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**New Patient Questionnaire**

|  |  |  |
| --- | --- | --- |
| **Personal Information** | Date  | Date of Birth |
| Last Name, First Name, Middle Initial: |  |
| Preferred Name: |  |
| Gender Assigned at Birth:    □ Female □ Male                                                  □ Intersex  | Last four digits of your social security  |
| Family Status: |        □ S     □ Sig Other       □ Sep □ M □ D □ W |
| Home Address: |  |
| City, State and Zip Code: |  |
| Mailing Address:                         □ Same as Above |  |
| City, State and Zip Code |  |
| Phone Number(s) *Check box representing preferred number for patient reminders, etc.*   | □ Home                                     □ Cell □ Work |
| Email Address: |  |
| Enable Patient Portal: |       □ Yes □ No   |
| Contact Name and #  In Case of Emergency / Relationship  |  |
| Name of Primary Care Provider:City and State of PCP |  |
| Employer Name: |  |
| Employer Address: |  |
| City, State and Zip Code |  |
| Your Occupation: |  |
| Who may we thank for referring you? |  |
| **Insurance Information** |
| Primary Insurance Company: |  |
| Telephone Number: | Policy Number: | Group Number: |
| Secondary Insurance Company: |  |
| Telephone Number: | Policy Number: | Group Number: |
| Policy Holder / Subscriber's Name |  |
| Financially Responsible Party: |  |

**New Patient Questionnaire - Continued**

|  |  |
| --- | --- |
| **Last Name, First, Middle Initial :** |  |

**Race: Ethnicity:**

□ American Indian □ Hispanic or Latin

□ Asian □ Not Hispanic or Latin

□ Native Hawaiian □ Refused to Report

□ Black or African American

□ White **Preferred Language:**

□ Hispanic □ English □ Spanish □ Creole

□ Other Race

□ Other Pacific Islander

□ Unreported / Refused to Report

|  |  |  |
| --- | --- | --- |
|  | Name & Address | Telephone Number |
| Name of Your Local Pharmacy |  |  |
| Name of Your Mail Order Pharmacy |  |  |
| What Lab Do You Use |  |  |

|  |
| --- |
| I hereby consent to Midway Specialty Care Center, Inc .obtaining my **Prescription History** from any/all sources.Patient's Signature:  |

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**Additional Questionnaire**

|  |  |
| --- | --- |
| My gender identity is: | □ Female □ Male □ Transgender (MTF) □ Transgender (FTM) □ Other □ Decline  |
| I live (please check all that apply) | □ Live alone □ Live with spouse □ Live with roommate(s) □ Live with parents/family □ Homeless □ Other |
| My sexual orientation is: | □ Bisexual Transgender (MTF) □ Heterosexual □ Queer □ Gay □ Lesbian □ Other □ Not sure |
| My pronoun is: | □ She/her□ He/Him□ They/Them/Their□ Other |
| Thinking of the last two weeks:Have you been feeling down, depressed or hopeless? | □ Yes □ No  |
| Thinking of the last two weeks:Have you had little interest or pleasure in doing things? | □ Yes □ No |
| Have you ever been non-consensually hit, slapped, kicked or otherwise been physically hurt by an intimate partner? | □ Yes □ NoIf yes, how long ago? |
| Have you ever been forced to have sexual activity against your will? | □ Yes □ NoIf yes, when did this happen?Was the incident reported to authorities?□ Yes □ No |

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**Medical Questionnaire**

|  |  |
| --- | --- |
| Do you have any Drug or other Allergies? |  |
| **Sexual & Behavioral History:** |  |
| Do you consider yourself? | □ Heterosexual □ Homosexual □ Bisexual |
| Are you sexually active?  | □ Yes □ No If so, how many partners have you had? |
| Sexual practices?  | □ Vaginal □ Anal □ Oral |
| Do you use condoms or some type of barrier protection?  | □ Yes □ No |
| Birth control method? | □ Oral Contraception □ IUD or other implant □ None □ N/A |
| Have you ever been in jail or prison? | □ Yes When? □ No  |
| Do you smoke? | □ Yes How long/much? □ No  |
| Do you use other tobacco products? pipe, cigar, snuff, chew | □ Yes Circle kind? □ No  |
| Do you have a history of using IV drugs or "street" drugs? | □ Yes What? □ No  |
| Do you drink alcohol? □ Beer/Wine □ Liquor | □ Yes Frequency? □ No  |
| Do you have a history of alcohol or substance abuse? | □ Yes Explain: □ No  |
| Do you drink coffee or other caffeine products?  | □ Yes How many cups per day? □ No  |
| What type of diet do you follow? |  |
| Place of Birth? City/State? |  |

|  |  |
| --- | --- |
| Please list all medications you are currently taking (include Over-The-Counter Medications and/or Supplements) |  |

|  |  |
| --- | --- |
| Please list any other symptoms or health concerns that you would like to discuss with your healthcare provider: |  |

**Past Medical History**

Have you had any of the following sexually transmitted diseases or other issues?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STD's** | **Yes** | **No** | **Other Diagnoses** | **Yes** | **No** | **Unk** |
| Syphilis |  |  | Hepatitis B |  |  |  |
| Gonorrhea |  |  | Hepatitis C |  |  |  |
| Venereal Warts |  |  | Psychological Disorder |  |  |  |
| Genital Herpes |  |  |  |  |  |  |
| Chlamydia |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Vaccination & Healthcare History:** | **Approximate Date** |
| Flu shot |  |
| Hepatitis A shot |  |
| Hepatitis B shot |  |
| Pneumonia vaccine |  |
| Tetanus shot |  |
| Tuberculosis PPD |  |
| Have you ever had a positive PPD test? |  |
| Meningitis |  |
| MMR |  |
| Varicella |  |
| Pap smear |  |
| Mammogram |  |
| Eye exam |  |
| Dental exam |  |
| Colonoscopy |  |
| Chest x-ray |  |
| Dexa scan |  |
| PSA |  |
| Have you ever had a blood transfusion? |  |
| Have you traveled out of the country | Where and when? |

|  |  |
| --- | --- |
| **Surgical History** | **Year** |
|  |  |
|  |  |

|  |  |
| --- | --- |
| **Hospitalizations / Facility** | **Year** |
|  |  |
|  |  |

Do you have any of the following symptoms?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Symptom** | **Yes** | **No** | **Symptom** | **Yes** | **No** |
| Rash, itchy skin or skin disorder |  |  | Change in vision |  |  |
| Sinus congestion |  |  | Difficulty swallowing |  |  |
| Hearing loss |  |  | Dental problems |  |  |
| Cough |  |  | Shortness of breath |  |  |
| Fever |  |  | Night sweats |  |  |
| Chest pain or palpitations |  |  | Nausea and/or vomiting |  |  |
| Constipation or diarrhea |  |  | Blood in stool or hemorrhoids |  |  |
| Vaginal or penile discharge |  |  | Painful urination |  |  |
| Genital/Rectal warts or ulcers |  |  | Muscle weakness |  |  |
| Muscle pain or joint swelling |  |  | Tingling, burning, pain or numbness in extremities |  |  |
| Poor appetite |  |  | Sudden weight loss or gain |  |  |
| Suicidal thoughts? |  |  | Suicide attempts |  |  |
| Anxiety/stress |  |  | Unexplained fatigue/weakness |  |  |

Do you have or is there a family history of the following conditions? (Check those that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Health Condition** | **Self** | **Family** | **Health Condition** | **Self** | **Family** |
| Alcoholism |  |  | High Blood Pressure |  |  |
| Anemia |  |  | Kidney Disease |  |  |
| Blood Disorder |  |  | Mental Illness |  |  |
| Cancer |  |  | Frequent Headaches or Migraines |  |  |
| Diabetes |  |  | Osteoporosis |  |  |
| Epilepsy/Seizures/Convulsions |  |  | Stroke |  |  |
| Glaucoma |  |  | Thyroid Disease |  |  |
| Hair Loss |  |  | Heart Disease |  |  |
| Heart Problems |  |  | Lung Problems |  |  |
| High Cholesterol or Triglycerides |  |  | Back or Joint Problems |  |  |
| Neuropathy |  |  | Prostate or Cervical Problems |  |  |

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**Patient Self Determination Act Questionnaire**

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745 of the Florida Statutes, Please answer the following questions by initialing the applicable response:

Declaration to decline Life-Prolonging Procedure (Living Will)

\_\_\_\_\_I have such a declaration

\_\_\_\_\_I have NOT made such a declaration

Health Care Surrogate

\_\_\_\_\_I have a designated health care surrogate

\_\_\_\_\_I have NOT designated a health care surrogate

Durable Power of Attorney

\_\_\_\_\_I have appointed a durable power of attorney

\_\_\_\_\_I have NOT appointed a durable power of attorney

**24-Hour Cancellation & No-Show Policy**

Each time a patient misses an appointment without providing proper notice, another patient is unable to receive care. Midway Specialty Care Center, Inc. reserves the right to charge a fee of $25.00 for all missed appointments ("no-shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour notice.

"No-Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple no-shows in any twelve (12) month period by result in discharge from the Practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have reviewed this notice and understand the policy.

|  |  |
| --- | --- |
| Printed Name: | Date: |
| Signature |

|  |  |
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 **CONSENTS**

**Health Insurance Portability and Accountability Act**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) require that we ask your permission before disclosing certain healthcare information to certain people or entities.

|  |
| --- |
|  |

In accordance with the Act, I

(patient'ssignature)

Hereby authorize Midway Specialty Care Center, Inc. to release any information regarding my health to the following persons or entities:

|  |  |  |
| --- | --- | --- |
| Name | Date of Birth | Relationship |
|  |  |  |
|  |  |  |
|  |  |  |

**Leaving Messages for You**

In the event that I am not available when Midway Specialty Care Center, Inc. calls with medical information:

*(Please check the applicable box* ***and*** *initial beside it.)*

□ Please DO leave messages on my answering machine or voicemail.

□ Please NO NOT leave messages on my answering machine or voicemail.

□ I DO NOT HAVE an answering machine or voicemail.

**Insurance Authorization and Assignment**

All Charges are payable at the time of service.

All professional services rendered are charged to the patient. Necessary forms will be complete to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage, it is also customary to pay for services when rendered unless other arrangements have been made in advance.

Insurance Authorization and Assignment:I hereby authorize Midway Specialty Care Center, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Furthermore, I am aware that if I have an HMO Plan a referral must be obtained from my primary care provider for EACH visit to Midway Specialty Care Center. If one is NOT obtained, I understand that I will be held responsible for all charges.

|  |  |
| --- | --- |
| Patient's Name: |  |
| Patient's Signature: |  |
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**NOTICE OF PRIVACY PRACTICES**

**ACKNOWLEDGEMENT**

**I understand that under the Health insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:**

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and/or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notices of Privacy Practices** from time to time and that I may contact the organization at any time or go to the Company's website to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

|  |  |
| --- | --- |
| Patient's Name: |  |
| □ Self or Relationship to Patient |  |
| Patient's Signature: |  |
| Date: |  |