



What is the reason for your visit today?

How did you hear about our office/who can we thank?

Patient Information			
Name (First, Middle, Last)	Birth Date	Age	Birth Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Phone#
Spouse Name		Spouse Phone #	
Mailing Address		Apt# City	City, State, ZIP
Email Address			
Employer (or parent/guardian employer if patient is a minor)			Work Phone#
Preferred Language			Ethnicity: Hispanic or Latino Not Hispanic or Latino
Race <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____ <input type="checkbox"/> Prefer not to answer			

Guarantor/Responsible Party		
Legal Name of Responsible Party	Birth Date	Relationship to Patient

Medical Insurance (Please present ID & insurance card to the front desk)		
PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Policy Holder Name	Insured Date of Birth	Patient Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent

Emergency Contact		
Contact Name	Phone Number	Relationship to Patient

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Faith Family Wellness or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Constitutional

- Weight loss
- Weight gain
- Fever or chills
- Trouble sleeping
- Fatigue
- Weakness
- Sleep Disturbance

Head

- Headache
- Head injury
- Metal in head

Neck

- Pain
- Swollen glands
- Stiffness

Eyes

- Vision Problems
- Glasses
- Contacts
- Pain
- Redness
- Blurry or double vision
- Glaucoma
- Cataracts
- Legally Blind

Ears

- Hearing loss
- Hearing Aide
- Earache
- Ringing in ears
- Vertigo

Nose

- Sinus pain
- Frequent sneezing
- Snoring
- Nosebleeds
- Hay fever
- Sleep apnea
- Nose congestion

Mouth/Throat

- Dry mouth
- Non-healing sores
- Sore throat
- Dentures
- Jaw claudication (pain in the jaw when chewing)

Cardiovascular

- Chest pain
- Shortness of breath with activity
- Palpitations
- Difficulty breathing lying down
- Swelling of the feet
- Abnormal Heart Rhythm

Respiratory

- Cough (dry or wet, productive)
- Sputum (color and amount)
- Coughing up blood (hemoptysis)
- Shortness of breath (dyspnea)
- Wheezing
- Painful breathing

Women:

- Abnormal period
- Abnormal PAP
- Abnormal bleeding
- Normal Cycle- every 28 days

Gastrointestinal

- Ulcer
- Hiatal Hernia
- Frequent heartburn/indigestion
- Gall bladder attacks/gallstones
- Frequent Diarrhea
- Frequent Constipation
- Acid Reflux/GERD
- Abdominal Pain
- Yellow eyes or skin
- Nausea
- Blood in Stool

Genitourinary

- Urinary Tract Infection-frequent
- Pain/burning with urination
- Trouble starting urinary stream
- Frequent night urination
- Kidney stones/infection
- Blood in Urine in the past year

MEN:

- Prostate Problems
- Prostatic Disease
- Sexual Dysfunction

Musculoskeletal

- Joint pain/problems _____
- Muscle pain _____
- Osteoporosis
- Joint Replacement
- Fibromyalgia
- Arthritis
- Metal in Body
- Rheumatoid Arthritis
- Low Back Pain
- Mid Back Pain
- Neck Pain

Skin/Integumentary

- Rashes
- Dry Skin
- Skin wound
- Change in Mole
- Itching
- Skin Cancer

Neurologic

- TIA (*transient ischemic attack*)
- Numbness
- Paralysis
- Fainting
- Seizures
- Epilepsy
- Memory loss/lapses
- Panic Attack
- Alzheimer's
- Dementia

Psychiatric

- Stress
- Depression
- Anxiety
- Nervousness

Endocrine

- Hyperthyroid
- Hypothyroid
- Thyroid Disease
- Cold Intolerance
- Heat Intolerance
- Diabetes
- Type: _____

Hematologic

- Anemia
- Easy bruising
- Easy bleeding
- Previous Blood Transfusion

Vascular

- Calf pain with walking (Claudication)
- Leg cramping

Other: _____

PSA Lab Test: _____ PSA Screening: _____ Other: _____

SOCIAL HISTORY

TOBACCO HISTORY

Are you an active cigarette smoker? Yes No
 Have you ever been a cigarette smoker? Yes No
 If yes, I smoked an average of _____
 packs/day for _____ years.

I quit in _____ (year)
 Do you use other tobacco products? Yes No
 If yes, please specify:
Oral Tobacco, Cigars, Pipe, Electronic Cigarettes

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? Yes No
 Do you currently drink alcohol regularly? Yes- currently Never Rarely
 If yes, approximately how many drinks per week (beer, wine, or liquor) _____
 Have you ever used intravenous drugs? Yes No

FAMILY HISTORY: Is there an history your family of? (check all that apply)
NO Significant Family History is Known

	Mother	Father	Brother	Sister	Grandmother (Maternal)	Grandmother (Paternal)	Grandfather (Maternal)	Grandfather (Paternal)
High Cholesterol								
Heart Attack								
Diabetes								
Prostate Cancer								
Kidney Cancer								
High Blood Pressure								
Kidney stones								
Other significant disease?								

ARE YOU INTERESTED IN LEARNING MORE ABOUT ? (check all that apply)

- Botox Filler Micro Needling Micro-Needling with PRP Facial/HydraFacial Massage
- IV therapy (fluid hydration) Weight Loss Program Nutrition Consult Zo Medical Skin Care

FINANCIAL AND CONSENT FOR TREATMENT AUTHORIZATION FORM

Please carefully review and initial the following rules and regulations related to our office. Please always try to follow these regulations as they are intended to make the workflow in our office more efficient and practical. If you have any questions about these, please do not hesitate to ask one of our office staff members.

_____ AUTHORIZATION FOR MEDICAL CARE AND TREATMENT: Consent for Treatment I consent freely and voluntarily to participate in the treatment that may be ordered by my healthcare provider. I understand that I may withdraw consent at any time. This may include but is not limited to telemedicine services, outpatient treatment, and diagnostic procedures by the Faith Family Wellness as may be deemed necessary or advisable by my provider /or consultants. If I need additional treatments or procedures my consent will be obtained except in emergencies or unusual circumstances.

_____ I authorize the release of any medical or demographic information to determine medical benefits or to facilitate payment for such services.

_____ I understand that I am financially responsible to Faith Family Wellness and the clinic for any charges not covered by my healthcare benefits. It is my responsibility to notify the aforementioned provider of health coverage changes or additions in a timely fashion. I understand that if all or part of the balance is denied by insurance, I am responsible for the balance in full.

_____ I understand that payment for services are due in full at the time of service unless other arrangements have been made in advance. At the time of service, I will pay for my co-pay or co-insurance portion and/or deductible.

_____ I authorize Faith Family Wellness to file my medical insurance. I request payment of the authorized insurance benefits, including Medicare (if I am a Medicare beneficiary) be made to the a fore mentioned provider for any services or equipment provided. A photocopy of this assignment will be considered effective and valid as the original.

PRESCRIPTIONS

_____ Prescription refills take 72 hours to process and complete. Please allow yourself at least three business days to get the medication filled. Please plan ahead if the prescription is due on a weekend or holiday and give us enough time to prepare the prescription.

_____ I understand that Faith Family Wellness may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my provider and my pharmacy. I have been informed and understand that my provider using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my provider to see this health information.

LATE POLICY /NO SHOW POLICY

_____ If you are running late for your appointment, please contact our office. We will determine whether or not your appointment will need to be rescheduled. If you arrive more than 15 minutes late to your scheduled Appointment time, we will make an effort to accommodate you. However, your appointment may be rescheduled.

_____ We may charge you a \$25.00 "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

Patient Signature: _____ **Date:** _____



Faith Family Wellness
207 Aberdeen Parkway Panama City, FL 32405
PH: (850) 788-3120 / FAX: (850) 788-3125

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION & MEDICAL RECORDS

(This authorization is renewed annually)

I hereby authorize Faith Family Wellness to use and disclose my protected health information and medical records as necessary for treatment, payment, healthcare operations, continuity of care, and coordination with other healthcare providers, facilities, laboratories, imaging centers, pharmacies, insurance companies, and third-party payers.

This authorization may include information related to **sexually transmitted diseases, HIV/AIDS, behavioral or mental health services, and treatment for alcohol or drug abuse**, as permitted by law.

I understand that:

- I have the right to inspect and obtain a copy of the information disclosed
- Reasonable fees for copying or mailing medical records may apply
- This authorization is **voluntary**
- I may **revoke this authorization in writing at any time**, except to the extent action has already been taken in reliance upon it
- Information disclosed pursuant to this authorization may no longer be protected by federal privacy regulations

Unless revoked earlier, this authorization will **expire one (1) year** from the date signed below.

Patient Signature or Representative

Date

Relationship to Patient

Date of Birth

∩
Patient Name _____

Date of Birth: _____ 2020



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ACKNOWLEDGEMENT OF AVAILABILITY OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices: You have the right to review our Notice of Privacy Practices before deciding whether or not to sign this consent. A copy of our Notice is available upon request. Our Notice describes our treatment, payment, and healthcare operations and the uses and disclosures of your protected health information.

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment, and healthcare operations.

I have been informed of the availability of this office’s Notice of Privacy Practices and understand that I may request a copy at any time. I understand that by signing this consent form, I am authorizing the use and disclosure of my protected health information for treatment, payment, and healthcare operations.

If this consent is signed by a personal representative on behalf of the patient, complete the following:

 Patient Signature or Representative

 Date

 Relationship to Patient

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This authorization is limited to communication related to my medical care, appointments, and billing.

NAME	Relationship to the patient

I understand that the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do it in writing.

Patient Signature: _____

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 Patient Name _____ Date of Birth: _____ 2026