
RELATIVE	AGE (CURRENT OR DEATH)	HEART ATTACK OR STROKE	CANCER	OTHER HEALTH PROBLEMS
Mother		<input type="checkbox"/> No <input type="checkbox"/> Yes at age _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (type) _____	
Father		<input type="checkbox"/> No <input type="checkbox"/> Yes at age _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (type) _____	
Sibling		<input type="checkbox"/> No <input type="checkbox"/> Yes at age _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (type) _____	
Sibling		<input type="checkbox"/> No <input type="checkbox"/> Yes at age _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (type) _____	
Sibling		<input type="checkbox"/> No <input type="checkbox"/> Yes at age _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (type) _____	
Grandmother <i>Maternal</i>		<input type="checkbox"/> No <input type="checkbox"/> Yes at age _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (type) _____	
Grandfather <i>Maternal</i>		<input type="checkbox"/> No <input type="checkbox"/> Yes at age _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (type) _____	
Grandmother <i>Paternal</i>		<input type="checkbox"/> No <input type="checkbox"/> Yes at age _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (type) _____	
Grandfather <i>Paternal</i>		<input type="checkbox"/> No <input type="checkbox"/> Yes at age _____	<input type="checkbox"/> No <input type="checkbox"/> Yes (type) _____	

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 EMERGENCY REFILLS.
5. Some insurances may take 7-10 days for prior authorization to be complete.

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION (HIPAA 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: _____

The physicians have an ownership interest in Radiology and Radiation Therapy services provided at Woodlands Medical Specialists. Please know that ancillary services including MRI, PET/CT Scans, and other imaging services ordered by the physicians at our practice can also be obtained at other facilities in the area. To obtain a list of these facilities, please see the Front Desk Staff.

Release of Information

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) 434-2647

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 ____

This authorization below may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION:

I _____ (patient name or legal guardian), authorize the release of information, including, if applicable, specific 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, all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia.

Patient Initials _____

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: _____

Communication Consent

Consent to Phone, Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via phone, email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, to provide general health reminders and practice news/information.

TEXT MESSAGE

____ (Patient Initials) I consent to receive text message reminders from Woodlands Medical Specialists on my cell phone.

- Cell Phone Number: The cell phone number that I authorize to receive text message reminders for my appointment is (____) _____.
- *The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).*

____ (Patient Initials) I decline to receive text messages from Woodlands Medical Specialists.

EMAIL MESSAGE

____ (Patient Initials) I consent to receive email reminders from Woodlands Medical Specialists.

- The email that I authorize to receive email reminders for my appointment is _____.

____ (Patient Initials) I decline to receive email reminders from Woodlands Medical Specialists.

PHONE MESSAGE

____ (Patient Initials) I consent to receive phone call reminders from Woodlands Medical Specialists.

- Phone Number: The phone number that I authorize to receive phone call reminders for my appointment is (____) _____.
- I do ____, I do not ____, give permission to leave relevant medical information on my answering machine or voice mail.
- I do ____, I do not ____, want relevant medical information shared with the person who may answer the telephone. The name(s) of the individuals(s) with whom you may leave pertinent information are:

Name _____

Contact Number (____) _____

Name _____

Contact Number (____) _____

____ (Patient Initials) I decline to receive phone call reminders from Woodlands Medical Specialists.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to such third parties limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

Patient Printed Name _____

Date of Birth _____

Patient Signature _____

Today's Date _____

Woodlands Representative _____

Today's Date _____