New Patient Paperwork – Primary Care

Full Name: _____ Date of Birth: ____/____/_____ Sex: Male Female

Preferred Name (if different from above): _____

Social Security #: _____-_____-_____ Phone: (_____) _____ - _____ Email: _____

Address: _____

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.: _____

CARE TEAM

Please mark all that apply to you					
	Specialist	**Name**		**Specialist**	**Name**
	Cardiology			OB/GYN	
	Dermatology			Ophthalmology	
	Endocrinology			Orthopedics	
	ENT			Pulmonology	
	Gastroenterology			Rheumatology	
	Nephrology			Urology	
	Neurology			*Other:*	

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		*Other*:
	Ulcerative Colitis		Fibroids		*Other:*
	Other:		*Other*:		*Other*:

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.).

Allergies **[ ] No known allergies**	
Allergen (food, medications, or supplements)	**Reaction**

Medication List **[ ] No current medications**			
Please list ALL medications and supplements, including creams, injections, etc.			
Medication/Supplement	**Dose**	**Frequency**	**Indication/Reason**

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 ____	

SURGICAL HISTORY

Surgery Type	**Year**

HOSPITALIZATIONS

Year	**Reason**	**Hospital Name**

SOCIAL HISTORY & LIFESTYLE

1. Have you EVER used tobacco products? [ ] Yes, current user [ ] Yes, former user [ ] No, never
   If current user, please mark all that apply: [ ] Cigarettes [ ] Vape [ ] Cigar [ ] Chew/Snuff [ ] Other: _____
   If current user, how much and how often: _____
2. Have you had an alcoholic drink in the past year? [ ] Yes [ ] No
   If yes, how often: [ ] Daily [ ] 3-5x/week [ ] 1-3x/week [ ] Less than once a week
3. Have you EVER used marijuana? [ ] Yes, current user [ ] Yes, former user [ ] No, never
4. Have you EVER used illegal drugs? [ ] Yes, current user [ ] Yes, former user [ ] No, never
   If yes, please describe use: _____
5. Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?
   [ ] Not at all [ ] Only a little [ ] To some extent [ ] Rather much [ ] Very much [ ]
6. Marital Status: [ ] Single [ ] Committed Partner [ ] To some extent [ ] Married [ ] Separated [ ] Divorced [ ] Widowed
7. How many children do you have? _____ What is your pregnancy status (females only)? [ ] Pregnant [ ] Not Pregnant
8. Occupation: _____ [ ] Retired
9. Highest Level of Education: _____ Hobbies: _____
10. Exercise: [ ] Daily [ ] 3-5x/week [ ] 1-3x/week [ ] Occasional [ ] Never
    Type of Exercise: _____
11. Are you able to care for yourself independently? [ ] Yes [ ] No Do you have difficulty walking or climbing stairs? [ ] Yes [ ] No
Do you have difficulty dressing/bathing/grooming/toileting? [ ] Yes [ ] No Do you have difficulty doing errands alone? [ ] Yes [ ] No
Do you have transportation difficulties? [ ] Yes [ ] No Which of your hands is dominant? [ ] Right [ ] Left
12. Do you live in Florida year-round? [ ] Yes [ ] No If no, where else do you have a residence? _____
13. Caffeine: [ ] Yes, how much? _____ servings daily [ ] No
14. Diet: [ ] Normal [ ] Diabetic [ ] Low salt [ ] Vegetarian [ ] Vegan [ ] Paleo [ ] Keto [ ] Other: _____
    Do you believe your typical diet is healthy or unhealthy? [ ] Healthy [ ] Unhealthy

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/cervical cancer screening		
DEXA (bone density)		`
Colonoscopy/colon cancer screening		
Low-Dose Chest CT/lung cancer screening		
PSA blood test/prostate cancer screening		
Total body skin exam/skin cancer screening		
Dental exam		
Eye exam		

Have you had any of the following vaccinations (if yes, please include the date completed):
[ ] Flu within 1 year: _____ [ ] COVID-19: _____ [ ] Pneumonia: _____ [ ] RSV: _____
[ ] Tetanus (TDaP) within 10 years: _____ [ ] Hepatitis B: _____ [ ] HPV : _____
[ ] Other: _____

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: _____

REVIEW OF SYSTEMS: Do you currently have a problem with the following? (please check all where 'yes' applies)

Constitutional:
[ ] Fatigue
[ ] Fever
[ ] Night sweats
[ ] Weight gain (____lbs)
[ ] Weight loss (____lbs)
[ ] Daytime somnolence

Eyes:
[ ] Dry eyes
[ ] Irritation
[ ] Vision change
[ ] Scotoma (vision loss)
[ ] Diplopia (double vision)

ENMT:
[ ] Ear pain
[ ] Nasal/sinus problems
[ ] Sore throat
[ ] Loss of hearing
[ ] Tinnitus (ringing in the ears)
[ ] Mouth sores
[ ] Dental caries (tooth decay/cavities)
[ ] Edentulous (no natural teeth)
[ ] Dentures

Respiratory:
[ ] Cough
[ ] Shortness of breath
[ ] Sputum production
[ ] Hemoptysis (coughing up blood)
[ ] Wheezing
[ ] Sleep apnea

Cardiovascular:
[ ] Chest pain
[ ] Palpitations
[ ] Edema
[ ] Cyanosis (bluish discoloration)
[ ] Orthopnea (lying flat shortness of breath)
[ ] Paroxysmal nocturnal dyspnea (sudden nighttime shortness of breath)
[ ] Heart murmur
[ ] Syncope (fainting/loss of consciousness)
[ ] Lightheadedness

Gastrointestinal:
[ ] Heartburn
[ ] Dysphagia (difficulty swallowing)
[ ] Nausea
[ ] Vomiting
[ ] Diarrhea
[ ] Bloody stool
[ ] Rectal bleed
[ ] Recent change in bowel habits
[ ] Constipation

Genitourinary:
[ ] Impotence (erectile dysfunction)
[ ] Hematuria (blood in urine)
[ ] Abnormal bleeding
[ ] Difficulty urinating
[ ] Abnormal urethral discharge
[ ] Increased urinary frequency
[ ] Urinary loss of control
[ ] Incomplete emptying
[ ] Feelings of urgency
[ ] Inadequacy of lubrication of vaginal mucosa (vaginal dryness)

Musculoskeletal:
[ ] Muscle aches
[ ] Muscle weakness
[ ] Arthralgias/joint pain
[ ] Back pain
[ ] Swelling in the extremities
[ ] Stiffness

Neurologic:
[ ] Headaches
[ ] Migraines
[ ] Dizziness
[ ] Loss of consciousness
[ ] Weakness
[ ] Numbness
[ ] Slurred speech
[ ] Seizures

Memory:
[ ] Memory loss

Annual Consents

Patient Consent for Receipt and Transmittal of Protected Health Information

Patient Name:_____ Date of Birth: _____

Does Center for 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 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 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 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 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/Show Policy/ Late Policy

Center for 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 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 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 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 Primary Care. Failure to 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 form 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 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:_____