4449 Meandering Way
Tallahassee, FL 32308
Phone: 850.644.1543
Fax: 850.645.0577

WELCOME!

Thank you for the opportunity for us to provide your healthcare with *FSU SeniorHealth*.

Attached is your registration packet; please complete this packet in its entirety. We ask that you call 850.644.1543, option 1 to schedule your appointment. If you have not selected the physician of your choice, we will schedule you with the first available appointment.

Please send your completed packet to us by fax to: 850-645-0577. You may also mail or hand-deliver your packet to: 4449 Meandering Way, Tallahassee, FL 32308 in the Lower Lobby of the Parry Center Building.

In addition to this registration packet, we ask that you bring the following to your appointment:

- **All medications and supplements/ name of your preferred pharmacy**
- **Insurance card(s)**
- **A photo ID**
- **Your email address (or your authorized representative email address)**

*So that our physicians can get to know you more quickly; we will ask to take a photo of you. *This is a onetime request that will be directly uploaded to your patient medical record.*

We are located on the campus of Westminster Oaks at 4449 Meandering Way, Tallahassee, FL 32308 in the Lower Level within the Parry Center Building. Once on the campus, feel free to park at one of the '*FSU SeniorHealth*' parking spots or visitors parking. If you have any questions or need to reschedule your appointment, please call 850.644.1543, option 1.

We look forward to seeing you at your first visit! And don't forget to tell your friends and family about us!

Sincerely,

Lynn Dorvil

Lynn Dorvil, MHA
Medical Practice Manager
850.644.1543

FSU SeniorHealth is focused on helping patients live an active and healthy lifestyle.

New Patient Questionnaire

(please complete all pages)

Full legal name:_____ Todays' date: _____

Name you wish to be called *(if different)*:_____

Date of birth:_____ Social Security #: _____

Gender: ◯ Male ◯ Female ◯ Other_____

Billing Address: _____

Street Address *Apt. Number*

City/State:_____ Zip code: _____

Mailing Address: _____

Street Address *Apt. Number*

City/State:_____ Zip code: _____

Preferred pharmacy:_____ Location: _____

Home phone #:_____ Cell phone #: _____

Work phone # *(if applicable)*:_____ Email address: _____

Contact preference *(check all that apply)*: ◯ home phone ◯ cell phone ◯ work phone ◯ email ◯ mail Race:_____ Ethnicity:_____ Language preference:_____

Who is completing this form? _____

*Relationship, if other than patient:_____ Phone #: _____

Name of primary doctor: _____

Address: _____

City/State:_____ Zip code: _____

Phone #:_____ Fax #: _____

A. PAST MEDICAL HISTORY

Which medical conditions do you have or have you had in the past? *(check all that apply)*

EYE & EAR PROBLEMS	HEART / VASCULAR PROBLEMS	LUNG PROBLEMS
◯ cataracts	◯ high blood pressure	◯ asthma
◯ glaucoma	◯ irregular heartbeats (arrhythmias)	◯ bronchitis
◯ macular degeneration	◯ heart failure	◯ emphysema
◯ hearing loss/hearing aid	◯ heart attack: year _____	◯ sleep apnea
◯ other, specify:	◯ hyperlipidemia	◯ other, specify:
	◯ other, specify:	

BONE/JOINT PROBLEMS	GLAND PROBLEMS	KIDNEY & URINARY TRACT PROBLEMS
◯ arthritis	◯ diabetes	◯ kidney disease
◯ osteoporosis	◯ overactive thyroid - high	◯ prostate disease
◯ fracture of hip, wrist or spine *(circle)*	◯ underactive thyroid - low	◯ bladder/kidney infections
◯ gout	◯ other, specify:	◯ urinary incontinence
◯ other, specify:		◯ other, specify:

GASTROENTESTINAL PROBLEMS	NERVOUS SYSTEM PROBLEMS	OTHER HEALTH PROBLEMS *(circle all that apply)*
◯ ulcers	◯ stroke	◯ allergies, specify:
◯ reflux / hiatal hernia	◯ dementia or Alzheimer's disease	◯ anemia
◯ diverticulosis	◯ Parkinson's disease	◯ hernia
◯ liver disease/cirrhosis	◯ epilepsy or seizures	◯ thrombosis (blood clots)
◯ hepatitis	◯ tremor	◯ depression
◯ polyps	◯ neuropathy	◯ sexual dysfunction
◯ gallbladder disease	◯ other, specify:	◯ cancer, specify:
◯ irritable bowel		
◯ other, specify:		
		◯ other, specify:

Surgeries – inpatient and outpatient *(use additional pages, if needed)*

DATE	SURGERY

Other Hospitalizations *(use additional pages, if needed)*

DATE	REASON FOR HOSPITALIZATION

Do you have any drug or other allergies? ◯ yes *(specify below)* ◯ no

NAME OF DRUG	REACTION

List all medicines that you currently use *(Prescriptions, Non-Prescriptions, Natural Products)*

Medications used regularly	**What dose OR strength?**	**How do you use it? (*How much OR how many tablets? How many times a day?)***
Example: Tylenol	*500 mg*	*1 pill 3 times a day*

B. SOCIAL HISTORY

With whom do you live? *(check one)*	**Which of the following best describes your residence?** *(check one)*
◯ alone	◯ single-family house
◯ spouse or partner	◯ condo or apartment
◯ child or other family member	◯ live with other in their house, condo or apartment
◯ friend	◯ other, specify:
◯ other, specify:	**Are there stairs in your home?** ◯ yes ◯ no

Are you currently…*(check one)*	**How many children do you have?** _____
◯ married	**Are you in regular contact with your children?**
◯ divorced/separated *(circle one)*	◯ yes ◯ no
◯ widowed	
◯ single *(never married)*	
◯ living with significant other	**Are you in regular contact with relatives?**
◯ other, specify:	◯ yes ◯ no

How much school did you complete? *(check one)*	**What has been your principal occupation?**
◯ less than 6th grade	_____
◯ less than high school	**Are you currently…***(check one)*
◯ high school graduate	◯ retired, not working
◯ some college	◯ working part-time
◯ college - undergraduate	◯ working full-time
◯ college – graduate/doctorate	◯ unemployed *(but not retired)*

Do you employ someone to provide care or help in your home? ◯ yes ◯ no	**Do you get help from a family member or friend in your home?** ◯ yes ◯ no
If yes, how many hours a day and how many days a week is the person available for you? _____hours/day_____days/week	**If yes, how many hours a day and how many days a week is the person available for you?** _____hours/day_____days/week
Is this sufficient to meet your needs? ◯ yes ◯ no	**Is this sufficient to meet your needs?** ◯ yes ◯ no

Who would you call if you were sick and needed help? _____	**Do you provide care for a family member?** ◯ yes ◯ no

How often do you drink alcohol? *(including beer, wine, other)*	**If you drink alcohol, has anyone ever been concerned about your drinking?** ◯ yes ◯ no
◯ never	
◯ less than 1 time a week	
◯ 1 to 3 times a week	
◯ almost daily *(4-6 times a week)*	
◯ daily	

Have you <u>ever</u> used tobacco? ◯ yes ◯ no	
If yes, do you currently use tobacco? ◯ yes ◯ no	**If you quit using tobacco…**
How many years have you used tobacco? _____	How many years ago did you quit? _____
How much tobacco do you use daily? _____	For how many years did you use tobacco? _____

Have you <u>ever</u> used other drugs? ◯ yes ◯ no	
If yes, do you currently use other drugs? ◯ yes ◯ no	**If you quit using other drugs…**
How many years have you used other drugs? _____	How many years ago did you quit? _____
What other drugs are you using? _____ _____	What other drugs have you used? _____ _____

C. DAILY FUNCTIONING

Do you require help with the following? If yes, who helps you?

TASK	NEED HELP	WHO HELPS YOU? *(name and relationship)*
feeding yourself	◯ yes ◯ no	
getting from bed to chair	◯ yes ◯ no	
getting to the toilet	◯ yes ◯ no	
getting dressed	◯ yes ◯ no	
bathing	◯ yes ◯ no	
walking safely	◯ yes ◯ no	
using the telephone	◯ yes ◯ no	
taking medicines	◯ yes ◯ no	
preparing meals	◯ yes ◯ no	
managing money/financial affairs (checkbook)	◯ yes ◯ no	
doing laundry	◯ yes ◯ no	
doing house work	◯ yes ◯ no	
shopping for groceries	◯ yes ◯ no	
driving	◯ yes ◯ no	
doing ‘handyman’ work	◯ yes ◯ no	
climbing stairs	◯ yes ◯ no	
getting to places beyond walking distance	◯ yes ◯ no	

D. FAMILY MEDICAL HISTORY

Have any members of your family had any of the following conditions?						
	Father	Mother	Brother/Sister *(indicate which)*	Brother/Sister *(indicate which)*	Brother/Sister *(indicate which)*	Brother/Sister *(indicate which)*
dementia or Alzheimers						
cancer, specify:						
heart disease or stroke						
diabetes						
depression						
other, specify:						

E. REVIEW OF SYSTEMS

During the last three months, have you had any of the following symptoms or problems? *(check all that apply)*

GENERAL	**MUSCULOSKELETAL PROBLEMS**
◯ weight loss	◯ back or neck pain
◯ weight gain	◯ arm or leg pain
◯ fevers	◯ joint pain or stiffness
◯ chills	◯ foot problems
◯ fatigue	**SKIN AND BREAST PROBLEMS**
EYES	◯ rash
◯ trouble seeing	◯ sores
◯ eye pain	◯ dry skin
◯ dry eyes	◯ breast tenderness
EAR, NOSE, MOUTH, THROAT	◯ breast lump or discharge
◯ trouble hearing	**BRAIN AND NERVOUS SYSTEM PROBLEMS**
◯ ear pain or itching	◯ frequent headaches
◯ sinus problems / runny nose	◯ frequent dizzy spells
◯ nose bleeds	◯ passing out or fainting
◯ sore throat	◯ falls
◯ hoarseness	◯ leg or arm weakness
◯ teeth problems	◯ numbness or loss of feeling
◯ mouth sores	◯ tremor or shaking
HEART PROBLEMS	**MENTAL HEALTH**
◯ chest pain or tightness	◯ depression
◯ rapid or irregular heart beat	◯ anxiety
◯ swelling of feet	◯ problems with sleep
LUNG PROBLEMS	◯ problems with memory or difficulty thinking
◯ persistent cough	**ALLERGIC / IMMUNOLOGIC**
◯ coughing up blood	◯ hives
◯ difficulty breathing or shortness of breath	◯ seasonal allergies
◯ wheezing	◯ frequent infections
GASTROINTESTINAL PROBLEMS	**BLOOD / LYMPH**
◯ difficulty swallowing	◯ easy bruising
◯ frequent indigestion or stomach ache, heartburn	◯ bleeding
◯ frequent nausea or vomiting	◯ blood clots
◯ change in bowel habits	◯ swollen lymph nodes

◯ black bowel movement or bleeding from rectum	**ENDOCRINE**
◯ diarrhea	◯ excessive thirst
◯ constipation	◯ feel too hot or too cold
GENITOURINARY PROBLEMS	◯ problems with sexual function
◯ urination at night (how many times_____)	◯ Men: problems with erection
◯ frequent urination	◯ Men: problems with prostate
◯ painful urination	◯ Women: vaginal dryness
◯ loss of urine or getting wet	◯ Women: vaginal discharge or bleeding

F. FALLS AND MOBILITY

Do you use a walking or mobility aid? ◯ yes ◯ no

If YES, check all that apply**:** ◯ cane ◯ walker / rollator ◯ wheelchair ◯ other, specify _____

Are you afraid of falling? ◯ yes ◯ no

Have you had a fall in the past year? ◯ yes *(Please continue to next question)*
◯ no *(STOP – proceed to section G below)*

Please tell us about your last two falls

If you have had less than two falls, just tell us about the one you have had. To describe the circumstances of each fall, please tell us: *what you were doing when you fell, what you think caused the fall, whether you experienced light-headedness or palpitations, how you landed (front/back/side), if there was loss of consciousness, what treatment (if any) you received for the fall, and anything else you think is important.*

Most Recent Fall

Date *(as best you can recall)*: Month:_____ Year: _____

How did this fall happen *(briefly describe circumstances)*:

_____

_____

Did you need to see a doctor or other professional for treatment after this fall? ◯ yes ◯ no

If YES, describe the treatment you received:

_____

_____

Prior Fall ____ Check here if not applicable *(if you have had only one fall)*

Date *(as best you can recall)*: Month:_____ Year: _____

How did this fall happen *(briefly describe circumstances)*:

_____

_____

Did you need to see a doctor or other professional for treatment after this fall? ◯ yes ◯ no

If YES, describe the treatment you received:

_____

_____

G. DRIVING

Do you currently drive? ◯ yes ◯ no

If you do not drive, how do you get around town? *(Check all that apply)*

◯ Family/Friend drives ◯ Cab ◯ Dial-a-Ride ◯ Public Bus

Do you (or your friends / family) have concerns about your driving? ◯ yes ◯ no

Have you had (in the past year) any: ◯ Accidents / Crashes ◯ Tickets ◯ Near Misses

Have you ever gotten lost driving? ◯ yes ◯ no

H. HEALTH MAINTENANCE

Have you ever had the Pneumovax vaccine (a shot to prevent pneumonia)?

◯ yes ◯ no If YES, in what year? _____

Have you ever had the Prevnar 13 vaccine (a shot to prevent pneumonia)?

◯ yes ◯ no If YES, in what year? _____

Have you ever had a Shingles vaccine? Zostavax ◯ yes ◯ no If YES, in what year? _____

Shingrix (2 shots) ◯ yes ◯ no If YES, in what year? _____

Have you ever had a tetanus shot? ◯ yes ◯ no

If YES, in what year did you have your last tetanus booster? _____

Did you get a flu shot during the most recent season (October-February)? ◯ yes ◯ no

Do you always wear a seatbelt when you drive or ride in a car? ◯ yes ◯ no

Do you currently participate in any regular activity to improve or maintain your physical fitness?

(either on your own or in a formal class) ◯ yes ◯ no

If YES, check all current activities

_____walking _____swimming

_____aerobics or exercise classes _____dancing

_____bicycling or stationary bike _____jogging

_____tennis or pickle ball _____golf or croquet

_____bowling or bocce _____other, specify: _____

How many minutes a week do you exercise?_____

Have you had a hearing test within the last two years? ◯ yes ◯ no

Have you had an eye exam within the past year? ◯ yes ◯ no

Have you seen a dentist in the last year? ◯ yes ◯ no

Have you ever had an examination of your bowel with a scope? ◯ yes ◯ no

(*Circle which one:* sigmoidoscopy or colonoscopy)?

If YES, in what year did you have your most recent sigmoidoscopy or colonoscopy? _____

In the past 12 months, have you had a test for blood in your stool? ◯ yes ◯ no

Men proceed to section I. Women proceed to section J.

I. QUESTIONS FOR MEN ONLY *(After completing this section, proceed to section K)*

Have you ever had a prostate exam (rectal exam)? ◯ yes ◯ no

If YES, in what year did you have your last prostate exam? _____

Have you ever had a blood test to look for cancer of the prostate (PSA)? ◯ yes ◯ no

If YES, in what year did you have your last PSA? _____

J. QUESTIONS FOR WOMEN ONLY

Do you perform breast self-exams (BSE) once a month? ◯ yes ◯ no

Have you ever had a mammogram? ◯ yes ◯ no

If YES, have you had a mammogram within the last year? ◯ yes ◯ no

If YES, when was your last mammogram? month/year_____/_____

Have you had a hysterectomy (surgical removal of the uterus)? ◯ yes ◯ no

If NO, have you ever had a Pap smear/pelvic examination? ◯ yes ◯ no

If YES, when was your last Pap smear? month/year _____/_____

***K.* PLANNING for FUTURE HEALTHCARE** *(please bring a copy of each document marked 'YES' below)*

Do you have a medical Durable Power of Attorney or Health Care Surrogate? Surrogate's name/relationship _____	◯ yes ◯ no
Do you have a Living Will?	◯ yes ◯ no
Do you have a 'Do Not Resuscitate Order Form' at your home or residence?	◯ yes ◯ no

Do you have any other health concerns that you would like your doctor to know about?

_____

_____

_____

FLORIDA MEDICAL PRACTICE PLAN
FLORIDA STATE UNIVERSITY College of Medicine

Florida Medical Practice Plan™
FSU Clinical Practices Financial Policies

MRN:_____ PATIENT NAME:_____ VISIT DATE:_____

1. Payment is expected at time of service. This includes co-pays, co-insurances and deductibles.

2. At check out, our staff will ask you for payment for any past due balances as well as your portion of the payment for today's service. Failure to meet your financial obligations could result in being discharged from the practice.

3. If you are unable to keep your appointment, it is important to notify us 24 hours prior to your appointment. This will allow us to free your appointment time for other patients. You may be charged a $25 cancellation or no show fee if you fail to notify us.

4. Adult patients who do not show up for a scheduled appointment 3 times within a 12 month period and fail to notify us prior to the appointment, may be discharged as a patient. Patients under the age of 18 may be discharged for the same.

5. If you are scheduled for an elective non-covered procedure, an estimate of your portion of the payment will be given to you. Payment will be expected at least 10 days prior to this procedure. If you have any outstanding balance, we will also expect payment 10 days prior to the procedure. Failure to make the required payments will result in the service being rescheduled. When you receive your estimate, you will also receive a payment voucher to send back with your payment. Please remember to include the voucher along with your payment.

6. Some insurances require that your labs be performed in a different location other than your doctor's office. If you choose to have the test performed at your physician's office, you will be expected to pay the fee for this service. Your insurance cannot be billed in those instances.

7. Similarly, if your insurance does not authorize a procedure or test and you choose to have the procedure or test done anyway, you will need to pay for the service up front. Your insurance cannot be billed in those instances.

If you have any questions, please call our Patient Relations department at (850) 644-1543, and select option 4, Monday thru Friday, 8:30 AM to 4:30 PM.

Patient or Guarantor Signature_____Date_____

FLORIDA MEDICAL PRACTICE PLAN™
FLORIDA STATE UNIVERSITY College of Medicine

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Reassignment of Benefits

I authorize the release of any medical or other information necessary to process my claims. I also request payment of all benefits including government benefits to the physician or supplier for services rendered under Florida Medical Practice Plan, Inc.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Authorization to Disclose Medical Information

I authorize the release of any medical or other information necessary to provide care for myself to the individual(s) listed below.

_____

Name

_____

_____

Name

Medical History Information

I authorize *FSU SeniorHealth*™ to access all of my prior medical records in order to provide consultation(s).

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

FLORIDA STATE UNIVERSITY
College of Medicine

Authorization for Release of Medical Records

Patient Name: _____ DOB: _____

From: _____
(Health Care facility releasing information)

To: _____
(Name of institution or individual receiving information)

_____
(Street Address)

_____
(City) (State) (Zip)

Information to be disclosed:

From (Date) _____ To (Date) _____

- ◯ Discharge Summary
- ◯ History and Physical Examination
- ◯ Operative Report
- ◯ Pathology Report
- ◯ Laboratory Results/
- ◯ X-ray Reports
- ◯ EKG/EEG Reports
- ◯ Emergency Room Record
- ◯ Clinic Notes
- ◯ Behavioral Health Information
- ◯ Physical/ Occupational Therapy Notes
- ◯ Prenatal (Pregnancy) Records
- ◯ Radiology Images
- ◯ Other (please specify) _____

Purpose of Release: ◯ Medical Care ◯ Transferring Care ◯ Personal Records ◯ Attorney

◯ Other _____

This Statement of Consent can be revoked at any time before disclosure of information, and expires on _____.
If no expiration date or identifiable event is listed, then authorization expires 12 months after it is signed. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Revoking the authorization will not have any effect on actions taken prior to revocation. I understand that the individual/ institution that receives the information described above, may not be covered by federal privacy regulations, and that the information may be disclosed publicly and no longer be protected by those regulations.

_____ _____
(Signature of Patient) (Signature of Parent, Guardian, or Authorized Representative)

_____ _____
(Date) (Print Name)

_____
(Relationship to patient)

Note:
Please fax all records to: (850) 645-0577
Or mail: *FSU SeniorHealth™*
4449 Meandering Way
Tallahassee, Florida 32308
ATTN: FSU SeniorHealth