

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: _____



DELAND MEDICAL
WELLNESS CENTER

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 HIPAA. 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.

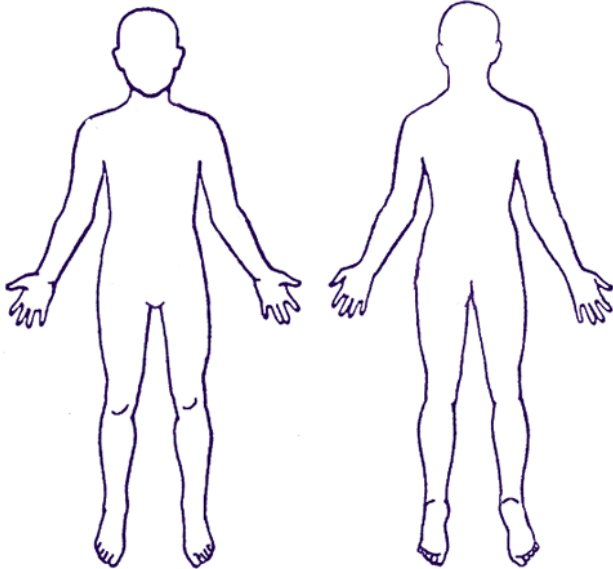
Patient Signature

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

_____ Chills
 _____ Depression
 _____ Dizziness
 _____ Fainting
 _____ Fever

GENITO-URINARY

_____ Blood in urine
 _____ Frequent Urination
 _____ Painful urination

MUSCLE/BONE/JOINT

CARDIOVASCULAR

_____ Chest Pain
 _____ High Blood Pressure
 _____ Irregular heart beat
 _____ Poor circulation
 _____ Rapid Heart Beat Low

- | | | |
|---|---|---|
| <input type="checkbox"/> Forgetfulness | Pain, weakness numbness in: | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Arms <input type="checkbox"/> Hips | <input type="checkbox"/> Ankles swelling |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Back <input type="checkbox"/> Legs | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Feet <input type="checkbox"/> Neck | |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders | |

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.

- | | | | |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Prostate problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> kidney disease | <input type="checkbox"/> Psych care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Mono | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Bleeding D/O | <input type="checkbox"/> Gout | <input type="checkbox"/> MRSA | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> heart disease | <input type="checkbox"/> MS | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> 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.

<u>Medication</u>	<u>Strength</u>	<u>Quantity per day</u>
_____	_____	_____
_____	_____	_____

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.

	<u>Living/Deceased</u>	<u>Age</u>	<u>Cause of Death</u>
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



DELAND MEDICAL
WELLNESS CENTER

******MISSED APPOINTMENT FEE NOTICE******

I understand that Deland Medical Wellness Center LLC charges a \$50 missed appointment fee that will be charged on my next appointment for any primary care or opioid addiction therapy appointments that were confirmed and not rescheduled or cancelled within a 24 hours prior to my appointment time.

Patient Signature: _____

Date: _____

Pharmacy Information

Patient Name: _____

Date: _____

Pharmacy Name: _____

Address: _____

Phone: _____

Fax: _____

Patient Signature: _____

*** If you have insurance please let the front office make a copy of the front and back of your insurance card**