New Patient Registration Form

Patient's Last Name / First Name / Middle Initial | Date of Birth

Mailing Address / P. O Box | Apt. Number / Suite Number

City / State / Zip Code | Home Phone Number | Cell Phone Number

Email Address | Marital Status | Social Security Number

Emergency Contact Name / Phone Number / Address | Relation

Student Status: ☐ Full Time ☐ Part Time ☐ Not a Student

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed

Employer Name & Address | Work Phone Number

Race:
☐ Choose not to disclose
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian, Other Pacific Islander
☐ White
☐ Other: _____

Ethnicity: ☐ Choose not to disclose ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Birth Sex: ☐ Male ☐ Female ☐ Unknown

Sexual Orientation:
☐ Choose not to disclose
☐ Straight or Heterosexual
☐ Bisexual
☐ Lesbian, Gay, or Homosexual
☐ Do not know
☐ Something else:_____

Gender Identity:
☐ Choose not to disclose ☐ Male ☐ Female
☐ Female-to-Male (FTM)/Transgender Male/Trans Man
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Genderqueer, neither exclusively male nor female
☐ Additional gender category or other, please specify:_____

☐ **Yes!** Please include me in your emails for upcoming lectures, upcoming specials in Dr. E's Choice Store and updates on the Dr. E's blog and new book *Ignite Your Healing Power.*

Guarantor Information

The guarantor is the person responsible for the patient's bill. 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. If the patient is responsible for his/her own bill, please skip the next section.

Guarantor's Last Name | Guarantor's First Name | Initial

Insurance Information

Primary Insurance Name | Policy Subscribers Name | Policy Subscriber Date of Birth

Patient's Relationship to Subscriber | Policy# | Group ID #

Secondary Insurance Name | Policy Subscribers Name

Patient's Relationship to Subscriber | Policy# | Group ID #

Medical Information and Records Release Consent

I authorize the staff of Absolute Health to release medical information regarding my healthcare to the following person(s): (Example: spouse, parent, sibling)

Name: _____ Relationship: _____ Ph #: _____

Name: _____ Relationship: _____ Ph #: _____

Name: _____ Relationship: _____ Ph #: _____

I understand that I may revoke or change this consent at any time by filling out another consent form to replace this one.

Patient Name (Print) | Signature (Patient/Parent/Personal Representative) | Date

Policy Acknowledgement and Agreement

By signing below, I acknowledge that I have received, understand, and agree to the following Absolute Health Internal Medicine and Pediatrics Policies and Practices (v05.10.2023):

- HIPAA – Notice of Privacy Practice
- Insurance Information Policy
- Electronic Communication Policy
- General Consent for Care and Treatment
- Photography Policy
- Self-Pay Patient Policy
- Service Not Covered by Insurance Policy
- Patient Scheduling Policy
- No Show and Rescheduling Policy
- On Call Policy
- Refill Policy
- Prescription Drug History Policy
- Health Information Exchange Policy ***Initial***: _____
- Good Faith Estimate for Self-Pay New Patient Appointments

I understand I am opting in today to optional policies (electronic communication, text messages and photography.) I also understand that if I wish to update, change, or revoke my consent to optional policies, I may do so at any time in writing, in person, or by phone.

I understand that if I have any questions about any policies, I may ask them in person, by phone or in writing by contacting Absolute Health Internal Medicine and Pediatrics at 7350 SW 60th Ave, Suite 2, Ocala FL 34476; phone number (352) 854-5530.

_____

Patient Name (Print) Signature (Patient/Parent/Personal Representative) Date

If other than the patient, specify name and relationship: _____

If you choose not to consent to any or all of the above listed policies and practices, you may do so. Please discuss this with our staff prior to signing this consent form. Failure to consent to certain policies and practices may prohibit our ability to serve as your healthcare provider.

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Please FAX Records. Please No Disk!

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 x-ray facilities you have received tests in:

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

OFFICE USE ONLY

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ History & Physical
- ☐ Progress Notes
- ☐ Care Plan
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Treatment Record
- ☐ Operative Report
- ☐ Hospital Reports
- ☐ Medication Record

1. _____
2. _____
3. _____

By signing this form I hereby authorize and release confidential health information of my and my dependant's medical records, or summary or narrative of my protected health information 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 **(Under 18) Relationship to Patient** **Date**

Print Patient's Name **(Under 18) Print Legal Guardian Name** **D.O.B**

Medications & Supplements

Instructions: Please list all medications, supplements, and vitamins that you are currently taking. Include names, dosage, and how many times per day you take them. *(You may provide us a list if you have one ready).*

Medication Name	Dosage	Daily Frequency

Preferred Pharmacies

1.

Pharmacy Name **Pharmacy Location** **Phone Number**

2.

Pharmacy Name **Pharmacy Location** **Phone Number**

Interim History

Who referred you to Absolute Health? _____

Medical History

Screening Tests if applicable:

When and where was your last Colonoscopy? _____ ☐ Normal ☐ Abnormal

When and where was your last Mammogram? _____ ☐ Normal ☐ Abnormal

When and where was your last Pap Smear? _____ ☐ Normal ☐ Abnormal

When and where was your last Bone Density? _____ ☐ Normal ☐ Abnormal

Please provide a list of your current diagnoses, the estimated date you were diagnosed, and by which Physician below:

Diagnosis	Date (Estimate)	Physician

Allergies

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

Medication Name	Reaction Type

Surgical History

Please list all previous surgeries, the dates they were performed, and if you had a hospital stay along with your procedure:

Dates	Surgery/Procedure	Inpatient
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Hospitalizations

Please list all hospitalizations, dates and reason:

Dates	Hospital	Reason

Family Medical History

Please place an X in the box that applies:

	Self	Father	Mother	Children	Siblings
Diabetes	☐	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐
Other Cancers	☐	☐	☐	☐	☐
Obesity/Overweight	☐	☐	☐	☐	☐
Hypertension/ High Blood Pressure	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐

Please list any other diseases that run in your family:

_____

_____

How many siblings do you have? Brothers:_____ Sisters:_____

How many children do you have? Boys:_____ Girls:_____

Are you or any of your children adopted? ☐ Yes ☐ No

Mother's Date of Birth: _____ **Father's Date of Birth**: _____

If any family members above are deceased, please list who and at what age they became deceased:

Relationship:_____ Age:_____

Relationship:_____ Age:_____

Relationship:_____ Age:_____

Relationship:_____ Age:_____

Social History

Are you a Smoker? ☐ Current: ☐ Former ☐ Never

Started smoking in**:** _____

Packs per day**:** _____

Quit date:_____

Any other smokers in the house? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Type: _____

How many glasses per week:_____

Do you use recreational drugs? ☐ Yes: Type:_____

☐ Past use: Type: _____

Last used: _____

☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐Other:_____

Do you have children? ☐ Yes ☐ No If so How many? _____

What is your occupation? _____

Do you have a religious preference? (Ex: Catholic) _____

Are you sexually active? ☐ Yes Number of current partners: _____

☐ No

Have you traveled outside the U.S. within the last 5 years? ☐ Yes ☐ No

If yes: Location, Date: _____

_____

Do you have smoke detectors in your home? ☐ Yes ☐ No

Do you have any pets? ☐ Yes ☐ No

If yes: Type and number of pets:_____

What type of water do you have in your home? ☐ City Water ☐ Well Water

Who lives in the home with you? _____

Where did you move to Ocala from? _____Year:_____ ☐ Lived here your whole life

Review of Systems (ROS)

Please place and **X** in the box for all symptoms that you are experiencing:

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

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Medical Symptom Questionnaire

Name: _____ DOB:_____Date: _____

Rate each of the following symptoms based on your typical health profile for the past 14 days.

Point Scale: **0 – *Never or almost never*** have the symptom
1 – *Occasionally* have it, the effect is ***not severe***
2 – *Occasionally* have it, effect is ***severe***
3– *Frequently* have it, effect is ***not severe***
4 – Frequently have it, effect is ***severe***

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision

(Does not include near or far-sightedness)

Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks

Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips

Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

Total _____

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Total _____

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DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain

Total _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness

Total _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight

Total _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

Total _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

Total _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

Total _____

Grand Total_____

7350 SW 60th Ave. Suite #2 Ocala, FL 34476 | P (352) 854-5530 | F (352) 854-5532 | www.AbsoluteHealthOcala.com| For our online Supplement store go to www.DoctorEstore.com