Faith Family Wellness
207 Aberdeen Parkway, Panama City, FL 32405 • Ph: 850-788-3120 • Fax: 850-788-3125

Patient Information			
How did you hear about our office/who can we thank?			
Name (First, Middle, Last)	Birth Date	Age	Birth Gender ❑Male ❑Female
Marital Status: □ Single □ Married □ Divorced □ Widowed			**Cell Phone#**
Spouse Name		Spouse Phone #	
Mailing Address		Apt# City	City, State, ZIP
Email Address:			
Contact Information: ☐ OK to Email ☐ Ok to Text ☐ Do not contact by these methods			
Employer (or parent/guardian employer if patient is a minor)			Work Phone#
Primary Care Provider:			**Ethnicity:** Hispanic or Latino Not Hispanic or Latino
Race ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Native American ☐Native Hawaiian ☐Pacific Islander ☐Other _____ ☐Prefer not to answer			
Guarantor/Responsible Party			□ **Self Pay**
Legal Name of Responsible Party:	**Relationship to Patient:**		**Birth Date**

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 □Self □Spouse □Dependent
SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship □Self □Spouse □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

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PATIENT MEDICAL HISTORY

HEIGHT: **WEIGHT:**

DOMINANT HAND: ☐ RIGHT ☐ LEFT

ALLERGIES (include medication, food latex and environmental allergies**)** **No Known Allergies**☐

Allergy to 1. _____ 2. _____ 3. _____

Severity/Reaction _____ _____ _____

CURRENT MEDICATION/SUPPLEMENTS- *please provide list if need more space* **No Current Medication** ☐

Medication Name	Dose	Frequency

Pharmacy Name/Address _____**Phone**_____

PROCEDURES/SURGERIES **No Surgeries/Procedures** ☐

_____ _____
Date Surgery Date Surgery

_____ _____
Date Surgery Date Surgery

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

	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								
Breast Cancer								
Ovarian Cancer								

Other:

TOBACCO HISTORY/ALCOHOL & DRUG HISTORY

Active cigarette smoker? ☐ Yes ☐ No
Ever been a cigarette smoker? ☐ Yes ☐ No
If yes, avg _____ packs/day for _____ yrs
Quit in _____ (year)
Other tobacco products? ☐ Yes ☐ No
If yes, specify: _____ (Oral, Cigar, Pipe, E-cig)

Ever diagnosed with alcoholism? ☐ Yes ☐ No
Do you currently drink alcohol? ☐ Yes ☐ Never ☐ Rarely
Approx. drinks/week: _____

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Patient Name: _____ **DOB:** _____

GYNECOLOGIC HISTORY

What is the reason for your visit today?

1. What is the first day of your last menstrual period (LMP)? _____

2. How long does your period usually last? _____

3. How many days apart are your menstrual cycles (from the first day of one to the first day of the next)? _____

4. What age did you start having menses (menarche)? _____

5. When was your last Pap smear and where was it performed? _____

6. Have you ever had an abnormal Pap smear? (Yes / No) If yes: When? _____

What abnormality? _____7. Age at menopause (if applicable): _____

8. Are you currently on hormone replacement therapy (HRT)? (Yes / No) If yes, what type? _____

Have you ever been treated for: ☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts ☐ Herpes ☐ Trichomonas ☐ Syphilis

Have you ever tested positive for HIV? ☐ No ☐ Yes
Did you mother take the drug DES when she was pregnant with you? ☐ No ☐ Yes

Are you currently sexually active? ☐ No ☐ Yes ☐ Never Sexual Orientation _____

Did you begin sexual activity before 16yo? ☐ No ☐ Yes If yes, Age started: _____

Have you had > 5 sexual partners in your lifetime? ☐ No ☐ Yes If yes, how many? _____

Are you currently using birth control? ☐ No ☐ Yes Trying to get pregnant: _____

Current birth control: _____ Are you satisfied with it: ☐ No ☐ Yes

Past Birth control methods: Condoms ☐ Birth control pills ☐ Withdrawal ☐ Tubal Ligation ☐
Diaphragm ☐ Patch ☐ Rhythm ☐ Vasectomy ☐ Vaginal Film ☐ Vaginal Ring ☐ IUD ☐ Essure ☐

	Number		Number		Number
Total times pregnant		Full term deliveries		Cesarean sections	
Miscarriages		Deliveries before 37 weeks		Forceps or vacuums	
Abortions		Living children			

List your children's information**
Child #1- SEX: _____ DOB: _____ Birth type: ☐ Vaginal ☐ C-Section
Child #2- SEX: _____ DOB: _____ Birth type: ☐ Vaginal ☐ C-Section
Child #3- SEX: _____ DOB: _____ Birth type: ☐ Vaginal ☐ C-Section
Child #4- SEX: _____ DOB: _____ Birth type: ☐ Vaginal ☐ C-Section

Describe any special pregnancy problems:

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Women's Health – Medical History & Review of Systems

Major Medical History: Please check all that apply

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Disease ☐ Thyroid Disease ☐ Anemia

☐ Blood Clots (DVT/PE) ☐ Clotting Disorder ☐ Autoimmune Disease ☐ Asthma/Lung Disease

☐ GERD/Reflux ☐ Liver Disease/Hepatitis ☐ Kidney Stones/Infections

☐ Arthritis/Joint Problems ☐ Osteopenia/Osteoporosis

☐ Anxiety ☐ Depression ☐ Fibroids ☐ Endometriosis ☐ PCOS

☐ Cancer (type): _____ ☐ Other: _____

General

☐ Fever ☐ Chills ☐ Fatigue ☐ Weight Gain ☐ Weight Loss

☐ Trouble Sleeping ☐ Snoring / Sleep Apnea

Eyes / ENT

☐ Vision Changes ☐ Blurry / Double Vision ☐ Glasses

☐ Contacts

☐ Ear Pain ☐ Ringing ☐ Sinus Problems ☐ Sore Throat

☐ Mouth Sores ☐ Dry Mouth

Heart / Lungs

☐ Chest Pain ☐ Shortness of Breath ☐ Palpitations

☐ Leg Swelling

☐ Wheezing ☐ Cough ☐ Coughing up Blood

Gynecologic

☐ Abnormal or Heavy Bleeding ☐ Irregular Cycles

☐ Vaginal Discharge / Odor ☐ Itching / Burning

☐ Pelvic Pain ☐ Menstrual Cramps

☐ Painful Intercourse ☐ Genital Lump / Lesion

☐ Fertility Concerns

Neuro / Mental / Hormonal

☐ Headaches ☐ Dizziness ☐ Fainting

☐ Numbness / Tingling ☐ Weakness

☐ Memory Changes ☐ Seizures ☐ History of TIA / Stroke

☐ Mood Swings ☐ Anxiety ☐ Panic Attacks ☐ Depression

☐ Suicidal or Homicidal Thoughts

☐ Hot Flashes ☐ Cold / Heat Intolerance ☐ Easy Bruising

☐ Heavy or Prolonged Bleeding

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GYN OFFICE FINANCIAL AND CONSENT FOR TREATMENT AUTHORIZATION FORM

Please carefully review and initial the following rules and regulations related to our office. These regulations are intended to make our workflow more efficient and practical. If you have any questions, please 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 provided by Faith Family Wellness, as deemed necessary or advisable by my provider and/or consultants. If additional treatments or procedures are required, my consent will be obtained except in emergencies or unusual circumstances.

Release of Medical Information

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

Financial Responsibility

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

_____ I understand that payment for services is 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, co-insurance portion, and/or deductible.

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

Prescriptions

_____ Prescription refills take **72 hours** to process. Please allow at least three business days to have your prescription filled. Plan ahead if the prescription is due on a weekend or holiday.

_____ 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 understand that my provider will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent for my provider to access this information.

Late / No-Show Policy

_____ If you are running late for your appointment, please contact our office. We will determine whether your appointment needs to be rescheduled. If you arrive more than **15 minutes late**, your appointment may need to be rescheduled.

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

Patient/Guardian Signature: _____Date: _____

Patient Name: _____ DOB: _____

AUTHORZATION TO DISCLOSE HEALTH INFORMATION & MEDICAL RECORDS

I authorize to release my medical records, including medical history, lab results, imaging, immunizations, medications, and treatment records, to *Faith Family Wellness.* I understand these records may include information related to sexually transmitted diseases, HIV/AIDS, behavioral or mental health services, and treatment for alcohol or drug abuse.

This authorization is for the purpose of continuity of care. I understand that I may inspect or obtain a copy of the information released. I understand that I may revoke this authorization at any time by providing written notice. Revocation does not apply to information already released. Signing this authorization is voluntary.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature or Representative Date

_____

Relationship to Patient

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

Notice of Private Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information. Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care 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

I, _____ give *Faith Family Wellness* permission to release and/or discuss my medical records or conditions with the following individual(s):

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: _____

Name _____ DOB: _____