Health & Wellness
CENTERS OF NORTH FLORIDA

Adolescent Demographic Record-please PRINT

Name: _____

Street: _____ City/State/ZIP: _____

Phone: _____ SSN: _____ Sex: Male/Female

Date of Birth: _____ Age: _____

Email address: _____

Parent Information (Please provide address if different than above)

Mother: _____ Father: _____

Hm Ph: _____ Wk Ph: _____ Hm Ph: _____ Wk Ph : _____

Contact in Case of Emergency (Other than above)

Name: _____ Relationship: _____ Phone: _____

Primary Insurance Information

Insurance: _____ Insured Name: _____

Street: _____ Insured SSN: _____

City/State/ZIP: _____ Date of Birth: _____

Policy # / Group #: _____ Relationship: _____

Secondary Insurance Information

Insurance: _____ Insured Name: _____

Street: _____ Insured SSN: _____

City/State/ZIP: _____ Date of Birth: _____

Policy # / Group #: _____ Relationship: _____

I certify that the above information is correct. I understand and agree that:

1. I am responsible in providing correct information on this form, and that I may become financially responsible for services if insurance information is incorrect or incomplete.
2. I am responsible to pay all co-payments at the time of service.
3. Health & Wellness Centers of North Florida will file my insurance as required by contracts, where applicable, and that I am responsible for full payment to Health & Wellness Centers of North Florida for services provided.
4. Health & Wellness Centers of North Florida will hold me responsible to pay costs of collection through outside collection agencies or other legal means should that become necessary.
5. Health & Wellness Centers of North Florida will release pertinent medical records for documentation of service dates in order to process medical insurance claims.
6. I understand that failure to show up for my appointment without 24 hour cancellation notice may incur a $25.00 NO-SHOW fee.

SIGNATURE: _____ DATE: _____

HEALTH &WELLNESS CENTERS OF NORTH FLORIDA
General Consent to Treatment & Financial Responsibility

Acknowledgement of Receipt of Privacy Practices

I _____, (print) hereby acknowledge receipt of the office notice of Privacy Practices.

Consent for Medical Treatment

The undersigned hereby consents to any and all diagnostic procedures, tests and medical treatment required in the diagnosis of my illness and course of treatment by the physician or his/her designed; other agents, and/or employees including medical students. I recognize that care may be observed and in some instances provided by medical students under supervision in their course of training. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of tests, examinations, treatments, procedures or any other services rendered.

Release of Medical Information (Third Party Payors, Guarantors, Physicians)

By signing this form, I hereby authorize this office to use and release information and/or copies of my medical records as necessary for my treatment, for payment for that treatment and for the health care operations of the provider treating me; including to a hospital, physician or other provider, guarantor of my accounts, or third party payors for which I have assigned benefits for my treatment and care, and, if requested, to my referring physician, or any other healthcare provider responsible for my care; an as otherwise provided in the Health & Wellness Centers notice of privacy practices.

Statement of Financial Responsibility

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of the Health & Wellness Centers of North Florida. I understand that my insurance will be billed; however, I understand that I am responsible for any charges not covered by my insurance company as allowed by law.

_____ _____

Signature Date

1965 Capital Circle NE
Tallahassee, FL 32308
Office: 850-656-2006
Fax: 850-

Health & Wellness
INTEGRATED HEALTHCARE CENTERS

IMPACT
BEHAVIORAL HEALTH

(Please PRINT)

MEDICAL RECORDS RELEASE and PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name **DOB** **SS#**

I authorize Health & Wellness Centers of North Florida to release my records to:

_____
(Name)

_____
(Address)

OR

I authorize_____
(Name of physician or facility)

at_____

to release my medical records including any treatment for alcohol abuse, drug abuse, psychiatric disorders, or HIV infection to Health & Wellness Centers of North Florida via mail to 1965 Capital Circle NE, Tallahassee, Florida 32308 or via Fax to 850-656-2820.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the 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 Internal Medicine and Pediatric Associates of Tallahassee, 1965 Capital Circle NE, Tallahassee, FL 32308.

A copy of the authorization shall be as valid as the original.

_____ _____
Signature of Patient or Legal Guardian **Date**

_____ _____
Printed Name **Relationship to patient**

Health & Wellness
CENTERS OF NORTH FLORIDA

(Please PRINT)

Authorization for Use and Disclosure of Protected Health Information to Family and/or Friends

Patient name	DOB	SSN

I, authorize Health & Wellness Centers of North Florida to release protected health information about me to:

Name	Relationship to patient
Name	Relationship to patient
Name	Relationship to patient

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the 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 Health & Wellness Centers of North Florida, 1965 Capital Circle NE, Tallahassee, FL 32308.

A copy of this authorization shall be as valid as the original.

Signature of Patient or Legal Guardian	Date
Relationship to Patient	Printed name of Guardian

Filename:release2

Health & Wellness
CENTERS OF NORTH FLORIDA

Health & Wellness Centers of North Florida has offered me a copy of their Notice of Privacy Practices as required by HIPAA.

_____ _____

Printed name of patient Date

_____

Signature of patient or legal guardian of patient

Filename:privacypracticeacknowledgement

PRESCRIPTIONS:

Please notify staff while at your appointment which prescriptions need to be refilled. Our office transmits prescriptions electronically to your pharmacy unless your medication is a controlled substance. If this is the case a handwritten prescription will be provided to you. It is your responsibility to maintain these prescription(s) in a safe place as they will not be re-written under ANY circumstances. Should you have to contact the office prescription line please note that this request may take up to 72 hours to be processed.

FORMS:

There is a charge for completion of all forms by this office. The price varies depending on the type of form to be completed. You will be notified prior to completion of the form what the charge is. No forms will be completed without payment up front. Please note our policy is 7 days to complete all forms.

A copy of medical records requires a pre-payment as follows: $1.00 per page for the first 25 pages and $.25 for each additional page.

By signing below I acknowledge my understanding of the statements above regarding prescriptions and forms.

_____ _____

Patient signature Date

Or

_____ _____

Parent or legal guardian signature Date

PLEASE PRINT

Name:_____ Date of Birth:_____

This is your protected health information. All information will be kept in the strictest confidence and will be reviewed with you in the office by your provider.

General state of health: ◯ Excellent ◯ Good ◯ Fair ◯ Poor

CURRENT MEDICATION LIST: (Please include over-the-counter medications & supplements/herbal meds)

Medication name, dose, frequency	Medication name, dose, frequency

PAST MEDICAL HISTORY:

Nervous System
- ◯ Chronic headache
- ◯ Dementia
- ◯ Dizziness/fainting
- ◯ Migraines
- ◯ Parkinson's
- ◯ Stroke
- ◯ Tremors
- ◯ Other_____

Psychiatric/Behavioral
- ◯ ADHD/ADD
- ◯ Anxiety
- ◯ Bipolar disorder
- ◯ Depression
- ◯ Excessive moodiness
- ◯ Memory loss
- ◯ Schizophrenia
- ◯ Sleep disorder
- ◯ Substance Use Disorder _____
- ◯ Other_____

Eyes/Ears/Nose/Throat
- ◯ Allergies/hay fever
- ◯ Cerumen impaction
- ◯ Glaucoma
- ◯ Hearing loss
- ◯ Vertigo
- ◯ Visual impairment
- ◯ Other_____

Cardiovascular
- ◯ Atrial Fibrillation
- ◯ Chest pain
- ◯ Coronary artery disease
- ◯ Heart failure
- ◯ Heart murmur
- ◯ Hypertension
- ◯ Other_____

Respiratory
- ◯ Asthma/wheezing
- ◯ Chronic cough
- ◯ COPD
- ◯ Oxygen (amount_____)
- ◯ Pneumonia
- ◯ Other_____

Gastrointestinal
- ◯ Abdominal pain (chronic)
- ◯ Constipation
- ◯ Diarrhea
- ◯ Diverticulitis
- ◯ Gallbladder
- ◯ GERD
- ◯ Heartburn/Indigestion
- ◯ Hemorrhoids
- ◯ IBS/Crohn's
- ◯ Liver disease (cirrhosis)
- ◯ Pancreatitis
- ◯ Peptic ulcers
- ◯ Other_____

Genitourinary
- ◯ Enlarged prostate
- ◯ Frequent UTIs
- ◯ Kidney failure
- ◯ Kidney stones
- ◯ STDs_____
- ◯ Other_____

Women's Health
- ◯ Heavy periods
- ◯ Irregular periods
- ◯ Menopause
- ◯ Pelvic inflammatory disease
- ◯ Pregnancy history
  - Number of:_____
  - Live births:_____
  - Miscarriages:_____
  - Abortions:_____
- ◯ Birth control
  - Type:_____
- ◯ Other_____

Musculoskeletal
- ◯ Arthritis
- ◯ Back pain
- ◯ Foot problems
- ◯ Gout
- ◯ Muscle weakness
- ◯ Osteoporosis
- ◯ Other_____

Endocrine
- ◯ Diabetes, Type_____
- ◯ Hypothyroidism
- ◯ Obesity
- ◯ Unexplained weight loss
- ◯ Other_____

Infectious Diseases
- ◯ Chickenpox
- ◯ Hepatitis
- ◯ HIV
- ◯ Measles
- ◯ Mumps
- ◯ Rubella
- ◯ Tuberculosis
- ◯ Other_____

Hematology/Cancer/Other
- ◯ Anemia
- ◯ Blood clots
- ◯ Blood transfusions
- ◯ Bruises easily
- ◯ Chronic fatigue
- ◯ Cancer: Breast Yr_____
- ◯ Cancer: Colon Yr_____
- ◯ Cancer: Lung Yr_____
- ◯ Cancer: Prostate Yr_____
- ◯ Cancer: Skin Yr_____
- ◯ Other cancer_____ Year_____
- ◯ Other:_____

Name:_____ Date of Birth:_____

ALLERGIES/INTOLERANCE:

Medication/substance	Type of reaction	Medication/substance	Type of reaction

GYNECOLOGIC HISTORY:

How often do you get your period?

◯ Every 28 days ◯ Every month ◯ Every 20-25 days ◯ Every 35-40 days ◯ irregular

Comments:_____

How heavy is your bleeding?

◯ Normal loss ◯ Light blood loss ◯ Heavy blood loss

Coomments:_____

Are you using birth control? ◯ Yes ◯ No (If yes, what type? Mark all that apply)

◯ Condoms ◯ Female condoms ◯ Oral contraceptives ◯ Depo-Medrol ◯ Nuva ring

◯ Intrauterine device (Type_____) ◯ Nexplanon implant ◯ Patch

◯ Diaphragm ◯ Spermacide ◯ Tubal ligation ◯ Partner has vasectomy

◯ Other Comments_____

OBSTETRIC HISTORY:

How many total pregnancies have you had?_____ How many living children do you have?_____

How many stillbirths?_____ Miscarriages?_____ Abortions?_____ C-sectoins?_____

SURGICAL HISTORY:

Month/Year	Surgery/Procedure	Month/Year	Surgery/Procedure

HOSPITALIZATIONS/INJURIES:

Month/Year	Reason for Hospitalization/Type Injury	Month/Year	Reason for Hospitalization/Type Injury

Name:_____ Date of Birth:_____

FAMILY HISTORY:

Family Member	Living?	Birth Yr	Age	Notes/Other	Diabetes	Hypertension	Heart disease	Stroke	Mental Illness	Cancer	Unknown
Daughter(s)											
Father											
Son(s)											
Spouse											
Mother											
Paternal Grandfather											
Paternal Grandmother											
Maternal Grandfather											
Maternal Grandmother											
Paternal Uncle											
Paternal Aunt											
Maternal Uncle											
Maternal Aunt											
Brothers											
Sisters											
Other											

SOCIAL HISTORY:

Tobacco

Are you a:	Additional findings: Tobacco user	Additional findings: Tob. nonuser
◯ current smoker	◯ chain smoker	◯ Aggressive nonsmoker
◯ former smoker	◯ chews tobacco	◯ Current nonsmoker
◯ nonsmoker	◯ heavy cigarette smoker (20-39 cig/d)	◯ ex-cigar smoker
◯ current every day smoker	◯ light cigarette smoker (1-9 cig/d)	◯ ex-cigarette smoker
◯ current some day smoker	◯ moderate cigarette smoker (10-19)	◯ ex-heavy cig smoker (20-39/d)
◯ tobacco user in other forms	◯ pipe smoker	◯ ex-light cig smoker (1-9/d)
	◯ snuff user	◯ ex-moderate cig smoker (10-19/d)
	◯ trivial cig smoker (less than 1/d)	◯ ex-pipe smoker
	◯ user of moist powdered tobacco	◯ ex-trivial cig smoker (less than 1/d)
	◯ very heavy cigarette smoker (40+/d)	◯ ex-user of moist powdered tobacco
		◯ ex-very heavy cig smoker (40+/day)
		◯ nonsmoker for medical reasons
		◯ nonsmoker for personal reasons
		◯ nonsmoker for religious reasons

Sexual history

Have you had sex in the past 12 months (vaginal, oral, or anal)? ◯ Yes ◯ No

If yes: with: ◯ Men only ◯ Women only ◯ Both men and women

If yes: Do you use protection? ◯ Yes ◯ No

How often? ◯ All of the time ◯ Most of the time ◯ Half of the time ◯ Some of the time

If yes: Have you had a sexually transmitted disease? ◯ Yes ◯ No

If yes: ◯ Chlamydia ◯ Gonorrhea ◯ Syphillis ◯ Herpes ◯ Other

Name:_____ Date of Birth:_____

SOCIAL HISTORY (continued):

Drugs

Have you used drugs other than those for medical reasons in the past 12 months? ◯ Yes ◯ No

If yes:

◯ Heroin ◯ Cocaine How many months ago did you last use?_____ Are you in a treatment program?_____ Have you ever injected drugs? ◯ Yes ◯ No Are you still using? ◯ Yes ◯ No Is there a minor (18 yrs or younger) at risk at home? ◯ Yes ◯ No	◯ PCP ◯ Ketamine ◯ Marijuana ◯ Prescription opiates ◯ Ecstasy ◯ LSD ◯ Crack ◯ Methamphetamine

Alcohol

Did you have a drink containing alcohol in the past year? ◯ Yes ◯ No

If yes:

In the past year...	0 points	1 point	2 points	3 points	4 points
How often did you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
How many drinks did you have on a typical day when you were drinking?	1 or 2 drinks	3 or 4 drinks	5 or 6 drinks	7 to 9 drinks	10 or more drinks
How often did you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Total points:					

DEPRESSION SCREENING:

Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half of days	Nearly every day	Declined to specify
Little interest or pleasure in doing things	0	1	2	3	0
Feeling down, depressed, or hopeless	0	1	2	3	0
Totals:					

WELLNESS SCREENINGS:

	Test & Date Last Completed	History of Abnormal?
All	**Colon cancer** ◯ Stool cards_____ ◯ Colonoscopy_____	◯ No ◯ Yes
	Osteoporosis ◯ DEXA scan_____	◯ No ◯ Yes
	Lung cancer (current or former smokers 55-80 yo) ◯ CT scan chest_____	◯ No ◯ Yes
Men	**Prostate cancer** ◯ PSA_____ ◯ Digital Rectal Exam_____	◯ No ◯ Yes
Women	**Cervical cancer** ◯ Pap smear_____	◯ No ◯ Yes
	Breast cancer ◯ Mammogram_____	◯ No ◯ Yes
Details of abnormals:_____		

Name:_____ Date of Birth:_____

ADULT VACCINATIONS:

Vaccine type	Recommended for	Received/Year
Influenza	All adults; yearly	◯ No ◯ Yes Year_____
Covid-19 (Manufacturer:_____)	All adults; number and frequency depends on manufacturer	◯ No ◯ Yes Year_____
Tetanus/Diphtheria/Pertussis (Tdap)	All adults; once	◯ No ◯ Yes Year_____
Tetanus/Diphtheria (Td)	All adults; Booster every 10 years after Tdap	◯ No ◯ Yes Year_____
Pneumococcal conjugate (PCV-13)	Adults age 65 & older; one dose	◯ No ◯ Yes Year_____
Pneumococcal polysaccharide (PPSV-23)	Adults age 50 & older; one or two doses depending on indication	◯ No ◯ Yes Year_____
Zoster recombinant (RZV) (Shingles)	Adults age 50 & older; two doses	◯ No ◯ Yes Year_____
Measles/Mumps/Rubella (MMR)	Adults born 1957 or later & not received/no history disease; one or two doses	◯ No ◯ Yes Year_____
Varicella	Adults born 1980 or later & not received/no history disease; two doses	◯ No ◯ Yes Year_____
Other		◯ No ◯ Yes Year_____
Other		◯ No ◯ Yes Year_____

OTHER PROVIDERS BEING SEEN:

Specialty	Condition seen for	Name of provider	Last seen (Mo/Yr)	Phone number	Record release signed?
Last primary care provider					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No

SPECIAL EQUIPMENT/SUPPLIES:

Equipment	Brand and/or company	Condition being treated	Last filled/obtained
Diabetes testing supplies			
Oxygen			
CPAP			
Walker/cane			
Wheelchair			
Ostomy supplies			