**ADVANCED MEDICAL OF FLORIDA**
1528 Lakeview Rd. Suite 150, Clearwater FL 33756

P: (727) 408-5222
F: (727) 408-5252

## NEW PATIENT INFORMATION

Date: ____/____/____

Name ______________________ Age _______ Sex _____ Date of Birth ____/____/____

Street Address ______________________ City ____________ State ________ Zip __________

Home Phone (____)_____-______ Cell Phone (____)_____-______ E-mail ______________________

Social Security Number _____-_____-_____ Employer ______________

Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact Name ______________________ Phone (____)_____-_____ Relationship __________

### HOW DID YOU FIND US?

☐ My Doctor __________ ☐ Family/Friend ____________ ☐ Google ☐ Expo/Trade Show

☐ Social Media __________ ☐ Insurance Company __________ ☐ Newspaper ☐ Postcard/Letter

☐ Outdoor Sign ☐ Other ____________________

## PATIENT'S PHYSICIAN INFORMATION

Primary Care Physician Name ______________________ Phone (____)_____-________

Referring Physician Name ______________________ Phone (____)_____-________

Welcome to our multi-specialty group practice, offering pain management medical care, chiropractic, physical therapy, and rehabilitation. We will strive to help restore or improve your health, but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients, regardless of race, color, national origin, age, sex, disability, or religious or political beliefs quality health care services delivered with dignity & concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. This Notice is detailed on page -3- of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or all staff of this Facility to use and share your confidential health information with others or to treat you and/or in order to arrange for payments of your bill and/or for issues that concern this Facility's operations and responsibilities. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment please notify us. We are available to immediately see new patients the same day. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know.

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## SYMPTOM SURVEY

What is your chief problem or symptoms? ______________________________

What caused the problem or symptoms to occur? ______________________________

When did they start? ______________________________

What tests/procedures have been performed? ☐ X-Ray ☐ MRI ☐ Surgery ☐ Hospitalization

Have you seen another office or provider for this problem? ☐ No ☐ Yes Name: ______________________

Have you tried any other treatments for this? ☐ No ☐ Yes Explain: ______________________

Is the problem or symptoms getting worse: ☐ No ☐ Yes Explain: ______________________

## PATIENT & FAMILY HISTORY

Preferred Language ______________ Race ______________

Do you use tobacco? ☐ No ☐ Yes Frequency (Packs/day): __________ ☐ Quit (Date) __________

Do you consume alcohol? ☐ No ☐ Yes Frequency (Drinks/Day or Drinks/Week): ______________

Do you consume caffeine? ☐ No ☐ Yes Frequency (Cups/Day or Cups/Week): ______________

Do you have a history of substance abuse? ☐ No ☐ Yes Frequency: ______________

Do you use recreational drugs? ☐ No ☐ Yes Frequency: ______________

Do you use medical or non-medical Marijuana? ☐ No ☐ Yes Frequency: ______________

Severe accidents or trauma & dates ______________________________

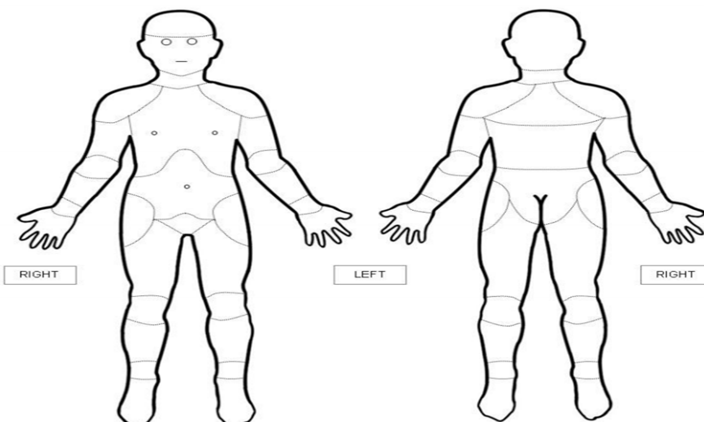
List all allergies: ______________________________

Topical Allergies: ☐Iodine ☐Latex ☐Tape Are you allergic to shellfish? ☐Yes ☐No

| **Family History** | **Current State of health & history of problems** | |
|---|---|---|
| Father | ______________________ | ☐Deceased - cause of death: ______________ |
| Mother | ______________________ | ☐Deceased - cause of death: ______________ |
| Siblings | ______________________ | ☐Deceased - cause of death: ______________ |

## PAIN DRAWING

**Circle** location(s) of your symptoms or pain on the body drawing.




On a scale of 1 to 10 how would you rate your pain level?
__________ (1 = Mild, 10 = Intense)

What if anything gives you relief?
______________________________

What makes your pain worse?
______________________________

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# PAST MEDICAL HISTORY

Please Mark All That Apply (☑)

**General Medical**

- ☐ Cancer ______________
- ☐ Diabetes ______________
- ☐ HIV /AIDS
- ☐ Pregnancy
- ☐ ______________________

**HEENT**

- ☐ Eye Pain/Strain
- ☐ Glaucoma
- ☐ Headache
- ☐ Head Injury
- ☐ Migraine
- ☐ ______________

**Cardiovascular / Hematologic**

- ☐ Anemia
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Mitral Valve Prolapse
- ☐ Murmur
- ☐ Phlebitis
- ☐ Poor Circulation
- ☐ Pacemaker
- ☐ Stroke
- ☐ ______________________

**Endocrine**

- ☐ Diabetes Type____
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ _________________

**Respiratory**

- ☐ Asthma
- ☐ Bronchitis Pneumonia
- ☐ COPD/Emphysema
- ☐ Shortness of breath
- ☐ Tuberculosis
- ☐ ___________________

**Gastrointestinal**

- ☐ Bowel Incontinence
- ☐ Constipation
- ☐ Gastrointestinal Bleeding
- ☐ GERD (Acid Reflux)
- ☐ Groin/Rectal Pain
- ☐ Hepatitis ___________
- ☐ ___________________

**Musculoskeletal**

- ☐ Amputation
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Chronic Neck Pain
- ☐ Chronic Joint Pain
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Phantom Limb Pain
- ☐ Rheumatoid arthritis
- ☐ Tennis Elbow
- ☐ Vertebral Compression Fracture
- ☐ ___________________

**Genitourinary/Nephrology**

- ☐ Kidney Infection(s)
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ ___________________

**Neuropsychological**

- ☐ Alcohol Abuse
- ☐ Alzheimer Disease
- ☐ Bipolar Disorder
- ☐ Depression/Anxiety
- ☐ Epilepsy/Seizures
- ☐ Multiple Sclerosis
- ☐ Prescription Drug Abuse
- ☐ Paralysis
- ☐ Peripheral Neuropathy
- ☐ Schizophrenia
- ☐ RSD/CRPS
- ☐ _________

| List of Prior Surgeries | Date (Month/Year) |
|---|---|
| ______________________________________________________ | ___________________ |
| ______________________________________________________ | ___________________ |
| ______________________________________________________ | ___________________ |
| ______________________________________________________ | ___________________ |
| ______________________________________________________ | ___________________ |

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## HEALTH CARE PRIVACY NOTICE - INFORMED CONSENT - ASSIGNMENT OF BENEFITS - AUTHORIZATION & LIEN

This office is committed to providing patients with quality healthcare services delivered with dignity, respect and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff. This Facility is required by law to abide by the terms of this Health Care Privacy Notice, Patient Bill of Rights and Informed Consent as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at any time without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility. Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstanding or concern to the Compliance Office of this Facility. Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must be in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with state law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you. You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice. You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated.You can obtain a complaint form from the Compliance Officer and/or the Office of Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility. I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However, as with any diagnostic test, procedure, examination or doctor's care, a guarantee of improvement or complete recovery cannot and has not been made and it is even possible that no change will occur. Our Facility further wants you to understand your Patient Bill of Rights, options for care and risks of treatments rendered by us. In the practice of medicine, surgery, chiropractic, spinal or joint manipulations/adjustments, podiatry, psychological counseling, massage, physical, occupational, speech & respiratory therapy there are some risks. These risks may include but are not limited to soreness, dizziness, fractures, joint injury, disk injuries, strokes, heart-attacks, dislocations, sprains-strains, drug interactions, procedural complications, reactions and/or other injuries which may be short or long term side effects which cannot be predetermined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgement during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. As our patient you can voluntarily stop care or ask questions about reasonable alternatives to the procedures we will recommend including but not limited to rest, home applications of therapy, prescription or over-the-counter medications, exercises and/or referral to a medical/surgeon specialist. In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you. Therefore I give my full consent to the doctor/provider to render treatment on me or the minor whom I am legally responsible for by a healthcare provider of this Facility. I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgement or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility. I, the assignee further authorizes any & all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and/or including all insurance or third party benefits. Assignee agrees that this Facility and staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of an attorney to endorse and/or sign my name on any & all checks for payment of any indebtedness owed this office and assignee.

## INSURANCE BENEFITS - CREDIT POLICIES - PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal, or other obligations or arrangement between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefits may result in an additional filing or medical report chargers, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgement, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products, and services rendered to the patient or minor shown below.
5. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.
6. A service charge is computed by a 'periodic rate' of 1.5% per month - 18% per annum and is added to all balances over 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly services charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fees. Returned checks, debit and credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.
7. Patients are eligible for a maximum $250 personal credit limit when approved. For your convenience we accept most major credit & debit cards.

## PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original. I have made my decision voluntarily and freely to submit for healthcare services in this Facility.

______________________________
Print Name

______________________________   ____/____/____
Signature of Patient   Date

# MEDICATION LIST

| Medication Name: | Dosage: | Frequency: |
|---|---|---|
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## IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE BELOW

☐ **AUTO ACCIDENT** Date of Accident ____/____/____ Location ________________________

Were You.....

☐ Driver ☐ Treated at Hospital ☐ Unconscious
☐ Passenger ☐ Wearing a Seatbelt ☐ Transported by Ambulance

Vehicle Damage

☐ Minimal - Moderate ☐ Severe - Totaled

Police Report

☐ None ☐ Yes, with Police Department ________________________________

Activities

☐ No Restrictions ☐ Missed _____ days of work or school ☐ I felt fine before the accident

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☐ **WORK RELATED** Date of Accident ____/____/____ Location ________________________

Describe injury and how it happened:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Accident Reported to: ________________________________________________________

Activities

☐ No Restrictions ☐ Missed ____ days of work or school ☐ I felt fine before the injury

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# REVIEW OF SYSTEMS

Please Mark All That Currently Apply (☑)

**1. Constitutional**
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Exercise Intolerance
- ☐ Lethargy/Sedation

**2. Eyes**
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Changes

**3. ENMT - Ears**
- ☐ Difficulty Hearing
- ☐ Ear Pain

**4. ENMT - Nose**
- ☐ Nosebleeds
- ☐ Nose Problems
- ☐ Sinus Problems

**5. ENMT - Mouth/Throat**
- ☐ Sore Throat
- ☐ Bleeding Gums
- ☐ Snoring
- ☐ Dry Mouth
- ☐ Oral abnormalities
- ☐ Mouth Ulcer
- ☐ Teeth abnormalities
- ☐ Mouth Breathing

**6. Cardiovascular**
- ☐ Chest Pain on exertion
- ☐ Arm Pain on exertion
- ☐ Shortness of breath:
  - ☐ with walking
  - ☐ with lying down
- ☐ Palpitations
- ☐ Heart Murmur
- ☐ Light-headed on standing

**7. Respiratory**
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Coughing Up Blood
- ☐ Sleep Apnea

**8. Gastrointestinal**
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Change in Appetite
- ☐ Black or Tarry Stool
- ☐ Frequent Diarrhea
- ☐ Vomiting Blood
- ☐ Dyspepsia
- ☐ GERD - Reflux

**9. Genitourinary**
- ☐ Urinary Loss of Control
- ☐ Difficulty Urinating
- ☐ Increased Urine Freq.
- ☐ Hematuria
- ☐ Incomplete Emptying

**10. Musculoskeletal**
- ☐ Muscle Aches
- ☐ Muscle Weakness
- ☐ Arthralgias/Joint Pain
- ☐ Back Pain
- ☐ Swelling in the Extremities

**11. Integumentary**
- ☐ Abnormal Mole
- ☐ Jaundice
- ☐ Rash
- ☐ Itching
- ☐ Dry Skin
- ☐ Growth/Lesions
- ☐ Laceration

**12. Neurological**
- ☐ Loss of Consciousness
- ☐ Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Dizziness
- ☐ Frequent Headaches
- ☐ Migraines
- ☐ Restless Legs
- ☐ Tremor

**13. Psychiatric**
- ☐ Depression
- ☐ Sleep Disturbances
- ☐ Feeling Unsafe in Relationship
- ☐ Restless Sleep
- ☐ Alcohol Abuse
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Suicidal Thought

**14. Endocrine**
- ☐ Fatigue
- ☐ Increased Thirst
- ☐ Hair Loss
- ☐ Increased Hair Growth
- ☐ Cold Intolerance

**15. Hematologic/Lymphatic**
- ☐ Swollen Glands
- ☐ Easy Bruising
- ☐ Excessive Bleeding

**16. Allergy/Immunologic**
- ☐ Runny Nose
- ☐ Sinus Pressure
- ☐ Itching
- ☐ Hives
- ☐ Frequent Sneezing