WOODLANDS
MEDICAL SPECIALISTS

New Patient Paperwork

Name *(Last, First, M.I.):* ☐ M ☐ F			**Today's Date:**
Patient Nickname *(if applicable)*			**DOB:**
Address:	**City:**	**State:**	**Zip:**
Primary Phone:	**Cell Phone:**		
Email Address:			**SS#**

Emergency Contact Information:

Name: _____

Phone: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ Caucasian ☐ Nat Hawaiian/Pacific Islander ☐ Unknown ☐ Decline to Answer

Ethnicity ☐ Hispanic ☐ Non-Hispanic or Latino

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

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		
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

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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 or have you ever used 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
Depression	In the past two weeks have you felt down, depressed or hopeless?	☐ Yes	☐ No
	In the past two weeks have you felt little interest or pleasure in doing things?	☐ Yes	☐ No
Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	☐ 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?	☐ Yes	☐ No
Drugs	Do you currently use recreational or illicit drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No

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FAMILY HISTORY				
RELATIVE	**AGE (CURRENT OR DEATH)**	**HEART ATTACK OR STROKE**	**CANCER**	**OTHER HEALTH PROBLEMS**
Mother		Heart Attack ☐ No ☐ Yes Age: _____ Stroke ☐ No ☐ Yes Age: _____	☐ No ☐ Yes (type) _____	
Father		Heart Attack ☐ No ☐ Yes Age: _____ Stroke ☐ No ☐ Yes Age: _____	☐ No ☐ Yes (type) _____	
Sibling		Heart Attack ☐ No ☐ Yes Age: _____ Stroke ☐ No ☐ Yes Age: _____	☐ No ☐ Yes (type) _____	
Sibling		Heart Attack ☐ No ☐ Yes Age: _____ Stroke ☐ No ☐ Yes Age: _____	☐ No ☐ Yes (type) _____	
Sibling		Heart Attack ☐ No ☐ Yes Age: _____ Stroke ☐ No ☐ Yes Age: _____	☐ No ☐ Yes (type) _____	
Grandmother *Maternal*		Heart Attack ☐ No ☐ Yes Age: _____ Stroke ☐ No ☐ Yes Age: _____	☐ No ☐ Yes (type) _____	
Grandfather *Maternal*		Heart Attack ☐ No ☐ Yes Age: _____ Stroke ☐ No ☐ Yes Age: _____	☐ No ☐ Yes (type) _____	
Grandmother *Paternal*		Heart Attack ☐ No ☐ Yes Age: _____ Stroke ☐ No ☐ Yes Age: _____	☐ No ☐ Yes (type) _____	
Grandfather *Paternal*		Heart Attack ☐ No ☐ Yes Age: _____ Stroke ☐ No ☐ Yes Age: _____	☐ No ☐ Yes (type) _____	

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APPOINTMENT REMINDERS AND $25 CANCELLATION FEE POLICY

Woodlands Medical Specialists uses various types of electronic communication to remind patients of appointments. If you do not wish to receive these reminders you do have the ability to opt out. Please know, if you are unable to keep your scheduled doctor's appointment, we require a 24-hour notice. In the event that notification is not received 24 hours in advance of the doctor's appointment, the patient is charged a $25 fee. This fee also applies to any work-in appointment that is missed or cancelled.

Patient Initials_____

PRESCRIPTION REFILL POLICY

I understand my doctor's refill policy:

1. Prescription refills MUST be requested through your pharmacy.
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 (HIPAA CONSENT)

I authorize Woodlands Medical Specialists to disclose my health care, billing and medication/prescription 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_____

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_____

Signature of Patient or Legal Guardian: _____ Date:_____

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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 requested specific information from my health record to:

Woodlands Medical Specialists
4724 N Davis Hwy
Pensacola, Florida 32503
Phone: (850) 696-4000 Fax: (850) 434-2647

ROI Policy

HIPAA Consent:

Woodlands Medical Specialists

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 provide authorization to request any records the provider deems necessary for adequate and thorough care including, 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.

I designate the individual(s) listed for disclosure of patient health information as described above for my health care, billing and medications/prescriptions.

☐ I Accept
☐ I Decline

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 up to 30 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: _____