Holistic Medical Care Clinic
400 Frandorson Cir #103, Apollo Beach FL 33572
Tel # 813 – 398 -0470 Fax #1-888-972-7928

Patient Registration form

DATE_____ PROVIDER_____

PATIENT INFORMATION

NAME LAST	FIRST	MI	DRIVER'S LICENCE #		
HOME PHONE ( )	SS#	D.O.B.	MO 1	DAY 1 /	YEAR SPOUSE'S NAME

RESPONSIBLE PARTY (If not Patient)

NAME LAST	FIRST	MI	DRIVER'S LICENCE #		
HOME PHONE ( )	SS#	D.O.B.	MO 1	DAY /	YEAR SPOUSE'S NAME
EMPLOYER	WORK PHONE ( )		EXT.		
HOME ADDRESS	CITY		STATE		ZIP

PREFERRED PHARMACY INFORMATION

PHARMACY NAME		PHONE ( )	
ADDRESS	CITY	STATE	ZIP

**Does your Insurance Offer Routine or Preventive Care Services? If yes, we need a copy of your handbook

INSURANCE INFORMATION **WE NEED A COPY OF YOUR INSURANCE CARDS AND DRIVER'S LICENCE. IF YOU HAVE YOUR CARDS, DO NOT COMPLETE THIS SECTION**

PRIMARY INSURANCE	ID#	GROUP #		CO-PAY
POLICY HOLDER'S NAME LAST	FIRST		MI	
DATE OF BIRTH	SEX (CIRCLE) M F		RELATIONSHIP TO PATIENT	
EMPLOYER	WORK PHONE ( )		EXT.	
SECONDARY INSURANCE	ID#	GROUP #		CO-PAY
POLICY HOLDER'S NAME LAST	FIRST		MI	
DATE OF BIRTH	SEX (CIRCLE) M F		RELATIONSHIP TO PATIENT	
EMPLOYER	WORK PHONE ( )		EXT.	

I consent to treatment necessary for the care of the above named patient. I acknowledge full financial responsibility for services rendered by Holistic Medical Care Clinic, I agree to pay all reasonable attorney fees and collection costs in the event of default of payment. I have read and fully understand the above consent for treatment and financial responsibility.

Date _____ Signature _____

PATIENT NAME _____

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MEDICARE EXTENDED PATIENT SIGNATURE AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE PHYSICIANS OF HOLICSTIC MEDICAL CARE CLINIC FOR ANY HOLDER OF MEDICAL INFORMATION ABOUT TO RELEASE TO HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NECESSARY TO DETERMINE THESE BENEFITS OR THE BENEFITS FOR RELATED SERVICES.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

PERSON OTHER THAN PATIENT RELATIONSHIP TO PATIENT

ROUTINE OR PREVENTIVE CARE ACKNOWLEDGEMENT

IF YOUR INSURANCE PROVIDES ROUTINE OR PREVENTIVE CARE SERVICES, IT IS YOUR RESPONSIBILITY TO PROVIDE THIS OFFICE WITH A COPY FROM YOUR HANDBOOK IDENTIFYING THESE SERVICES TO THE PHYSICIAN BEFORE COMPLETION OF YOUR PHYSICAL.

_____ _____

PATIENT SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES RECEIPT

I HAVE RECEIVED AND REVIEWED THE NOTICE OF PRIVACY PRACTICES PROVIDED BY HOLICTIC MEDICAL CARE CLINIC.

_____ _____

PATIENT SIGNATURE DATE

FINANCIAL RESPONSIBILITY AND MEDICAL RECORDS

I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT. I AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO HOLISTIC PRIMARY CARE CLINIC WILL ATTEMPT TO COLLECT ASSIGNED INSURANCE BENEFITS FOR A PERIOD OF 45 DAYS AFTER DATE OF SERVICE AT WHICH TIME PAYMENT OF THE FULL AMOUNT WILL BE MY RESPONSIBILITY. I REALIZE THAT HOLISTIC MEDICAL CARE CLINIC MAY SEEK ASSISTANCE OUTSIDE THIS OFFICE TO EXPEDITE COLLECTION OF THE BALANCE DUE.

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO THE REFERRING AND HEALTH CARE PROVIDERS AND TO MY INSURANCE COMPANY, IF APPLICABLE. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS IF NECESSARY.

_____ _____

PATIENT SIGNATURE DATE

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PATIENT INTAKE

Important: This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible, even if you do not feel certain questions pertain to your present condition. Thank you.

Patient Name: (Last) _____(First)_____ (MI) _____
Patient Address: _____City: _____State: _____Zip: _____
Home Phone: _____ Mobile/Cellular: _____
Email: _____ preferred contact method: email / phone
Birth date: _____Age: _____Sex: M ☐ F ☐
Country of Birth: _____Country of Parents' Birth: _____
Education: ☐Elementary ☐ High School/Tech School ☐2-yr College ☐4-yr College ☐Grad. School (Check Highest Level)

Employment Information:

Patient Employer: _____Occupation: _____
Number of years in this type of work_____
Retired: Number of years in retirement:_____ Occupation when in workforce (please fill out the previous line)
Social Security: _____Drivers License: _____

Marital Status: ☐single ☐ married ☐ divorced ☐widowed ☐ with a significant other
Are you a caregiver for dependents? ☐Yes ☐ No If yes, how many children?_____ How many adults_____
How did you hear about us? Please circle one and write the name

- ☐ Current patient: _____
- ☐ Friend: _____
- ☐ Doctor: _____
- ☐ Insurance: _____
- ☐ Advertisement: _____
- ☐ Other: _____

Are you currently under the care of any other health care provider (physician, chiropractor, therapist, massage therapist,etc.)? ☐ Yes ☐No

If yes, please provide:
Title of the practitioner(s)_____
The condition being treated _____
The length of time you have been receiving this treatment _____

Emergency Contact:

Name: _____ Phone: _____
Patient's Spouse:_____ Phone: _____
Referred by: _____

SOSIAL HISTORY

Birthplace _____ Nationality _____ Religion _____
Do you currently smoke? ☐ Yes ☐No
If yes, what?_____ How much per day?_____ How long?_____

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Did you previously smoke? ☐ Yes ☐ No
If yes, what?_____ How much per day?_____ How long?_____

Do you currently drink alcohol? ☐ Yes ☐ No
If yes, what?_____ How much?_____ How often?_____

Do you exercise regularly? ☐ Yes ☐ No
If yes, please describe what you do:_____
How many hours a week: _____

Emotional stress scale

Please circle

1 2 3 4 5 6 7 8 9 10

No Stress → Moderate → Extremely stressed

What do you do when you want to release stress and/or just relax?

_____

_____

How many hours do you usually sleep per night?_____ When do you go to bed?_____
Do you wake up feeling refreshed?_____
Your present height (in)_____ Your present weight (lb)_____ Your weight one year ago(lb)_____
The most you have ever weighed (lb)_____ When?_____
How often do you have a bowel movement? _____

PAST MEDICAL HISTORY

Have YOU ever had? (IF YES, CHECK APPROPRIATE BOXES)

- ☐ Cancer
  Type:_____
- ☐ Heart attack/coronary
- ☐ Artery disease
  type _____
- ☐ Rheumatic fever
- ☐ Heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Gallstones
- ☐ Liver disease
- ☐ Hepatitis/Jaundice
- ☐ Ulcer disease
- ☐ Heartburn/reflux
- ☐ Asthma
- ☐ Seizures
  type_____
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Positive TB Skin Test
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Gout
- ☐ Frequent bladder infection
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Polio
- ☐ Chicken pox
- ☐ Infectious Mono
- ☐ Anemia
- ☐ Frequent Sinus Infections
- ☐ Glaucoma
- ☐ Thyroid problems, define
  _____
- ☐ Hives
- ☐ Depression
- ☐ Head injury define
  _____
- ☐ Broken bones
- ☐ Blood transfusions
- ☐ Sexually Transmitted Disease: Herpes, HIV
- ☐ Gonorrhea, Chlamydia
- ☐ Syphilis
- ☐ Intravenous drug abuse
- ☐ Needle injury
- ☐ Mumps
- ☐ Migraines
- ☐ Prostate Enlargement
- ☐ Malaria
- ☐ Other _____

IMMUNIZATIONS:

- ☐ Pneumococcal vaccine

- ☐ Tetanus booster date _____
- ☐ Measles, mumps and rubella vaccine
- ☐ Chicken pox vaccine
- ☐ Influenza vaccine date _____
- ☐ Shingles vaccine

PAST SURGICAL HISTORY: If yes, please check the box and enter the year.

☐ Eyes (Laser or Vision Corrected)	_____	☐ Intestine/Colon	_____	☐ Vasectomy	_____
☐ Eyes (Cataract/Glaucoma)	_____	☐ Hemorrhoids	_____	☐ Tubal Ligation	_____
☐ Ears	_____	☐ Hernia	_____	☐ Varicose Veins	_____
☐ Sinus/Nasal Septum	_____	☐ Breast	_____	☐ Prostate	_____
☐ Tonsils/Adenoid	_____	☐ Uterus/Hysterectomy	_____	☐ OTHER	_____
☐ Thyroid	_____	☐ Ovaries	_____	_____	
☐ Heart	_____	☐ Spinal Surgery/Neck	_____	_____	
☐ Stomach	_____	☐ Spinal Surgery/Back	____ __		
☐ Gall Bladder	_____	☐ Orthopedic (Hips/ Knee	_____		
☐ Appendix	_____	☐ Shoulder/ Feet/Hands)	_____		
		☐ C-section	_____		

ALLERGIES and Bad Reactions to Medications, Food, Environment

	Name	Type of Reaction
1		
2		
3		
4		
5		

Current Medications (vitamins, birth control pills):

	Name	Dosage	Times a day
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

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FAMILY HISTORY:

Father:

Health: ☐Good ☐ Poor ☐ Living ☐ Deceased Age _____

If deceased, please indicate the probable cause _____

Mother:

Health: ☐Good ☐ Poor ☐ Living ☐ Deceased Age _____

If deceased, please indicate the probable cause _____

# of siblings:_____ # living_____ #deceased: _____ Cause _____

Has anyone in your FAMILY ever had? (If yes check box and list relationship)

☐	Cancer & Type	_____	☐	Thyroid problems	_____	☐	Seizures	_____
☐	Dialysis	_____	☐	Anemia	_____	☐	Kidney stones	_____
☐	Crohn's/colitis	_____	☐	Valvular heart Disease	_____	☐	Gallstones	_____
☐	Diabetes	_____	☐	Osteoporosis	_____	☐	Migraine headaches	_____
☐	Chronic lung disease	_____	☐	Gout	_____	☐	Kidney disease	_____
☐	Alzheimer's	_____	☐	High Blood Pressure	_____	☐	OTHER	_____
☐	Cardiac Dysrhymthia	_____	☐	Cystic Fibrosis	_____		_____	
☐	Tuberculosis	_____	☐	Depression	_____		_____	
☐	Alcoholism	_____	☐	High Cholesterol	_____		_____	
☐	Congestive Heart Failure	_____	☐	Asthma	_____		_____	
☐	Rheumatoid Arthritis	_____	☐	Mental illness	_____			
☐	Bleeding tendency	_____	☐	Stroke	_____			
☐	Coronary Artery Disease	_____	☐	Peptic Ulcer	_____			

GYNECOLOGICAL/ OBSTETRICAL HISTORY:

Name of OB-GYN _____

Are you pregnant? ☐ Yes ☐ No

If yes, how many month? _____

Age when you Started Menstruating? _____

Number of Pregnancies? _____

Date of Last PAP? _____

Date of Last Mammogram? _____

Age at menopause _____

Method of Contraception _____

☐ History of abnormal Pap's

☐ History of abnormal mammograms

☐ Pain with period

Number of Births _____

☐ Vaginal

☐ C-section

Do you CURRENTLY have? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL

☐ Fatigue
☐ Fever
☐ Weight Gain over 10 pounds
☐ Weight Loss over 10 pounds

SKIN

☐ Nail Changes
☐ New Lesions
☐ Skin Color Changes

HEENT

☐ Double Vision
☐ Eye Pain
☐ Eye Redness
☐ Decreased Hearing
☐ Earache
☐ Ear Ringing
☐ Nose Bleeds
☐ Dry Mouth
☐ Hoarseness
☐ Oral Ulcers
☐ Sore Throat

NECK

☐ Neck pain
☐ Swollen glands

RESPIRATORY

☐ Chronic Cough
☐ Decreased Exercise Tolerance
☐ Difficulty Breathing
☐ Coughing Up Blood
☐ Sputum Production
☐ Wheezing

BREAST

☐ Breast Mass

- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ Skin Changes

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Leg Pains whit walking
- ☐ Leg Swelling
- ☐ Night Awakening due to Trouble Breathing
- ☐ Palpitations
- ☐ Shortness of Breath

GASTROINTESTINAL

- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal Bleeding
- ☐ Trouble Swallowing

GENITOURINARY

- ☐ Vaginal Discharge
- ☐ Menstrual Irregularities
- ☐ Difficulty Starting/stopping urinary Stream
- ☐ Painful Urination
- ☐ Change in Urinary Stream
- ☐ Increased Frequency
- ☐ Blood in Urine
- ☐ Loss of Bladder Control
- ☐ Nighttime Urination
- ☐ Urinary Retention
- ☐ Urethral Discharge
- ☐ Impotence
- ☐ Penile Lesions
- ☐ Testicular Mass
- ☐ Testicular Pain

MUSCULOSKELETAL

- ☐ Decreased Range of Motion
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Muscle Wasting
- ☐ Muscle Weakness
- ☐ Muscle Aches/Pains

NEUROLOGICAL

- ☐ Loss of Bowel Control
- ☐ Dizziness/Vertigo
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Passing out
- ☐ Seizures
- ☐ Tremor

PSYCHIATRIC

- ☐ Anxiety
- ☐ Chang in Sleep Pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal Thoughts

ENDOCRINE

- ☐ Appetite Changes
- ☐ Cold Intolerance
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Hair Changes
- ☐ Sexual Dysfunction

HEMATOLOGY

- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Prolonged Bleeding

EXAMINATIONS:

Date of last physical examination _____ Reason:

Hospitalizations # _____ Dates _____ Reasons:

CURRENT HEALTH CONCERNS

Please list your health concerns in order of priority:

1. _____ 4._____
2. _____ 5._____
3. _____ 6._____

What do you believe is causing your most important health concerns?

_____

_____

_____

What is your main reason for today's visit?_____

How long have you had this condition?_____

How does it impact your quality of life?_____

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Have you seen a physician or other health practitioner about this? ☐ Yes ☐ No

If you answered yes, please indicate:

When the treatment was received?_____

What was the diagnosis (if any)?_____

Describe any treatment you received and the results:_____

_____

What aggravates this condition?_____

What improves this condition?_____

Everything I have written and answered in this form is true to the best of my knowledge. I will update this office when there are significant changes.

Signature_____ Date_____

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NUTRITION HISTORY

Please fill if you have concerns/want to discuss you weight and nutrition with practitioner

Patient Name: (Last) _____(First)_____ (MI) _____
Your present height (in)_____ Your present weight (lb)_____ Your weight one year ago(lb)_____
The most you have ever weighed (lb)_____ When?_____
What do you think is your ideal weight (lb)_____
How often do you have a bowel movement? _____
When did you first become overweight? (your age then) _____
How did your weight gain start?_____
Describe any circumstances:
_____
_____

What do you think is the cause of your weight problem:
_____
_____
_____

What was your highest weight? (excluding pregnancy) _____your age then _____# of years ago_____
What was your lowest weight_____ your age then _____# of years ago_____
Have you ever stayed the same weight for 10 years or more ☐ Yes ☐ No

Have you attempted to lose weight before ☐ Yes ☐ No
Most lbs lost _____ how long it took _____
Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture) and describe your results:
_____
_____
_____
_____
Where and when do you do most of your overeating?
_____
_____

Please make any comments that you think might be helpful:
_____
_____

NUTRITION

Do you drink coffee ☐Yes ☐No How many cups per day?_____

Do you drink caffeinated tea? ☐ Yes ☐No How many cups per day?_____
Do you drink soda? ☐Regular ☐ Diet ☐None If yes, how much/day?_____
Do you have regular meals? ☐Yes ☐ No

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How many meals a day do you have _____

Do you have snacks between meals?

How many snacks/day _____, what kind of snack do you usually eat_____

Do you eat while engaged in other occupations? ☐ Yes ☐ No

How do you eat when under stress or feeling depressed? ☐ More ☐ Less ☐ Regular

Do you experience sudden drops in energy? ☐ Yes ☐ No

If yes, when?_____

Please describe a typical day's diet for you: _____

_____

_____

_____

_____

You normally have Breakfast at _____ o'clock Lunch at _____ o'clock Dinner at_____ o'clock Snacks at _____ o'clock

Everything I have written and answered in this form is true to the best of my knowledge. I will update this office when there are significant changes.

Signature_____ Date_____

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Notice of Privacy Practices

It is the policy of our practice that all providers and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its providers and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not fear about providing information to our practice and its providers and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its providers and staff will :

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its providers and staff will not use or disclose PHI for uses outside of practice's TOP, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments only with their consent.
- Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our practice and its providers and staff will:
  Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its physicians and staff will respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential.
  Consequently, our practice and its physicians and staff will:
  Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
  Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release, or law otherwise authorizes the release.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will:
  Permit patients access to their medical records when their written requests are approved by our practice. If we deny such requests, we will inform the patients that they may request a review of our denial. In such cases, we will have an onsite healthcare professional review the patients' appeals.
  Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All practitioners and staff of our practice will maintain a list of all disclosures of PHI for purposes other than TOP for each patient. We will provide this list to patients upon request, so long as their requests are in writing.
- All practitioners and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All practitioners and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

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PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for HOLISTIC MEDICAL CARE CLINIC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (HOLISTIC MEDICAL CARE CLINIC'S Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. HOLISTC MEDICAL CARE CLINIS reserves the right to revise its Notice of Privacy Practices at any time.

With this consent, HOLISTIC MEDICAL CARE CLINIC may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, HOLISTIC MEDICAL CARE CLINIC or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that HOLISTIC MEDICAL CARE CLINIC restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to HOLISTIC MEDICAL CARE CLINIC 's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, HOLISTIC MEDICAL CARE CLINIC may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

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CONSENT FOR THE RELEASE OF MEDICAL INFORMATION TO SPECIFIED INDIVIDUALS

HOLISTIC MEDICAL CARE CLINIC is committed to the protection of our patient's personal health information. However, we recognize that individuals other than themselves attend to many of our patient's healthcare needs. In accordance with new HIPAA regulations, we ask that you take a moment to give us the names of individuals with whom we are able to discuss your medical appointments, condition, treatment options, insurance payment information, or other information necessary to our responsibility in your treatment. Please list the names (and phone numbers, if readily available) of any individuals with whom we may have communication, which may include all, or part of your personal health information. If you fail to list any names, we will not discuss your medical information with anyone other than yourself.

Examples include: spouse, parent, child, brother/sister, friend, etc.

Patient's signature: _____ Date: _____

Contact/Relationship to patient: Telephone Number:

1_____ _____

2_____ _____

3_____ _____

( ) Home answering machine message only

( ) Voicemail message only

( ) Cell/Pager # _____