1905 West Busch Boulevard Tampa, Florida 33612
Phone: 813.365.3525 **Fax**: 813.365.3515
www.alviormedicalclinic.com

NEW PATIENT REGISTRATION

PATIENT INFORMATION				
PATIENT NAME:			RESPONSIBLE FOR PAYMENT?	
(First)	(Initial)	(Last)	Yes ◯ No ◯	
PATIENT ADDRESS:				
(Number & Street)	(APT #)	(City)	(State)	(Zip)
HOME PHONE NO:		CELL PHONE NO:	EMERGENCY PHONE NO:	
DATE OF BIRTH:	Sex: M ◯ F ◯	Marital Status:	Single ◯	Married ◯
(mm/dd/yyyy)			Divorced ◯	Widowed ◯
SOCIAL SECURITY:		EMPLOYER NAME:		
EMPLOYER PHONE NO:		EMPLOYER ADDRES		
EMAIL ADDRESS:		May we leave confidential messages on:		
OTHER PHYSICIAN:		Email: Yes ◯ No ◯	Voicemail: Yes ◯ No ◯	
RACE:	ETHNICITY:	Language Preference:		
IF PATIENT IS A DEPENDENT, GIVE GUARDIAN/PARENT INFORMATION				
MOTHER'S NAME:			RESPONSIBLE FOR PAYMENT?	
(First)	(Initial)	(Last)	Yes ◯ No ◯	
ADDRESS:				
(Number & Street)	(APT #)	(City)	(State)	(Zip)
HOME PHONE NO:		EMPLOYER:	WORK PHONE:	
FATHER'S NAME:			RESPONSIBLE FOR PAYMENT?	
(First)	(Initial)	(Last)	Yes ◯ No ◯	
ADDRESS:				
(Number & Street)	(APT #)	(City)	(State)	(Zip)
HOME PHONE NO:		EMPLOYER:	WORK PHONE:	
GUARDIAN'S NAME:			RESPONSIBLE FOR PAYMENT?	
(First)	(Initial)	(Last)	Yes ◯ No ◯	
ADDRESS:				
(Number & Street)	(APT #)	(City)	(State)	(Zip)
HOME PHONE NO:		EMPLOYER:	WORK PHONE:	
INSURANCE INFORMATION				
PRIMARY INSURANCE:		GROUP NO:	POLICY/ID NO:	
ADDRESS:		EFFECTIVE DATE:		
POLICY HOLDER'S NAME:		RELATIONSHIP TO PATIENT:		
DATE OF BIRTH:	Sex: M ◯ F ◯	SUBSCRIBER EMPLOYER INFO:		
SECONDARY INSURANCE:		GROUP NO:	POLICY/ID NO:	
ADDRESS:		Effective Date:		
POLICY HOLDER'S NAME:		RELATIONSHIP TO PATIENT:		
PERSON TO NOTIFY IN CASE OF EMERGENCY				
NAME:		RELATIONSHIP TO PATIENT:		
HOME PHONE NO:		CELL PHONE NO:	WORK PHONE:	
REFERRING PHYSICIAN				
PHYSICIAN'S NAME:			PHONE NO:	
ADDRESS:				
How did you hear about us?	Yellow Pages ◯	Saw Office/Sign ◯	Family/Friend ◯ _______	Website ◯
	Other ____	Insurance Plan Provider List ◯	Physician ◯ __________	

Thank you for choosing us for your health care.

*** IMPORTANT INFORMATION REGARDING YOUR ACCOUNT ***

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred.

NOTICE OF "NON-COVERED" SERVICES

I am aware that some services performed by the practice may be considered "non-covered" by my insurance carrier or Medicare, therefore I will become fully responsible for payment of these services.

WAIVER OF "USUAL, CUSTOMARY AND REASONABLE" CLAUSES

(For patients with UCR coverage) I acknowledge that the fees charged by the Practice for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable, due to specialized services and staff. However I agree to pay the Practice fees in full even if the amount is greater than what I am reimbursed for from my insurance company.

BILL TO / PAYMENT INSTRUCTIONS

◯ COMMERCIAL INSURANCE / THIRD PARTY PAYOR ◯ MEDICARE ◯ MEDICAID

I hereby authorize the practice to bill my insurance company and or Medicare (indicated or initialled above) for services provided to me and request that payments for such services to made to the Practice on my behalf.

*IF TRICARE ______________________ ______________________
Name of Insured Birthdate

LIST OF NAMES OF THOSE WITH WHOM YOU WANT US TO SHARE YOUR HEALTH INFORMATION:

NAME:	RELATIONSHIP TO PATIENT:
____	____
____	____
____	____

PERMISSION FOR TREATMENT

Permission is hereby granted for physicians, employees or agents of the Practice to render the patient named below such medical and surgical treatment as is deemed necessary.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with the Practice's notice of Privacy Practices that provides a description of Protected Health Information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this statement. I understand that the practice reserves the right to change its Notice of Private Practices that will be effective for health information the practice already has about me, as well as any they receive in the future. The practice will post a current copy of the Notice. I understand that I may obtain a copy of the current Notice in effect upon request.

I have read all of the above and understand agree to all provisions therein regarding responsibility for payment, permission for treatment, and Notice of Privacy Practices.

PATIENT'S NAME: ____

PATIENT'S or LEGAL GUARDIAN'S SIGNATURE: __________________________ DATE : ______________

IF LEGAL GUARDIAN, RELATIONSHIP TO PATIENT: ____

DRUG TEST CONSENT

Federal law requires drug screening for controlled substances. Most of the insurance will reimburse but when submitted they deny. If this happens we will charge as patient's resposibility.

**** ALL PATIENTS WHO ARE ON PAIN MEDICATIONS INCLUDING ANTI-ANXIETY, ANTI DEPRESSANTS, MUSCLE RELAXERS, ETC. WILL BE SUBJECTED TO RANDOM DRUG SCREENINGS AT THE PROVIDER'S DISCRETION AT ANY TIME.****

______________________________ Patient's Signature

______________________________ Date

NEW PATIENT HEALTH QUESTIONNAIRE

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office.
Information contained here will not be released to any person except when you have authorized us to do so.

What medical concerns brings you to the office? : ____
Occupation: (if retired, previous occupation) ____
If disabled, check here: _______ Nature of disability: _________________ Birthplace: _________________
Do you exercise routinely? (circle) No Yes If Yes, what exercise/how often _______________________________
Have you ever smoked? (circle) No Yes If Yes, # cigarettes/day _____ # years ______
If you have never smoked skip this question: Do you still smoke now? (circle) No Yes If No, when did you quit? _____
Caffeine: Do you drink (circle) Coffee, Caffeinated Teas or Sodas regularly? No Yes #/day ____________________
Have you completed Advance Directives or Do you have a Living Will? No Yes ______________________________
Tell us a little about your home environment: (e.g. live alone, with family, single parent, house, apt, etc.)
____
Are you a under a lot of pressure at work or at home? (circle) No Yes, Which? _____________________________

MEDICAL INFORMATION

Allergies: Are you allergic to any drugs? No Yes If yes, Please list ____

MEDICATIONS: (List all your medications you are taking regularly, include over the counter, herbal or natural remedies.)

Name of Medicine	Frequency	Name of Medicine	Frequency
___________________	_________	___________________	_________
___________________	_________	___________________	_________
___________________	_________	___________________	_________
___________________	_________	___________________	_________

MEDICAL ILLNESSES or CONDITIONS (List any chronic conditions you have been diagnosed to have)

_____________________________	____________________________	_____________________________
_____________________________	____________________________	_____________________________
_____________________________	____________________________	_____________________________
_____________________________	____________________________	_____________________________

Have you ever had or been diagnosed to have: *check box with all that apply*

Cataracts □	TB / Lung Disease □	Anemia □
Glaucoma □	Pleurisy □	Bleeding Disorder □
Asthma □	Jaundice □	Bone / Joint Disease □
Allergies □	Liver Disease □	German Measles □
Stroke □	Ulcers □	Rheumatic Fever □
Seizure □	Digestive Disorder	Chicken Pox □
Heart Attack □	Hemorrhoids □	Syphillis □
Heart Disease □	Kidney Disease	Depression □
Heart Murmur □	Kidney Stone(s)	Frequent Infection □
High Blood Pressure □	Diabetes □	Cancer □
Pneumonia □	Thyroid Disease □	Prostate Enlargement □

Operations

Please list any surgery and approximate year

Year	Surgery
____________	____________________
____________	____________________
____________	____________________
____________	____________________

Hospitalizations

Other than operation

Year	Reason	Hospital
________	____________________	__________________
________	____________________	__________________
________	____________________	__________________
________	____________________	__________________

Family Medical History	Age	Health (List significant Ilnesses)	Age at Death	If Deceased, Cause
Father				
Mother				
Brothers / Sisters				
Spouse				
Children				

Has any blood relative ever had? *Check if yes and indicate relationship*

_________	Alzheimers	__________________	_________	Seizures	____________________
_________	Tuberculosis	__________________	_________	Depression / Suicide	____________________
_________	Diabetes	__________________	_________	Alcoholism	____________________
_________	High Blood Pressure	__________________	_________	Mental Disorder	____________________
_________	Heart Disease	__________________	_________	Allergies	____________________
_________	Heart Attack before 55	__________________	_________	Asthma	____________________
_________	Bleeding Disease	__________________	_________	Cancer	____________________
_________	Stroke	__________________			

Health Maintenance

_________	Last Physical Exam	_________	Last Colonoscopy	_________	Last PSA (Prostate Check)
_________	Last Eye Exam	_________	Last Mammogram	_________	Last Shingles Shot
_________	Last Blood Work	_________	Last Pap Smear	_________	Last Hepatitis A/B Shot
_________	Last Flu Shot	_________	Last Bone Density Scan		

Transfusion: Have you ever had a blood or plasma transfusion? ___________

Weight: What is your weight now? _____ One year ago? _____ Maximum? _____ When? _____

Females Only: Are you pregnant, Planning a pregnancy or Nursing a Child? ___________

NEW PATIENT HEALTH QUESTIONNAIRE

System Review: Please indicate those items that have been a recurrent or a recent significant change.

YES	NO	SYSTEMIC SYMPTOMS
_________	_________	Feelig Fatigued
_________	_________	Fever
_________	_________	Chills
_________	_________	Sweating Heavily at night
_________	_________	Recent weight loss
_________	_________	Recent weight gain

YES	NO	HEAD SYMPTOMS
_________	_________	Sinus Pain
_________	_________	Headache

YES	NO	EYE SYMPTOMS
_________	_________	Worsening Vision
_________	_________	Floaters
_________	_________	Diplopia / Double Vision
_________	_________	Photopsia / Presence of flashing light
_________	_________	Pain with Eye movement
_________	_________	Photophobia / Intolerance to visual light
_________	_________	Red Eyes
_________	_________	Currently wearing eyeglasses
_________	_________	Currently wearing contact lenses
_________	_________	Eye Trauma

YES	NO	EARS/NOSE/MOUTH/THROAT/NECK
_________	_________	Hearing loss or ringing in the ears?
_________	_________	Earaches
_________	_________	Ear Discharge
_________	_________	Tinnitus / Ringing in the ears
_________	_________	Epistaxis / Nose Bleeding
_________	_________	Sneezing
_________	_________	Nasal Itching
_________	_________	Nasal Discharge

_________	_________	Premenopausal
_________	_________	Menopause has occurred
_________	_________	Vaginal Discharge
_________	_________	Irregular length of period
DATE: / /		Date of last menstruatior

YES	NO	ENDOCRINE
_________	_________	Polydipsia / Abnormal T
_________	_________	Polyuria / Abnormally large volumes of dilute urine
_________	_________	Heat Intolerance
_________	_________	excessive sweating
_________	_________	Feelings of weakness
_________	_________	Dry Skin

YES	NO	MUSCULOSKELETAL
_________	_________	Neck Pain
_________	_________	Back Pain
_________	_________	Muscle Aches
_________	_________	Arthralgias / Joint Pain
_________	_________	Muscle Cramps
_________	_________	Joint Swelling
_________	_________	Joint Stiffness

YES	NO	NEUROLOGICAL
_________	_________	Dizziness
_________	_________	Vertigo
_________	_________	Fainting
_________	_________	Confusion
_________	_________	Memory Loss
_________	_________	Speech Disturbance

________	________	Sore Throat / Hoarseness of Voice
________	________	Mouth Sores
________	________	Mouth Dryness
________	________	Bleeding Gums
________	________	Lumps or swollen glands in neck
________	________	Dysphagia / Difficulty Swallowing
________	________	Gum Bleeding
________	________	Hearing Aid

YES	NO	CARDIOVASCULAR
________	________	Chest Pain or Angina Pectoris
________	________	Palpitations
________	________	Leg Pain with exercise
________	________	Slow heart rate
________	________	Tachycardia / Fast heart rate
________	________	Exertional Breathing

YES	NO	RESPIRATORY
________	________	Difficulty in breathing
________	________	Shortness of Breath
________	________	Awakening at night for shortness of breath
________	________	Orthopnea / shortness of breath when
________	________	laying flat
________	________	Cough
________	________	Loose Cough
________	________	Dry Cough
________	________	Coughing up sputum
________	________	Hemoptysis / Coughing up blood
________	________	Wheezing

YES	NO	GASTROINTESTINAL
________	________	Loss of Appetite
________	________	Anorexia
________	________	Dysphagia / Difficulty in swallowing
________	________	Heartburn
________	________	Abdominal Pain
________	________	Nausea
________	________	Vomitting
________	________	Hematemesis / Vomitting of blood
________	________	Jaundice
________	________	Melena / Dark sticky stool
________	________	Diarrhea
________	________	Constipation
________	________	Hematochezia / Passage of blood with stool

YES	NO	GU WOMEN
________	________	Total Number of previous deliveries
________	________	Aborted Pregnancies
________	________	Birth control being practiced

________	________	Limb Weakness
________	________	Paralysis
________	________	Involuntary Movements
________	________	Difficulty with balance
________	________	Tingling
________	________	Numbness
________	________	Trauma to head

YES	NO	PSYCHOLOGIC
________	________	Confusion
________	________	Memory Loss
________	________	Nervousness
________	________	Insomnia
________	________	Depressed

YES	NO	HEMATOLOGIC
________	________	Slow to Heal after Cuts or wounds
________	________	Bleeding or Bruising tendency
________	________	Swelling, warmth or tenderness of Veins or History of Phlebitis

YES	NO	SKIN SYMPTOMS
________	________	Dry Skin
________	________	Itching
________	________	Peeling of skin
________	________	Skin Scaling
________	________	Rash
________	________	Change in Skin Color
________	________	Change in Mole
________	________	Varicose Veins

YES	NO	BREAST SYMPTOMS
________	________	Nipple Discharge
________	________	Breast Pain
________	________	Lump or Mass in Breast

YES	NO	ALLERGIC / IMMUNOLOG
________	________	Stopped medication because of rash
________	________	Allergic Reaction to iodinated contrast material
________	________	Allergy to penicillins
________	________	Reaction to narcotic agents
________	________	Reaction to Anesthetics
________	________	Allergy to foods

Please Note: This section of the medical history contains questions that may be of a personal and highly confidential aspect of your health. While we treat all information in your medical chart as confidential records, this section of the questionnaire is filed separately from the general medical data. It can be released upon written consent from you for psychiatric, mental health and substance abuse records.

The following sets of questions are to help us identify problem areas that may be difficult to discuss. Circle yes or no to each question and discuss any yes with your Physician or Nurse Practicioner.

Do you drink Alcohol? **NO** **YES** If yes, check the following below:

_________ Rarely social (less than once/week)
_________ Beer, 12 oz/day
_________ Wine, 1 glass/day
_________ Hard Liqour, 1-3 oz/day
_________ Beer, 2 bottles/day
_________ Wine, 2 glasses/day
_________ Hard Liqour, over 3 oz/day
_________ Beer, 3 bottles or more/day
_________ Wine, 3 or more glasses/day

Do you use regularly or have you used in the past marijuana, coccaine, heroin, speed, crack or other inhalants?
_________ YES _________ NO

Have you felt you need alcohol or other drugs (such as wine, beer, hard liqour, pot coke, heroin, or other inhalants?
_________ YES _________ NO

Have you felt that you use too much alcohol or other drugs?
_________ YES _________ NO

Have you tried to cut down or quit drinking alcohol or your use of drugs?
_________ YES _________ NO

Do you feel you have a drinking or drug problem at this time?
_________ YES _________ NO

Personal Safety

Do you feel safe at home?
_________ YES _________ NO

We all have arguments - when you and your partner or a family member argue, have you ever been physically hurt or threatened?
_________ YES _________ NO

Do you feel your partner or a family member controls (or tries to control) your behavior too much?
_________ YES _________ NO

Does he or she threatens you?
_________ YES _________ NO

Has your partner (or a family member) ever hit, pushed, shoved, punched or kicked you?
_________ YES _________ NO

Have you ever felt forced to engage in unwanted sexual acts or sexual contact with your partner or other family member?

_________ YES _________ NO

Mental Health

Have you ever been diagnosed to have depression?

_________ YES _________ NO

Have you ever been diagnosed to have bipolar disorder, obsessive compulsive disorder, or other psychiatric conditions?

_________ YES _________ NO

HIV Exposure

Have you ever been diagnosed to be HIV Positive? _________ YES _________ NO

Do you have any concerns about possible exposure that you would like to dicuss or be tested for?

_________ YES _________ NO

Patient Signature: ____

PHYSICIANS YOU HAVE SEEN:

Previous Primary Care Physician:

Name: ____

Address: ____

Phone Number: ________________

Recent Specialist you have seen:

Name: ____

Address: ____

Phone Number: ________________

Specialty: ____

Name: ____

Address: ____

Phone Number: ________________

Specialty: ____

Name: ____

Address: ____

Phone Number: ________________

Specialty: ____