HIPAA Disclosure

Due to HIPAA patient privacy regulations I agree to not discuss my treatment with other patients at any time while I am a patient of Deland Medical Wellness Center.

Patient Signature: _____

Date: _____

MEDICAL LIABILITY RELEASE FORM

Deland Medical Wellness Center policy for malpractice is as follows: As per Florida law we post on the wall in the reception area a notice that advises our patients that our physicians do not carry malpractice insurance. By signing this form, you agree not hold liable Deland Medical Wellness Center its partnering physicians, or staff legally responsible for injuring, harm or medical negligence resulting from treatment provided by Deland Medical Wellness Center. Patient's must complete this form to be eligible for any services with Deland Medical Wellness Center.

PLEASE PRINT ALL INFORMATION:

Patients Name: _____
Home Address: _____
Date Of Birth: _____
Telephone: _____
Patients Primary Care Physician: _____

LIABILITY RELEASE: I certify that the information described above is accurate and complete to the best of my knowledge. I understand that each individual is responsible for his/her emergency care. I hereby release Deland Medical Wellness Center and its Partner Physicians or Staff from any legal, medical or financial responsibility.

PATIENT /PARENT/GUARDIAN: Please check one of the following and sign your name.
_____ I give my permission for immediate medical treatment as required in the judgment of the attending physician. Notify me and/or any persons listed above as soon as possible.
_____ I do not give permission for medical treatment until I have been contacted.

Parent/Guardian's Signature: _____
Date: _____
(The above line is applicable for delegates under the age of 18 and must be signed by the parent or legal guardian.)

PATIENT REGISTRATION FORM

Patient Name: _____ Birthdate: _____

Address: _____Apartment: _____

City, State Zip Code _____ SSN _____-_____-_____

Best Contact Number: _____ Alternate Number: _____

Email Address: _____

Alternate Names used for PDMP: _____

Emergency Contact: _____Phone Number: _____

Please list any doctors who have prescribed controlled substances for you. Failure to disclose this information may lead to your dismissal as a patient of DMWC.

Doctor	Phone Number	Date Last Seen
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

With my signature, I affirm that all the information provided is true and I have omitted nothing. I waive any applicable privilege and give permission to Deland Medical Wellness to obtain my medical records and discuss my medical history with any physicians, hospitals, clinics, diagnostic centers, pharmacies, insurance companies, family, and law enforcement without violating HIPPA. I hold Deland Medical Wellness, its officers, directors, employees, and contractors harmless for any information that may be discussed with any physician, hospital, clinic, diagnostic center, pharmacy, insurance company, family, and law enforcement.

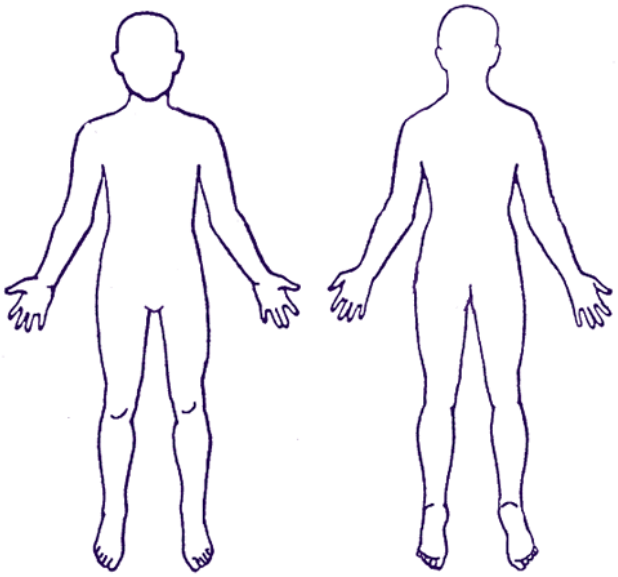
_____ _____

Patient Signature Date

Health History

_____
Patient Name

1. Please mark anywhere you may have pain and if it travels or radiates:



XXXXX-Pain
OOOOO-Numbness

/////////-Aching

*******-Pins & Needles

If you have pain, is it CONTINUOUS?
_____

2. Please mark any applications you have tried in the past.
   Injections, joint _____ Injections, epidural _____Acupuncture_____
   Yoga _____ Chiropractor _____ Ultrasound _____ Massage_____ Electrical
   Stimulation _____ Hot Pack_____ Pain Psychologist _____

3. Please check any positions that aggravate your pain.
   Standing _____ Sitting_____ Lying down _____
   Bending waist _____ Bending, knees_____ Sleep w pillow_____
   Walking_____ Bowel Movement _____

4. Do you have control of your bowels and bladder? YES NO

5. Please check any symptoms you have now or have had in the past.

GENERAL	**GENITO-URINARY**	**CARDIOVASCULAR**
_____ Chills	_____ Blood in urine	_____ Chest Pain
_____ Depression	_____ Frequent Urination	_____ High Blood Pressure
_____ Dizziness	_____ Painful urination	_____ Irregular heart beat
_____ Fainting		_____ Poor circulation
_____ Fever	**MUSCLE/BONE/JOINT**	_____ Rapid Heart Beat Low

_____ Forgetfulness
_____ Headache
_____ Loss of sleep
_____ Loss of weight
_____ Nervousness

Pain, weakness numbness in:
_____ Arms
_____ Back
_____ Feet
_____ Hands
_____ Hips
_____ Legs
_____ Neck
_____ Shoulders

_____ Low Blood Pressure
_____ Ankles swelling
_____ Varicose veins

7. Please check any symptoms you have had within the past 12 months.

GASTROINTESTINAL
____Appetite poor
____Bloating
____Bowl changes
____Constipation
____Diarrhea
____Excessive hunger
____Excessive thirst
____Gas
____Hemorrhoids
____Indigestion
____Nausea
____Rectal bleeding
____Stomach Pain
____Vomiting
____Vomiting blood

EAR, EYE, NOSE, THROAT
____Bleeding gums
____Blurred vision
____Crossed eyes
____Difficulty swallowing
____Double vision
____Earache
____Ear discharge
____Hay fever
____Hoarseness
____Loss of hearing
____Nosebleeds
____Persistent Cough
____Ringing in ears
____Sinus problems
____Vision – flashes or halos

SKIN
____Bruise easily
____Hives
____Itching
____Change in moles
____Rash
____Scars
____non-healing sores

8. Please check any symptoms you have had within the past 12 months.

MEN
____Breast lump
____Erection difficulties
____Lump in testicles
____Penis discharge
____sore on penis

WOMEN
____Abnormal pap smear
____Bleeding between period
____Breast lump
____Extreme menstrual pain
____Hot flashes
____ Nipple discharge
____ Painful intercourse
____ Vaginal discharge
_____Last GYN exam

9. Please check any conditions you have had within the past 12 months.

____AIDS
____Alcoholism
____Anemia
____Anorexia
____Appendicitis
____Arthritis
____Asthma
____Bleeding D/O
____Breast lump
____Bronchitis
____Cancer
____Cataracts
____Chicken Pox
____Diabetes
____Emphysema
____Epilepsy
____Glaucoma
____Goiter
____Gonorrhea
____Gout
____heart disease
____Hepatitis
____Hernia
____Herpes
____HIV Positive
____kidney disease
____Liver Disease
____Measles
____Migraines
____Miscarriage
____Mono
____MRSA
____MS
____Mumps
____Pacemaker
____Pneumonia
____Prostate problem
____Psych care
____Rheumatic fever
____Scarlet fever
____Stroke
____Suicide attempt
____Thyroid problem
____Tonsillitis
____Tuberculosis
____Typhoid fever
____Ulcers
____Vaginal infect

____Chemical Dep ____Hi Cholesterol ____Polio ____Venereal Disease

10. Please list any medications or substances to which you have had allergic reactions.

11. List all medications you are currently taking.

Medication	Strength	Quantity per day

12. Do you have a history of substance abuse? YES NO When

13. Please check if you use any of the substances listed and how often.

Heroin_____ How often_____ How much_____
Opioid Pain Pills_____ How often_____ How much_____
Benzos_____ How often_____ How Much_____
Alcohol _____ How often _____ How much _____
Caffeine _____ How often _____ How much _____
Cocaine _____ How often _____ How much _____
THC _____ How often _____ How much _____
Tobacco _____ How often _____ How much _____

14. Why are you seeking care from Deland Medical Wellness Center LLC?

_____

15. Please list your immediate blood relatives and, if deceased, please note cause of death.

	Living/Deceased	Age	Cause of Death
Father	_____	___	_____
Mother	_____	___	_____
Brothers	_____	___	_____
Sisters	_____	___	_____

16. Have you been to any detox treatment centers or addiction/drug counseling for your addiction? If so, please explain when and where and for what exactly.

_____
_____
_____

I certify that the information I have provided on this health history questionnaire is correct to the best of my knowledge. I will not hold my doctor, Deland Medical Wellness Center, its affiliates, officers, directors, employees and contractors responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Signature Date