FOR BEST RESULTS, USE MOUSE TO NAVIGATE FIELDS, DO NOT USE TAB!

AbsoluteHealth
The Way Medicine Should Be
7350 SW 60th Ave, Suite #2
Ocala, FL 34476
Phone: (352) 854-5530
Fax: (352) 854-5532

NEW PATIENT REGISTRATION FORM

*

Patient's Last Name/ First Name / Middle Initial

*

Mailing Address **Apt. Number/ Suite Number**

*

City / State / Zip Code **email address**

*

Home Phone Number **Cell Phone Number** **Work Phone Number**

*

Patient Date of Birth **Patient Age** **Patient Sex** **Marital Status**

*

Social Security Number **Employer Name & Address**

Employment Status
(Full Time/Part Time/Unemployed/Retired)

Student Status
(Not a Student/Part Time/Full Time)

*

Emergency contact name/Phone number **Emergency Contact Address**

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GUARANTOR INFORMATION

The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip the next section. If the patient is a minor (under the age 18), the parent or guardian the patient to the visit is usually the guarantor for the patient.

Guarantor's last name **Guarantor's first name** **Initial** **Social Security Number**

INSURANCE INFORMATION

*

Primary Insurance Name **Policy Subscribers name** **Policy Subscriber's Date of Birth**

*

Patient's relationship to subscriber

*

Secondary Insurance Name **Policy Subscribers name** **Policy Subscriber's Date of Birth**

*

Patient's relationship to subscriber

OTHER INFORMATION

*

Pharmacy Name **Pharmacy Location** **Pharmacy Phone number**

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Authorization to Release Protected Health Information

By signing, I authorize **Absolute Health Internal Medicine & Pediatrics** to use and/or disclose certain protected health information (PHI) about me for treatment, payment or healthcare purposes.

This authorization permits **Absolute Health Internal Medicine & Pediatrics** to use and/or disclose the following individually identifiable health information about me: paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatments, and plans for future care or treatment. I also authorize my insurance benefits, if any, to be paid directly to **Absolute Health Internal Medicine & Pediatrics.**

The information will be used or disclosed for the following purposes:

1. A basis for planning my care and treatment.
2. A means of communicating with other health professionals who may contribute to my care.
3. A source of information for my bill.
4. A means by which a third-party payer can verify that services billed were actually provided.
5. At the request of the patient.

The purposes are provided above so that I can make an informed decision whether to allow release of the information.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Absolute Health Internal Medicine & Pediatrics.** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the Practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at **Absolute Health Internal Medicine & Pediatrics.**

*

Signature of Patient/Legal Guardian **Relationship to Patient** **Date**

*

Print Patient's Name **Print Legal Guardian Name**

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Please list all physicians that you have seen in the past:

Physician/Office Name	Specialty	Phone Number
1.		
2.		
3.		
4.		
5.		
6.		

List recent hospital stays:

Hospital Name	Date of admission	Phone Number
1.		
2.		
3.		
4.		

Please list all laboratory and xray facilities you have received tests in:

Facility Name	Date of Test	Phone Number
1.		
2.		
3.		
4.		

Please include the following information:
Provider' s summ ary of di agnos is, medications, treatments, prognosis and recent care, admissions information, X-ray reports, lab reports, special studies, immunization record, history, op reports, H&P, all others.

I hereby authorize and release the custodian of my/my dependant's medical records to make available to ***Absolute Health Internal Medicine & Pediatrics*** as they are related to the course of my treatment. I understand that this authorization constitutes a waiver of any claims that I may have against the physicians listed below (or any of their agents or employees) as a result of their compliance with this request and that neither the physicians nor their agents or employees shall have any responsibility for any acts or omissions concerning said records or their release after the records are made available as I have hereby authorized and requested.

Signature of Patient/Legal Guardian **Relationship to Patient** **Date**

Print Patient's Name **Print Legal Guardian Name** **D.O.B**

Please mail records to: **Absolute Health**
7350 SW 60TH Ave Suite 2
Ocala, Fl 34476

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Family History

Please place an X in the box that applies:

	Father	Mother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Children	Siblings
Diabetes								
Alzheimers								
Heart Disease								
Colon Cancer								
Breast Cancer								
Prostate Cancer								
Ovarian Cancer								
Other Cancers								
Obesity/ Overweight								
Hypertension/ High Blood Pressure								

Please list other Diseases that Run in your family:

_____

_____

How many siblings do you have? Brothers: _____ Sisters: _____
How many children do you have? Boys: _____ Girls: _____

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Please answer YES/NO. Are you experiencing any of the following?

Fever		Weakness	
Chills		Dizziness	
Sweats		Headaches	
Chest Pain		Blurred Vision	
Palpitations		Hearing Loss	
Abdominal Pain		Ear Pain	
Nausea		Sore Throat	
Vomiting		Cough	
Diarrhea		Wheezing	
Constipation		Shortness of Breath	
Joint Pain		Pain with Urination	
Muscle Pain		Decreased Urine	
Joint Swelling		Increased Urine	
Back Pain		Rash	
Depression		Anxiety	
Heartburn		Difficulty Swallowing	
Weight Loss		Weight Gain	
Blood In Stool		Loss of Appetite	
Bleeding		Bruising	
Runny Nose		Congestion	

Screening Tests if applicable:

When was your last Colonoscopy? _____

When was your last Mammogram? _____

When was your last Pap smear? _____

When was your last Bone Density? _____

How did you hear about us? Who referred you? _____

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Social History

Email address:_____
Smoker? **Yes/No** _____ What age started?_____How much per day?_____
Quit age:_____ Any other smokers in the house? **Yes/No**_____

Do you drink alcohol? **Yes/No** _____ What kind?_____
How much per week?_____

Do you use recreational drugs? **Yes/No** _____What kind?_____
Past use? **Yes/No** _____ What kind? _____

Maritial Status: Married/ Divorced/ Single/Widowed _____

Do you have any children? **Yes/No** _____ How many Boys?_____Girls?_____

What is your occupation?_____

Do you have a religious preference?(Ex: Christian-No Preference, Catholic, Baptist, Jehovah's Wittness, Judaism, Islam, Other)_____

Do you Exercise? **Yes/No** _____If yes, What kind?_____
How many times per week?_____

Do you drink caffeine? **Yes/No** _____
What kind? Coffee/Tea/Soda/Energy Drinks _____
How much per day?_____

Are you sexually active? **Yes/No** _____ How many partners?_____

Have you traveled outside the U.S. within the last 5 years? **Yes/No** _____
Where have you been?_____

Do you have smoke detectors in your home? **Yes/No** _____

Do you have any pets? **Yes/No** _____ What kind? _____

How long have you lived in Ocala?_____

Where did you move from?_____

Who lives in the home with you?_____

Do you have city or well water?_____

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No Show & Rescheduling Policy

Breaking an appointment hinders our ability to care for you as well as others because we lose a time slot that could have been used to help another patient. **A scheduled appointment must be cancelled within 24 hours of the appointment**. If an appointment is scheduled for Monday it must be rescheduled by Friday of the previous week. This is to insure space and availability for all of our patients. **Failure to comply with the policy will result in a $25.00 fee**.

***Refill Policy**

All refill medication must be requested within 48 hours either on the phone or in person. The name, strength, and quantity must be verified when requesting refills on medications. No medications will be refilled outside business hours including weekends and holidays.

***On Call Policy**

There will always be a physician on call for all urgent matters that cannot wait until the following business day. (This does not include medication refills). If there is an emergency you are instructed to call 911.

***Patient Scheduling**

Once you are an established patient and are in need of a sick visit, call first thing in the morning so we can make sure you get treated as soon as possible. All visits require an appointment; we do not accept walk-ins.

***Messages**

When calling the office or dropping by to leave a message for the doctor or staff please remember that in most cases there are patients in the office requiring treatment so messages may not be addressed until there is time in between patients or end of the day. We do assure it will be as soon as possible.

By signing below, I agree to the above policies at Absolute Health.

Signature Printed Name Date

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Thank you for choosing Absolute Health Internal Medicine & Pediatrics.

Please list all medications that you are currently taking: Name, dose and how many times per day. We want to know the supplements and vitamins you are taking as well. *(You may provide us a list if you have one ready).*

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Please list all previous surgeries and dates they were performed:

1.
2.
3.
4.
5.

Please list any history of illness or medical condition such as Diabetes, High Blood Pressure, High Cholesterol:

1.
2.
3.
4.
5.
6.
7.

Please list any allergies to medications and what happens when you take them:

1.
2.
3.
4.
5.

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Office Use Only

Superbill

Patient Name: _____

Date: _____

- Co-Pay: $____or___% Paid: ____ Initials:___

- Wt Loss/B12: $25 Paid: ____ Initials:___
- Wt Loss/Dr. Visit: $75 Paid: ____ Initials:___
- Wt Loss/ Dr. Visit New: $100 Paid:___Initials: ____
- Self Pay: $___Paid:____Initials: ____
- Bio-Impedence testing: $ 25 Paid: ___ Initials:___
- Spectrocell Testing: $15 Paid:___Initials:____
- Salivary Hormone Testing: $ 25 Paid:___Initials:____
- H1N1 Vaccine $25 Paid:_____Initials:_____

Checked out by: _____ **Signature:** _____