Faith Family Wellness
207 Aberdeen Parkway Panama City, FL 32405
PH: (850) 788-3120 / FAX: (850) 788-3125

What is the reason for your visit today?
How did you hear about our office/who can we thank?

Patient Information			
Name (First, Middle, Last)	Birth Date	Age	Birth Gender ❑Male ❑Female
Marital Status: ◻ Single ◻ Married ◻ Divorced ◻ Widowed			Phone#
Spouse Name	Spouse Phone #		
Mailing Address	Apt# City	City, State, ZIP	
Email Address			
Employer (or parent/guardian employer if patient is a minor)			Work Phone#
Preferred Language			**Ethnicity:** Hispanic or Latino Not Hispanic or Latino
Race African American Asian Caucasian Hispanic Native American Native Hawaiian Pacific Islander Other ________________________ Prefer not to answer			

Guarantor/Responsible Party		
Legal Name of Responsible Party	**Birth Date**	**Relationship to Patient**

Medical Insurance (Please present ID & insurance card to the front desk)		
PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Policy Holder Name	Insured Date of Birth	Patient Relationship ◻Self ◻Spouse ◻Dependent
SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship ◻Self ◻Spouse ◻Dependent

Emergency Contact		
Contact Name	Phone Number	Relationship to Patient

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Faith Family Wellness or insurance company to release any information required to process my claims.

____ _____________________________

Patient/Guardian signature Date

Patient Name ____ **Date of Birth:** ____________________

PAST MEDICAL HISTORY Please Mark All That Apply (☑) No Known History □

Constitutional
□ Weight loss or gain
□ Fever or chills
□ Trouble sleeping
□ Fatigue
□ Weakness
□ Sleep Disturbance

Head
□ Headache
□ Head injury
□ Metal in head

Neck
□ Pain
□ Swollen glands
□ Stiffness

Eyes
□ Vision Problems
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Glaucoma
□ Cataracts
□ Legally Blind

Ears
□ Hearing loss
□ Hearing Aide
□ Earache
□ Ringing in ears
□ Vertigo

Nose
□ Sinus pain
□ Frequent sneezing
□ Snoring
□ Nosebleeds
□ Hay fever
□ Sleep apnea

Mouth/Throat
□ Dry mouth
□ Non-healing sores
□ Sore throat
□ Dentures
□ Jaw claudication (pain in the jaw when chewing)

Cardiovascular
□ Chest pain
□ Shortness of breath with activity
□ Palpitations
□ Difficulty breathing lying down
□ Swelling of the feet
□ Abnormal Heart Rhythm

Respiratory
□ Cough (dry or wet, productive)
□ Sputum (color and amount)
□ Coughing up blood (hemoptysis)
□ Shortness of breath (dyspnea)
□ Wheezing
□ Painful breathing

Women:
□ Abnormal period
□ Abnormal PAP
□ Abnormal bleeding

Gastrointestinal
□ Ulcer
□ Hiatal Hernia
□ Frequent heartburn/indigestion
□ Gall bladder attacks/gallstones
□ Frequent Diarrhea
□ Frequent Constipation
□Acid Reflux/GERD
□ Abdominal Pain
□Yellow eyes or skin
□ Nausea
□ Blood in Stool

Genitourinary
□ Urinary Tract Infection-frequent
□ Pain/burning with urination
□ Trouble starting urinary stream
□ Frequent night urination
□ Kidney stones/infection
□ Blood in Urine in the past year

MEN:
□ Prostate Problems
□ Prostatic Disease

Musculoskeletal
□ Joint pain/problems
□ Muscle pain
□ Osteoporosis
□ Joint Replacement
□ Fibromyalgia
□ Arthritis
□ Metal in Body
□ Rheumatoid Arthritis

Skin/Integumentary
□ Rashes
□ Dry Skin
□ Skin wound
□ Change in Mole
□ Itching
□ Skin Cancer

Neurologic
□ TIA (***transient ischemic attack***
□ Numbness
□ Paralysis
□ Fainting
□ Seizures
□ Epilepsy
□ Memory loss/lapses

Psychiatric
□ Stress
□ Depression
□ Anxiety
□ Alzheimer's
□ Dementia
□ Nervousness

Endocrine
□ Hyperthyroid
□ Hypothyroid
□ Thyroid Disease
□ Cold Intolerance
□ Heat Intolerance

Hematologic
□ Anemia
□ Easy bruising
□ Easy bleeding
□ Previous Blood Transfusion

Vascular
□ Calf pain with walking (Claudication)
□ Leg cramping

Other: ____

Patient Name ______________________________ **Date of Birth:** ______________

PATIENT MEDICAL HISTORY

HEIGHT:	**WEIGHT:**
ALLERGIES (include medication, food latex and environmental allergies**)**	**No Known Allergies**□

Allergy to 1. ____________________________ 2. ________________________ 3. _____________________

Severity/Reaction _____________________ ________________________ ______________________

CURRENT MEDICATION/SUPPLEMENTS (May provide detailed list or bring in bottles) **No Current Medication** □

Medication Name	Dose	Frequency

Preferred Pharmacy

Pharmacy Name __________________________ **Address:** _______________________ **Phone**______________

PROCEDURES/SURGERIES **No Surgeries/Procedures** □

____ ____

Date Surgery Date Surgery

____ ____

Date Surgery Date Surgery

HEALTH MAINTENANCE CHECK RECENT TEST - Give month/year of last exam

Bone Density: __________________________ Tetanus Shot: ___________________________

Colonoscopy: _________________________ Flu Shot: _________________________________

Eye Exam: _____________________________ Last Labs-When/Where**:**_________________________

Dental Exam: _________________________ Professional Skin Exam: _____________________

Physical: _______________________________

WOMEN'S HEALTH

No. of Pregnancies: _______ No. of Deliveries: ________Last Menstrual cycle: _______________ Pregnant:_____________

Mammogram: _____________ Pap Smear: ________________ □ Abnormal bleeding □ Abnormal PAP □ Abnormal period

MEN'S HEALTH

PSA Lab Test:_________________ PSA Screening:______________ Other:_______________________________________

Patient Name ____ **Date of Birth:** ____________________

ARE YOU INTRESTED IN LEARNING MORE ABOUT ? (check all that apply)

❑ Botox ❑ Filler ❑ Micro Needling ❑Micro-Needling with PRP ❑ Facial/HydraFacial ❑ Massage
❑ IV therapy (fluid hydration) ❑ Weight Loss Program ❑ Nutrition Consult ❑ Zo Medical Skin Care Products

SOCIAL HISTORY

TOBACCO HISTORY

Are you an active cigarette smoker? □ Yes □ No
Have you ever been a cigarette smoker? □ Yes □ No
If yes, I smoked an average of ____________
packs/day for __________ years.

I quit in _________(year)
Do you use other tobacco products? □ Yes □ No
If yes, please specify:
Oral Tobacco, Cigars, Pipe, Electronic Cigarettes

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? □ Yes □ No
Do you currently drink alcohol regularly? □ Yes- currently □ Never □ Rarely
If yes, approximately how many drinks per week (beer, wine, or liquor) ________________________________
Have you ever used intravenous drugs? □ Yes □ No

FAMILY HISTORY: Is there an history your family of? (check all that apply)

NO Significant Family History is Known ☐

	Mother	**Father**	**Brother/ Sister**	**Grandmother** *(Maternal)*	**Grandmother** *(Paternal)*	**Grandfather** *(Maternal)*	**Grandfather** *(Paternal)*
High Cholesterol							
Heart Attack							
Diabetes							
Prostate Cancer							
Kidney Cancer							
High Blood Pressure							
Kidney stones							
Other significant disease?							

Patient Name ____ **Date of Birth:** ___________________

FINANCIAL AND CONSENT FOR TREATMENT AUTHORIZATION FORM

Please carefully review and initial the following rules and regulations related to our office. Please always try to follow these regulations as they are intended to make the workflow in our office more efficient and practical. If you have any questions about these, please do not hesitate to ask one of our office staff members.

________ AUTHORIZATION FOR MEDICAL CARE AND TREATMENT: Consent for Treatment I consent freely and voluntarily to participate in the treatment that may be ordered by my health care provider. I understand that I may withdraw consent at any time. This may include but is not limited to Telemedicine services, outpatient treatment, and diagnostic procedures by the Faith Family Wellness as may be deemed necessary or advisable by my provider /or consultants. If I need additional treatments or procedures my consent will be obtained except in emergencies or unusual circumstances.

________I authorize the release of any medical or demographic information to determine medical benefits or to facilitate payment for such services.

________I understand that I am financially responsible to Faith Family Wellness and the clinic for any charges not covered by my healthcare benefits. It is my responsibility to notify the aforementioned provider of health coverage changes or additions in a timely fashion. I understand that if all or part of the balance is denied by insurance, I am responsible for the balance in full.

________I understand that payment for services are due in full at the time of service unless other arrangements have been made in advance. At the time of service, I will pay for my co-pay or co-insurance portion and/or deductible.

_______ I authorize Faith Family Wellness to file my medical insurance. I request payment of the authorized insurance benefits, including Medicare (if I am a Medicare beneficiary) be made to the a fore mentioned provider for any services or equipment provided. A photocopy of this assignment will be considered effective and valid as the original.

PRESCRIPTIONS

_____________ Prescription refills take 72 hours to process and complete. Please allow yourself at least three business days to get the medication filled. Please plan ahead if the prescription is due on a weekend or holiday and give us enough time to prepare the prescription.

________ I understand that Faith Family Wellness may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my provider and my pharmacy. I have been informed and understand that my provider using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my provider to see this health information.

LATE POLICY /NO SHOW POLICY

_____________ If you are running late for your appointment, please contact our office. We will determine whether or not your appointment will need to be rescheduled. If you arrive more than 15 minutes late to your scheduled Appointment time, we will make an effort to accommodate you. However, your appointment may be rescheduled.

_____________ We may charge you a $25.00 “No Show” fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

Patient Signature: ____ Date: ______________

Patient Name ____ Date of Birth: ___________________

Faith Family Wellness
207 Aberdeen Parkway Panama City, FL 32405
PH: (850) 788-3120 / FAX: (850) 788-3125

AUTHORZATION TO DISCLOSE HEALTH INFORMATION & MEDICAL RECORDS

I hereby authorize the release of my medical records and understand that may include information relating to sexually transmitted disease, AIDS, HIV, behavioral or mental services, and treatment for alcohol and drug abuse. 1 understand that I have the right to inspect and obtain a copy of the information to be disclosed. The cost of copying and releasing the medical records, if any, has been explained to me. Unless revoked, this authorization will expire in one year. I understand that the revocation will not apply to any information that has been released as a result of this authorization. The authorization to disclose health information is voluntary. I am aware that this information is subject to disclosure by the recipient and may no longer be protected by the Privacy Rule.

Patient Name: ______________________________________

____ _________________________
Patient Signature or Representative Date

____ __________________________
Relationship to Patient Date of Birth

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Private Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information. Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. If this consent is signed by a personal representative on behalf of the patient, complete the following:

____ __________________________
Patient Signature or Representative Date

____
Relationship to Patient

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, ______________________________ give *Faith Family Wellness* permission to release and/or discuss my medical records or conditions with the following individual(s):

NAME	Relationship to the patient

I understand that the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do it in writing.

Patient Signature: ____