



New Patient Paperwork – Primary Care

SECTION 1. PATIENT INFORMATION

Full Name: _____

Preferred Name (if different from above): _____

Date of Birth: ___/___/___ Sex: Male Female Social Security #: _____ - _____ - _____

Address: _____

Phone: (____) _____ - _____ Email: _____

How did you hear about us?: Primary Care Physician Specialist Physician Word of Mouth Hospital
 Insurance Company Patient in the Practice Other _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Decline to Specify

Race: American Indian Asian African American White Other Race Decline to Specify

Special Communication Needs: Yes, please specify: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (____) _____ - _____ Alternative: (____) _____ - _____

Primary Insurance Carrier: _____ Member ID: _____

Group #: _____ Policy Holder Name and D.O.B.: _____

Secondary Insurance Carrier: _____ Member ID: _____

Group #: _____ Policy Holder Name and D.O.B.: _____

SECTION 2. PERSONAL MEDICAL HISTORY

Please mark all that apply to you			
Angina	Diabetes Mellitus Type 1	Arthritis	
Atrial Fibrillation	Diabetes Mellitus Type 2	Neuropathy	
Congestive Heart Failure	Osteopenia	Epilepsy/Seizure Disorder	
Heart Attack	Osteoporosis	Stroke	
Heart Murmur	Hypothyroidism	Headache Syndrome/Migraines	
High Cholesterol	Hyperthyroidism (overactive)	Parkinson's	
High Blood Pressure	Prediabetes	Anxiety Disorder/Panic Attacks	
Asthma	Renal (Kidney) Disease	Depressive Episode/Depression	
COPD/Bronchitis/Emphysema	Hepatic (Liver) Disease	Substance Abuse	
Sleep Apnea	Prostate Disorder	Bipolar Disorder	
GERD	Urinary Tract Infections	Schizophrenia	
IBS (Irritable Bowel Syndrome)	Kidney Stones	Dementia	
Peptic Ulcer	Polycystic Ovarian Syndrome	Cancer:	
Crohn's Disease	Endometriosis	<i>Other:</i>	
Ulcerative Colitis	Fibroids	<i>Other:</i>	
<i>Other:</i>	<i>Other:</i>	<i>Other:</i>	

Age at Menarche (First Period): _____ Date of Last Menstrual Period: ___/___/___ -OR-

Pregnant Breastfeeding Post-Menopause; My Age at Menopause: _____

Pregnancy History: ___ Full Term, ___ Premature Births, ___ Miscarriages or Abortions

Total # of Pregnancies: _____

I am on hormone therapy.

I am on a contraceptive (birth control pill, IUD, injection, etc.).

Medication List			
Please list ALL medications and supplements, including creams, injections, etc.			
Medication/Supplement	Dose	Frequency	Indication/Reason
Allergies			
<input type="checkbox"/> No known allergies			
Allergen (food, medications, or supplements)		Reaction	

(use back of paper for extra space)

SECTION 3. SURGICAL HISTORY

(use back of paper for extra space)

Surgery Type	Year

SECTION 4. HOSPITALIZATIONS

(use back of paper for extra space)

Year	Reason	Hospital Name

SECTION 5. FAMILY HISTORY

[] I am adopted/I do not know my family history.

Relative		Conditions
Father	[] living, [] deceased at age ____	
Mother	[] living, [] deceased at age ____	
Sister 1	[] living, [] deceased at age ____	
Sister 2	[] living, [] deceased at age ____	
Brother 1	[] living, [] deceased at age ____	
Brother 2	[] living, [] deceased at age ____	
Child 1	[] living, [] deceased at age ____	
Child 2	[] living, [] deceased at age ____	
Other	[] living, [] deceased at age ____	
Other	[] living, [] deceased at age ____	

SECTION 6. SOCIAL HISTORY & LIFESTYLE1. Occupation: _____ Retired

2. Highest Level of Education: _____ Hobbies: _____

3. Marital Status: Single Married Divorced Widowed Separated Minor4. Do you live in Florida year-round? Yes No If no, where else do you have a residence? _____5. Exercise: Daily 3-5x/week 1-3x/week Occasional Never

Type of Exercise: _____

6. Caffeine: Yes, how much? _____ servings daily No7. Diet: Normal Diabetic Low salt Vegetarian Vegan Paleo Keto Other: _____Do you believe your typical diet is healthy or unhealthy? Healthy Unhealthy8. Have you had an alcoholic drink in the past year? Yes NoIf yes, how often: Daily 3-5x/week 1-3x/week Less than once a week10. Have you EVER used tobacco products? Yes, current user Yes, former user No, neverIf current user, please mark all that apply: Cigarettes Vape Cigar Chew/Snuff Other: _____

If current user, how much and how often: _____

11. Have you EVER used marijuana? Yes, current user Yes, former user No, never12. Have you EVER used illegal drugs? Yes, current user Yes, former user No, never

If yes, please describe use: _____

SECTION 7. PREVENTIVE CARE

Please provide the approximate date and results of most recent medical care.		
Physical exam/PCP visit		
Routine lab work (CBC, CMP, Lipid panel, A1c diabetic screening)		
EKG		
Mammogram		
Pap Smear		
DEXA (bone density)		
Colonoscopy/Colon cancer screening		

Have you had any of the following vaccinations:

Flu within 1 year Tetanus (TDaP) within 10 years Pneumonia Shingles (2 doses) Other: _____

SECTION 8. ADDITIONAL ASSESSMENTS

Pain Assessment

Are you in any pain today? No Yes, location: _____

My pain is: Aching Burning Stabbing Sharp Dull

On a 1-10 scale, at rest, my pain today is: 1 2 3 4 5 6 7 8 9 10

Urinary Incontinence Assessment

Do you ever urinate when you aren't trying to? Yes No

If yes, please specify if any of the following conditions are present when symptoms occur:

Coughing, sneezing, laughing, or jumping Trying to hold my stream/Unable to make it to the restroom in time

I am unable to feel when I have to urinate

PHQ-2 Depression Screening

Over the last 2 weeks, how often have you been bothered by the following problems?

Question	Not at all (0)	Several days (1)	More than half of days (2)	Nearly every day (3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				

Total: _____

Annual Consents

Patient Consent for Receipt and Transmittal of Protected Health Information

Patient Name: _____ Date of Birth: _____

Does Center for Women’s Primary Care have permission to:

Email protected health information to you: Yes No

Email promotional/ aesthetic & wellness/ medical informational material: Yes No

*If an email is chosen, I accept and agree that email is not a secure way to share Protected Health Information. Choosing this option, I agree to hold Center for Brain and Spine, Center for Regenerative & Aesthetic Wellness, Center for Women’s Primary Care and Re3 Stem Cell and Healing Institute harmless for any claims arising from the same.

Mail notices to your home address: Yes No

Leave the following information on your **HOME/ CELL** voicemail:

- Appointment Information: Yes No
- Billing Information Yes No
- Medical Information Yes No
- Prescription Refills Yes No
- Authorizations or Referrals Yes No

Leave the following information on your **WORK** voicemail:

- Appointment Information: Yes No
- Billing Information Yes No
- Medical Information Yes No
- Prescription Refills Yes No
- Authorizations or Referrals Yes No

I give permission to Center for Women’s Primary Care to share Protected Health Information with the following people (e.g., spouse, parent, adult child, friend, caregiver):

Name: _____ Relationship: _____
Permission granted: All or Appointment Billing Medical

Name: _____ Relationship: _____
Permission granted: All or Appointment Billing Medical

Name: _____ Relationship: _____
Permission granted: All or Appointment Billing Medical

Signature: _____ Today’s Date: _____

If signed by legal representative - name & relationship: _____

Consent and Office Policies Policy

Patient Name: _____ Date of Birth: _____

Consent for Treatment

I give permission to the physicians and staff of Center for Women's Primary Care ("the practice") to administer or perform medical treatment. I acknowledge that risks, if any, will be explained to me as well as any other medical options. I understand that no guarantee can be made as to the efficacy or outcome of treatment. I acknowledge that neither Re3 Stem Cell and Healing Institute nor any of its owners, directors, or employees shall have any liability, whether direct or indirect, if I do not follow the prescribed course of treatment, including prescribed return visits or the failure to properly use prescribed medications and/ or treatments. The practice may also use my Protected Health Information (PHI) to treat me or disclose my PHI to other health care providers, such as my referring physician or primary care physician, for purposes related to my treatment.

Consent to Release Information

I consent that the practice may release any medical information that has been obtained during my course of treatment to any lab, hospital, physician or insurance company to answer any inquiries per Federal and State regulations. The practice may use or disclose my PHI internally or disclose my PHI to other health care providers and entities as necessary to operate their business. The practice may use and disclose my PHI to contact me for appointment reminders and to inform me of potential treatment options or alternatives. The practice may use and disclose my PHI to advise a friend or family member that is involved in my care or who assists in taking care of me. My PHI may also be used and disclosed when Federal, State, or local law requires. The practice may share my PHI with third-party "Business Associates" that perform activities on their behalf such as billing and/or software maintenance.

Written Acknowledgement of Notice of Privacy Practices

I have been offered a copy of Center for Women's Primary Care Notice of Privacy Practices that describes how health information is used and shared. I understand that the practice has the right to change this notice at any time, and that I may obtain a current copy by contacting the Privacy Officer at the practice.

Consent for Audio Recording for Documentation

With your permission, your visit may be audio-recorded to assist with accurate medical documentation. Recordings are stored and handled in a secure, HIPAA-compliant manner and deleted after documentation is completed. You may decline or withdraw consent at any time. Your care will not be affected if you choose not to consent.

Cancellation/ No Show Policy/ Late Policy

Center for Women's Primary Care understands that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel your appointment, you are preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly "full" appointment schedule.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a \$50 fee. This fee is not covered by your insurance carrier.

We understand that delays happen (especially with the traffic here), however, we must try to keep the patients and doctor on time. Please call the office as soon as you know you are delayed. We will try to accommodate your appointment as best as possible.

If you are 15 minutes or more delayed, we will reschedule your appointment without a phone call.

Account Balances

All account balances must be paid in full before seeing the physician. Patients with questions regarding their balance or who would like to discuss payment plan options may call the billing department to review their account and concerns.

Irene – Billing Department – 941-893-2688 ext. 205

By signing below, I certify that I have read the above information. My signature certifies my understanding of and agreement with the above consents.

Signature: _____ Today's Date: _____

If signed by legal representative - name & relationship: _____

Office and Financial Policy

Patient Name: _____ Date of Birth: _____

Insurance Carrier(s): _____

We are dedicated to you, and our goal is to give you the best care available. We know that dealing with the financial side of your care may be confusing and stressful; therefore, we are providing you with information to clarify your financial responsibility.

- ❖ Our **Consent Form** must be updated yearly. This form allows us to submit medical claims for services provided to your insurance company, as well as appeal improperly paid claims. *Refusal to sign this form will result in you being considered a self-pay. You will then be responsible for our entire billed amounts.*
- ❖ Your personal information (address, phone number, etc.) must be updated whenever there is a change, as well as your insurance information. You will be asked to produce a picture ID, as well as proof of insurance. We will verify coverage prior to services being provided. We rely on the information you provide in order to bill third parties for your medical services. **Balances that are not paid due to errors or omissions in the information you provide may result in the entire balance becoming your responsibility.** Please be sure to report all potential third-party sources of payment (auto insurance, worker's compensation, supplemental, secondary, etc.)
- ❖ If you are covered by insurance and wish to receive services at Center for Women's Primary Care that have not been authorized, we are happy to provide the service, but you will however be responsible for payment on the day of service. You will also be responsible for any deductible, copay or coinsurance that is assigned to you from your insurance company. We accept cash, check, and all major credit cards.
- ❖ We accept assignments from Medicare. You will be responsible for your Medicare deductible and 20% coinsurance if your secondary insurance denies payment.
- ❖ If surgery is indicated, our financial department will provide you with a surgical estimate for our physicians' services. Most policies require a patient co-insurance until your deductible and out-of-pocket requirements have been met. *Payment of the estimated co-insurance is required prior to surgery.*
- ❖ If you are self-pay, payment in full is expected at the time of service.
- ❖ Center for Women's Primary Care is contracted with many insurance networks. If you are unsure if we participate with your insurance, please ask to speak with someone in our financial department.
- ❖ Center for Women's Primary Care may not be a participating provider with your insurance company. Your insurance company may send payment for our services directly to you. By signing our **Consent Form**, you agree that it is your financial responsibility to settle any financial obligations to this office for services provided by Center for Women's Primary Care. Failure to do so may result in your account being turned over to collections.

I hereby authorize direct remittance of payment of insurance benefits including Medicare, if applicable, to the practice for all covered medical services rendered. I understand and agree this assignment of benefits will have continuing effect for as long as I am being treated by the practice, and will constitute a continuing authorization, maintained on file with the practice, for all subsequent and continuing treatment, services, and/or supplies provided to me by the practice. The practice may use and disclose my PHI in order to directly bill and collect payment for services and items I receive, to obtain payment from me or from third parties that may be responsible for such costs, or to assist other health care providers in their billing and collections. I accept legal responsibility for charges that my insurance company does not cover, and I will pay for these at the time of my visit unless prior arrangements have been made. I am also responsible for all legal fees, collection fees, and interest incurred in the event my account becomes delinquent. I understand that the practice may not be a participating provider with my insurance company. I understand that I will be held legally responsible for payment in full for all services or equipment that has been provided.

Signature: _____ Today's Date: _____

If signed by legal representative - name & relationship: _____

Release of Records Authorization

Patient Name: _____

Date of Birth: _____

Name of facility/physician releasing records: _____

Phone: _____

Fax: _____

From (Date): _____

To (Date): _____

Records to include: _____ Office notes
 _____ Pathology reports
 _____ Operative reports
 _____ Imaging reports
 _____ ALL RECORDS
 _____ Other: _____

Name of facility/physician receiving records: Center for Women's Primary Care

Address: 3534 Fruitville Rd, Sarasota FL 34237

Phone: 941-893-2688

Fax: 941-893-2690

By signing below, I authorize my records to be released as designated above.

Signature: _____ Today's Date: _____

If signed by legal representative - name & relationship: _____