NEW PATIENT PACKET

Todays' Date:

PATIENT DEMOGRAPHICS		
Full Name:		Nickname/Preferred Name:
Date of Birth:		Social Security Number:
Home Telephone Number:		Mobile Telephone Number:
Mailing Address:		
Email Address:		
Preferred Gender:	Marital Status:	Preferred Religion:
Race:	Ethnic Group:	Preferred Language:

INSURANCE INFORMATION	
PRIMARY INSURANCE	SECONDARY INSURANCE
Name:	Name:
ID#	ID#
Group#	Group#

RESPONSIBLE PARTY - ONLY IF NOT PATIENT	
Full Name:	
Date of Birth:	Social Security Number:
Home Telephone Number:	Mobile Telephone Number:
Mailing Address:	
Relationship to Patient:	

EMERGENCY CONTACT/NOTIFICATION OF KIN - SOMEONE NOT IN HOUSEHOLD	
Full Name:	Full Name:
Telephone Number:	Telephone Number:
Relationship to Patient:	Relationship to Patient:

Dear Valued Patient,

We are pleased that you have chosen to partner with us in the care of your health; however, in order to insure that you receive the best care possible and needs are met in the most efficient way, we ask that you review the following office policies.

Compliance	We ask that you make every effort to comply with the provider's recommendations regarding routine follow-up office visits, mediations, labwork/tests ordered, procedures, referrals, etc.
Medication	Please bring ALL of your current medications (or a list) to EVERY appointment
Pain Management	Our office is not a pain management clinic. A referral will be made to a pain management specialist for chronic pain medication management at the discretion of Dr. Hill and/or provider.
Results	A follow-up appointment is required minimally every quarter of the year and labwork or imaging results will be reviewed at the time of your appointment. You will receive a copy of the results at your scheduled follow-up appointment.
Cancellation	Time has been specifically reserved for your appointment, procedure, or treatment. Please call at least 24 hours in advance to cancel appointment. There is a $25 charge if you fail to show for a scheduled appointment or cancel with less than 24 hours notice.

Full Name:	Date of Birth:

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my insurance claim. I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me; I understand and agree that regardless of my insurance status I am responsible for any balance of my account.

I AGREE:

RELEASE OF PRESCRIPTION HISTORY

By signing this consent form you are agreening that your provider at West Volusia Family & Sports Medicine may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes. You may decided not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an affect on any actions taken prior to receiving the revocation. Understanding all of the above, I hereby provide informed consent to West Volusa Family & Sports Medicine to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

I AGREE:

Family, Significant Others, and Friends

Under certain circumstances, we may disclose PHI (Protected Health Information) to family members, other relatives, close personal friends, or others that you identify to improve communication of relevant information (most commonly laboratory results, prescription issues and/or changes, appointment scheduling, etc) to their involvement in your care or payment related to your care; or to notify them of your location, general condition, or death. In compliance with this office's HIPPA policy, I am authorizing West Volusia Family & Sports Medicine's staff to release PHI as necessary to support and assist in my care. Please list each individual authorized to receive information as stated above and provide us with the information requested.

Name:	Relationship:	Telephone:	
Address:	City:	State:	Zip:
Date:	Authorize Release of my PHI to this person		
Name:	Relationship:	Telephone:	
Address:	City:	State:	Zip:
Date:	Authorize Release of my PHI to this person		
Name:	Relationship:	Telephone:	
Address:	City:	State:	Zip:
Date:	Authorize Release of my PHI to this person		
Name:	Relationship:	Telephone:	
Address:	City:	State:	Zip:
Date:	Authorize Release of my PHI to this person		

I hereby expressly acknowledge receipt of West Volusia Family and Sports Medicine's Notice of Privacy Practices

I Agree

Full Name:	Date of Birth:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnare are protected by privacy acts under HIPPA and will become part of your medical record. Fill in the blanks or check appropriate answers.

Previous Primary Care Providers	
Provider: Practice Name: Telephone Number: Fax Number:	Provider: Practice Name: Telephone Number: Fax Number:

* Medical Records Will Be Requested For Review and Included in WVFSM Electronic Medical Record

Current Specialists (Ex: Cardiologist, Pulmonologist, Endocrinologist, Nephrologist, etc)	
Provider: Practice Name: Telephone Number: Fax Number:	Provider: Practice Name: Telephone Number: Fax Number:
Provider: Practice Name: Telephone Number: Fax Number:	Provider: Practice Name: Telephone Number: Fax Number:

* Medical Records Will Be Requested For Review and Included in WVFSM Electronic Medical Record

Patient Preferences	
Pharmacy Name: Address: Telephone Number:	**Laboratory Name:** Address: Telephone Number:
Imaging Center Name: Address: Telephone Number:	**Hospital Name:** Address: Telephone Number:

Reason To Establish At WVFSM/Any Concern That Needs to Be Addressed At First Office Visit

Allergies - List Medication Allergies, Food Allergies, Environmental Allergies - Include Reactions Examples: Bactrim (Antibiotic) - Generalized Rash; Bees - Anaphylaxis
1
2
3
4
5

Full Name:	Date of Birth:

List All Current Prescribed Medications and Over-The-Counter Medications/Supplements Used					
	Drug Name Ex: Metformin	**Dosage (mg, mL)** 500 mg	**Amount** 1 Tablet	**Route (Oral, Inject)** Oral	**Frequency** Twice Daily
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					

PAST MEDICAL HISTORY

Check/Circle if Experienced Any of the Following Childhood Illnesses

Rheumatic Fever Measles Mumps Rubella Polio Chickenpox Pertussis RSV

Current or Previously Diagnosed Medical Conditions

Ophthalmology	Glaucoma	Cataracts	Uveitis	Conjunctivits			Other:
ENT	Ear Infection	Nasal Polyps	Hearing Loss	Tinnitus			Other:
Pulmonary	Asthma	COPD	Fibrosis	Sarcoidosis	Pulm Nodules		Other:
Cardiovascular	Hypertension	Cholesterol	Heart Attack	Murmur	At Fibrillation	Coronary Artery Disease	Other:
Gastroenterology	GERD	Diverticulosis	Colon Polyps	Crohn's/UC	IBS	Hemorrhoids	Other:
Genitourinary	Incontinence	Bladder Prolapse		BPH	Erectile Dysfunction		Other:
OB/GYN	PCOS	Endometriosis	Irregular Menses		Vaginal Prolapse		Other:
Musculoskeletal	Osteoarthritis	Spondylosis	Herniated Disc		Fracture	Osteopenia/Osteoporosis	Other:
Neurology	Migraines	Tremor	Parkinson's	Dementia	Multiple Sclerosis		Other:
Hematology/Onc	Anemia	Blood Clot	Transfusion	Cancer (Specify Type)			Other:
Dermatology	Acne	Rash	Fungal Infection				Other:
Immune/Allergy	Allergies	Hives	Immune Deficiency				Other:
Endocrinology	Hypo or Hyper Thyroid		Diabetes	Addison/Cushing		Testosterone Deficiency	Other:
Nephrology	Chronic Kidney Disease		Polycystic Kidney		Renal Cell Carcinoma		Other:
Rheumatology	Rheumatoid	Lupus	Sjogren's	Fibromyalgia			Other:
Infectious Disease	Hepatitis C	Gonorrhea	Chlamydia	HIV	Lyme Disease		Other:
Psychiatry	Depression	Anxiety	Bipolar	Schizophrenia	ADD/ADHD		Other:
Podiatry	Heel Spur	Bunion	Hammer Toe	Plantar Fasciits			Other:

Full Name:	Date of Birth:

Surgical Procedure History: Provide Date and Surgeon/Provider If Known			
Ophthalmology	Cataracts (Right, Left, Both)	Date	Surgeon
ENT	Tonsillectomy	Date	Surgeon
	Adenoidectomy	Date	Surgeon
	ET Tubes	Date	Surgeon
Pulmonary/Chest	Bronchoscopy/EBUS	Date	Surgeon
	VATS (Video-Assisted Thorocotomy)	Date	Surgeon
Cardiovascular	Carotid Endarterectomy	Date	Surgeon
	Cardiac Catheterization	Date	Surgeon
	Stent Placement	Date	Surgeon
	Pacemaker/AICD	Date	Surgeon
	Aortic Aneurysm Repair	Date	Surgeon
	Vascular Bypass	Date	Surgeon
Gastroenterology	EGD	Date	Surgeon
	Colonoscopy	Date	Surgeon
	Cholecystectomy	Date	Surgeon
	Gastric Bypass	Date	Surgeon
	Appendectomy	Date	Surgeon
Genitourinary	Bladder Suspension	Date	Surgeon
	TURP	Date	Surgeon
OB/GYN	Hysterectomy	Date	Surgeon
	Ovaries/Tubes	Date	Surgeon
	Tubal Ligation	Date	Surgeon
Breast	Mastectomy (Right, Left, Both)	Date	Surgeon
	Lumpectomy	Date	Surgeon
	Biopsy	Date	Surgeon
Musculoskeletal	Hip Replacement (Right, Left, Both)	Date	Surgeon
	Knee Replacement (Right, Left, Both)	Date	Surgeon
	Herniated Disc Repair	Date	Surgeon
Dermatology	Mohs' Surgery	Date	Surgeon
Endocrinology	Thyroidectomy (Partial, Total)	Date	Surgeon
Nephrology	Nephrectomy (Right or Left)	Date	Surgeon
Podiatry	Bunion	Date	Surgeon
	Hammer Toe	Date	Surgeon
Other		Date	Surgeon
Other		Date	Surgeon
Other		Date	Surgeon
Other		Date	Surgeon

Hospitalizations Within The Last 3 Years		
Dates Hospitalized	**Name of Hospital**	**Reason For Hospitalization**
1		
2		
3		
4		
5		

Full Name:	Date of Birth:

Family History			
	Alive or Deceased	**Age (Current or at Death)**	**Medical Conditions**
Father			
Mother			
Siblings Gender, Age, Health			
Children Gender, Age, Health			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			

Social History: Health Habits and Personal Safety **All Questions in This Section Are Optional and Will Be Confidential in Compliance with Privacy Policies**		
Meals Consumed		(#) Meals Consumed on Daily Basis
Smoking History Cigarettes/Cigars Chew Tobacco		Never Smoker Current Smoker (#) Packs Per Day (#) Years Former Smoker (#) Packs Per Day (#) Years Year Quit Interest in Quitting: Yes or No
Alchohol Consumption		None Beer Wine Mixed Drinks/Coolers Other (#) Servings Per Week Concerned About Your Drinking? History of Blackouts? Binge Drinking? Drive After Drinking?
Caffeine Consumption		None Coffee Tea Cola Other (#) of Cups/ Cans Per Day
Exercise Weekly Basis		Sedentary (No Exercise) Mild Exercise (Walks 3 Blocks, Climb Stairs, Golf) Occasional Exercise (Work or Recreation, Less than 4x/week for 30 min) Regular Exercise (Work or Recreation, 4x/week or more for 30 min)
Health and Personal Safety		Do you live alone? Do you have frequent falls? Do you rely on contacts or glasses to correct vision? Do you rely on hearing aids to correct loss of hearing? Do you rely on dentures?
Personal Wishes		Do you have an Advance Directives or Living Will? If Yes, please furnish copy. Have you designated a Healthcare Surrogate? If Yes, please furnish copy. Are you an Organ Donor?
Travel History		Any Travel Outside of the US in the Past 6 Months?

Full Name:	Date of Birth:

Urinary/Infectious Concerns
Do you have a history of recurrent urinary tract, bladder, or kidney infections?
Do you have problems with control of urination?
Do you feel any pain or burning with urination?
(#) of Times You Get Up During the Night to Urinate
Have you had any of the following infections: HPV Herpes HIV Chlamydia Conorrhea

Sexual/Reproductive Health		
Are you sexually active?		
If not trying for pregnancy, what methods are used for prevention?		
Any discomfort (pain or dryness) with intercourse?		
Any problems with frequency or loss of interest in intercouse?		
(Females)	Age at Start of Menstruation	Age at Menopause
(Females)	Date of Last Menstral Period	
(Females)	How Many Pregnancies?	How Many Live Births?
(Females)	Are You Pregnant?	Are You Breastfeeding?
(Males)	Any difficulty with erection or ejaculation?	
(Males)	Any testicle pain or swelling?	

Vaccination History					
Vaccine Name	**Date**	**Vaccine Name**	**Date**	**Vaccine Name**	**Date**
Tetanus		Pneumococcal 23		Varicella	
Influenza		Prevnar 13		Shingles	
Hepatitis (Series of 3)		MMR		HPV	
				Meningiococcal	

Preventative Screenings		
Screening Exam/Imaging	**Date of Exam/Screening**	**Location Completed**
Last Physical/Wellness Exam		
Eye Exam		
Dental Exam		
Hearing Exam		
Diabetes Screening (Labwork)		
Cholesterol Screening (Labwork)		
Screening Mammogram		
PAP Smear		
Rectal Exam		
Prostate Specific Antigen (PSA)		
Lung Cancer Screening (CT)		
Colonoscopy/Cologuard		
Osteoporosis (DEXA)		
Abd Aortic Aneurysm (AAA)		