Holistic Medical Care Clinic
205 W Morgan St., Brandon FL 33510
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. /	DAY /	YEAR	SPOUSE'S NAME

RESPONSIBLE PARTY (If not Patient)

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

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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?	_____	History of abnormal Pap's
Age when you Started Menstruating?	_____	History of abnormal mammograms
Number of Pregnancies?	_____	Pain with period
Date of Last PAP?	_____	
Date of Last Mammogram?	_____	Number of Births _____
Age at menopause	_____	Vaginal
Method of Contraception _____		C-section

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

GENERAL	Eye Pain	Neck pain
Fatigue	Eye Redness	Swollen glands
Fever	Decreased Hearing	**RESPIRATORY**
Weight Gain over 10 pounds	Earache	Chronic Cough
Weight Loss over 10 pounds	Ear Ringing	Decreased Exercise Tolerance
SKIN	Nose Bleeds	Difficulty Breathing
Nail Changes	Dry Mouth	Coughing Up Blood
New Lesions	Hoarseness	Sputum Production
Skin Color Changes	Oral Ulcers	Wheezing
HEENT	Sore Throat	**BREAST**
Double Vision	**NECK**	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 # _____