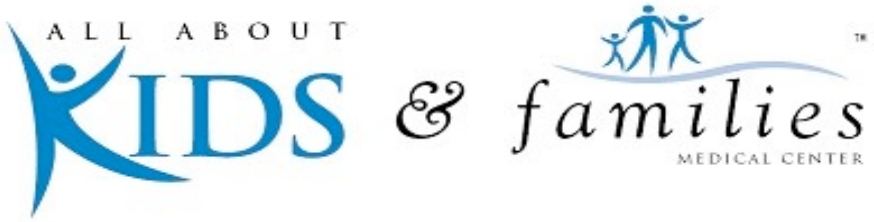

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Date: _____

Patient's Full Legal Name _____

Nickname or name patient goes by _____

Social Security # _____ DOB _____ Age _____

Address_____

City, State, Zip _____

Home Phone # _____ Cell Phone # _____

Email Address _____

Driver's License # _____

Gender: Male Female Marital Status: Single Engaged Married Divorced

Employer_____Occupation _____

Business Address _____

City, State, Zip _____Work Phone # _____

Who may we thank for referring you to our office? _____

In case of emergency,
who should be notified? _____ Relationship to patient _____

Home Phone# _____ Cell Phone # _____

Preferred Pharmacy:_____Phone #_____

Insurance Information (Primary coverage)

Name of Person Holding Policy_____

Relationship to Patient_____

Insurance Co. Name_____ Policy #_____

Address _____Group #_____

Address con't _____ Phone #_____

City, State, Zip_____ Effective date coverage began _____

Insurance Information (Secondary - if applicable)

Name of Person Holding Policy_____

Relationship to Patient _____

Insurance Co. Name_____ Policy #_____

Address _____ Group #_____

Address con't _____ Phone #_____

City, State, ZIP_____ Effective date coverage began_____

Insurance Assignment and Release

I, the undersigned, certify that I have insurance coverage with_____

(Name of Insurance Company)

and assign directly to All About Kids & Families all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the providers to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____Date _____

Medical and Family History Form

Date of Last Annual Wellness Exam: _____

Most important concerns for this visit:

1._____

2._____

ALLERGIES to Medication(s): [ ] Yes (detail below) [ ] No Known Drug Allergies

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Other Allergies (please list):_____

MEDICATIONS: Please list all prescription medications, over-the-counter medications, vitamins, and other supplements you are currently taking:

	Medication Name	Dose (mg)	Type (tablet, cream, IV)	How Often?
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Please indicate if you have had any of the following screening tests, and the most recent date:

Colonoscopy: _____ DEXA (bone density): _____ Women: Pap: _____ Mammogram: _____

Adult immunizations: It is very important for us to have the dates of your most recent immunizations. Please check with your previous provider for dates.

Tetanus [ ] Yes [ ] No Date: _____ Was pertussis included (Tdap)? [ ] Yes [ ] No

Pneumonia [ ] Yes [ ] No Date: _____ Zostavax [ ] Yes [ ] No Date: _____

Hepatitis B [ ] Yes [ ] No Dates (3 shots): _____

HPV [ ] Yes [ ] No Dates (3 shots): _____

CURRENT HEALTH SYMPTOMS
Please complete all questions:

1. Have you had a recent weight gain or loss that worries you? [ ] Yes [ ] No
2. Have you had any unexplained fevers or night sweats? [ ] Yes [ ]No
3. Do you have sinus or nasal allergy symptoms that affect your quality of life? [ ] Yes [ ] No
4. Do you have any vision or hearing problems that are bothersome? [ ] Yes [ ] No
5. Are you experiencing chest pains or irregular beats that worry you? [ ] Yes [ ] No
6. Do you have unusual shortness of breath or a persistent cough? [ ] Yes [ ] No
7. Do you have leg swelling that is recurrent or bothersome? [ ] Yes [ ] No
8. Do you experience wheezing when you breathe? [ ] Yes [ ] No
9. Do you have sleep problems that interferes with quality of life? [ ] Yes [ ] No
10. Have you been told that you snore and stop breathing during sleep? [ ] Yes [ ] No
11. Do you have constipation, diarrhea, stomach pain or other problems with digestion that interfere with your quality of life? [ ] Yes [ ] No
12. Have your bowel movement patterns changed in recent months? [ ] Yes [ ] No
13. Do you have problems with urination that affects quality of life? [ ] Yes [ ] No
14. Do you have problems with sexual function that affects quality of life? [ ] Yes [ ] No
15. Do you have joint or back problems that affect your quality of life? [ ] Yes [ ] No
16. Do you have leg pain, numbness or weakness that limits how fast or far you can walk? [ ] Yes [ ] No
17. Do you have headaches that affect your ability to function? [ ] Yes [ ] No
18. Have you had an unexpected fall with injury in the past year? [ ] Yes [ ] No
19. Do you have poor balance or fear of falling? [ ] Yes [ ] No
20. Do you have little pleasure in doing things? [ ] Yes [ ] No
21. Do you feel down, depressed, or hopeless? [ ] Yes [ ] No
22. Are you concerned about anxiety or stress in your life? [ ] Yes [ ] No
23. Are you concerned about your memory? [ ] Yes [ ]No
24. Have you noticed unusual bruising or bleeding? [ ] Yes [ ] No
25. Do you have unusual skin lesions that concern you? [ ] Yes [ ] No

Comments: _____

_____

* Note: Evaluation of these concerns is not usually part of an annual wellness or preventative exam. It is likely that your doctor will need to schedule extra time or an additional appointment to follow up on these problems.

*Patient initials _____

CONSENT FOR MEDICAL TREATMENT

1. CONSENT FOR HEALTH CARE SERVICES. I authorize physician(s), therapists(s), their assistants and/or designees to administer any treatment as may be necessary or advisable in my diagnosis and treatment at All About Kids & Families. This authorization includes, but is not limited to, medical services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, which my physician or provider considers necessary. My health care providers will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that health care services may be rendered by students, interns or residents under supervision. I understand that the All About Kids & Families may release copies of my medical records to other physicians, practitioners and healthcare facilities for treatment and other purposes, as permitted by law. I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered by the practice.

2. ALL ABOUT KIDS & FAMILIES PRACTITIONERS. I understand that I may receive services from professionals who provide care to me who are not employees or agents of All About Kids & Families. These professionals may include other physicians requested by my physician to participate in my care as well as radiology, pathology and laboratory services. As a result, I understand that I may receive bills for these services that are separate from the bills I receive from All About Kids & Families. I understand that, in some cases, these non All About Kids & Families professionals or facilities may not be participating providers under my insurance plan. I understand it is my responsibility to verify whether professionals providing my care are participating providers under my insurance, and that I may be responsible for any out of network costs incurred due to non-participation.

3.MEDICARE and/or MEDICAID CERTIFICATION. I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the practice on my behalf for the charges for which the practice is authorized to bill in connection with these health care services.

4. FINANCIAL AGREEMENT. I understand that there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of the practice and of physicians rendering services not otherwise paid by my health insurance or other payor. Estimated patient responsibility is due at the time of service. Any remaining charges are due upon receipt of the bill. I understand the practice may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the practice. I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by the practice or any entity to which the practice assigns my account. I also consent to the use of any updated or additional contact information that I may provide to the practice or any entity to which the practice assigns my account, as well as the use of technology including auto-dialing and/or prerecorded messages in contacting me.

All official All About Kids & Families policies are maintained electronically and are subject to change. No printed policy should be taken as the official policy except to the extent it is consistent with the All About Kids & Families policy that is electronically maintained.

5. PREAUTHORIZATION REQUIREMENTS. I understand that it is my sole responsibility to verify that all pre-authorizations are in place and to comply with all requirements of any insurance plan upon which I am relying for coverage of the practice's and physicians' charges. I also understand that my insurance may require an office visit referral from my primary care physician to see a specialist. It is my responsibility to contact my primary care physician and acquire the necessary referral prior to my scheduled appointment. If a referral is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visit.

6. ASSIGNMENT FOR DIRECT PAYMENT. I authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my physicians. I understand that I am financially responsible to the practice or my physicians for charges not covered or paid pursuant to this authorization.

7. ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES. I acknowledge that All About Kids & Families has offered me a copy of its Notice of Privacy Practices.

By checking one of the boxes below, I acknowledge:

- ☐ I have been offered or accepted a copy of the Notice of Privacy Practices
- ☐ I declined a copy of the Notice of Privacy Practices

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

_____

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME (PRINT) DATE TIME

_____

RELATIONSHIP / REASON WHY PATIENT IS UNABLE TO SIGN

_____

ADDRESS OF PATIENT

All official All About Kids & Families policies are maintained electronically and are subject to change. No printed policy should be taken as the official policy except to the extent it is consistent with the All About Kids & Families policy that is electronically maintained.

CLASSIFICATION OF ETHNICITY & RACE

Providing you with the very best care is our highest consideration. In order do that, it will help us to know a little bit about you.

While most diseases cross all ethnic/racial and gender boundaries, there are certain disease processes that are more likely to occur in a certain race or gender. In fact, some people may have different symptoms, or respond differently to treatments, because of these factors.

For that reason, we would like for you to share some information with us about your race/ethnicity. Sharing this information is entirely optional, but we believe it will assist our physicians and other care-givers in serving you best. It will not be used as a basis to deny or otherwise restrict the health care services you receive. Please consider the information below. Thank you.

Ethnicity

Do you consider yourself to be Hispanic or Latino according to the definition below?

(Choose only one)

- **Yes, I am Hispanic or Latino**---A person of Mexican, Puerto Rican, Cuban, Central American, South American, or other Spanish culture or origin, regardless of race

- **No, I am not Hispanic or Latino**

Race

What race do you consider yourself to be?

- **American Indian or Alaska Native**---A person having origins in any of the original peoples of North, Central, or South America, and who maintains tribal affiliation or community attachment

- **Asian**---A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam

- **Black or African American**---A person having origins in any of the black racial groups of Africa.

- **Native Hawaiian or other Pacific Islander**---A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

- **White**---A person having origins in any of the original peoples of Europe, the Middle East, or North Africa

- **Refuse to provide information**--- I do not wish to provide some or all of the above information

- **More Than One Race** Please list:_____

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EMERGENCY CARE/CONSENT FOR TREATMENT

Patient Name_____ Date of Birth _____

I hereby give permission to all of the providers of All About Kids & Families Medical Center to direct any medical treatment to my children during my absence.

It is understood that they will make every effort to contact me in case of a medical emergency. It is further understood that if they are unable to contact me, I give them this permission with my full consent.
If hospitalization is necessary, I direct the providers of All About Kids & Families Medical Center to arrange admission. I will be financially responsible for all hospital expenses.

For non-urgent care (well care, immunizations, minor illnesses, etc.), it is necessary for you to list the individuals to whom you have given permission to bring the child in for care.

Do you consent to Clinical Trials or Research ( ) Yes ( ) No. Please Initial _____

I authorize the following people to bring my child in for medical care, in my absence. Please check the boxes to give them additional specific authorizations.

Name: _____ _____Relationship: _____
I authorize the above named person to: ☐ **Pick up Prescriptions** ☐ **Receive Medical Information** ☐ **Pick up Medical Forms**

Name: _____ _____Relationship: _____
I authorize the above named person to: ☐ **Pick up Prescriptions** ☐ **Receive Medical Information** ☐ **Pick up Medical Forms**

Name: _____ _____Relationship: _____
I authorize the above named person to: ☐ **Pick up Prescriptions** ☐ **Receive Medical Information** ☐ **Pick up Medical Forms**

Name: _____ _____Relationship: _____
I authorize the above named person to: ☐ **Pick up Prescriptions** ☐ **Receive Medical Information** ☐ **Pick up Medical Forms**

Signature of patient/parent/ guardian_____ Date _____
Witness: _____ (AAKF Staff)

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FINANCIAL POLICY

Your understanding of our FINANCIAL POLICY is important to us. Please let us know if have any questions about our fees, financial policy or your responsibilities.

* CO-PAY, CO-INSURANCE, DEDUCTIBLES AND BALANCES ARE DUE AT THE TIME OF SERVICE

* WE ACCEPT CASH, VISA, MASTERCARD & DISCOVER

* BILLING
  All About Kids & Families does not bill or extend credit. You are required to pay your co-pay, deductible, or any balance due at the time of service. We cannot hold checks. If you have an emergency situation or an issue that will prevent you from paying for your service, please contact our billing department in advance and they will discuss arrangements with you.

* INSURANCE
  If we accept your insurance, you are responsible for any deductibles, co-insurance or co-pays at the time of service. IF YOUR INSURANCE CARRIER CHANGES, IT IS YOUR RESPONSIBILITY TO NOTIFY US WHEN CHECKING IN. IF YOU FAIL TO DO SO, YOU MAY BECOME RESPONSIBLE FOR THE FULL AMOUNT OF THE VISIT. Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company. You are responsible for the timely payment of your account.

* I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered, not covered by insurance. I have read all of the information above and understand it to the best of my knowledge. I will notify you of any and all future changes.

Signature of Patient_____ Date_____

All About Kids & Families Medical Center

Privacy Policy Notification

INTRODUCTION

All About Kids & Families Medical Center is committed to protecting the privacy of our patients. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), All About Kids & Families Medical Center has created a Privacy Policy. The purpose of this notification is to familiarize you with the existence of our policy, as well as give you an overview of its contents. The full written policy is available to you on request.

As a patient you have the right to:

- Be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- Prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his or her care.
- Know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- To receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- To know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- To express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

As a patient you have the responsibility to:

- For providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- For reporting unexpected changes in his or her condition to the health care provider.
- For reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- For following the treatment plan recommended by the health care provider.
- For keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- For his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- For assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- For following health care facility rules and regulations affecting patient care and conduct.

Signed by Patient / Guardian: _____ Date:_____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Patient Name _____ Patient SS# _____ DOB _____

Patient's Address_____

I hereby authorize All About Kids and Families Medical Center to (please check one of the following):

☐ **Obtain copies of my medical record (s) from:** ☐ **Release copies of my medical record (s) to**:

Name_____

Address _____

Phone Number _____Fax Number _____

Information as identified below is to be released:*(check all that apply)*

☐ **All Medical Records ***	☐ Emergency Room Report	☐ Mental/Behavioral Health Notes
☐ Progress Sheets/Clinic Notes	☐ Cardiac Rehab	☐ X-ray Reports
☐ Doctors Orders	☐ Operative Report	☐ Pulmonary Rehab
☐ Lab/Pathology Report	☐ Occupational Health	☐ Immunization Record
☐ PT/OT/ST	☐ Psychological Report	☐ History & Physical
☐ Discharge Summary	☐ Chemical Dependency	☐ Other_____

All records pertaining to psychiatric/mental health, chemical dependency and/or communicable diseases (*if any such information exists),* may be released unless otherwise specified above.

*This information is needed for the following purpose(s):_____

HIPAA Privacy Rule. I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named above.

I acknowledge that I have read and understand this authorization and its content.

Signature of Patient_____ Date _____

Signature of Parent or Legal Guardian _____ Date _____

Prohibition of Disclosure: Federal Law (42 CFR Part 2) and HIPAA 1996 prohibit further disclosure of this information except with written consent from the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

Witness _____(Staff Name) Date _____

Past Medical History:

Please review the list below and check any conditions you have had now or in the past.

- ☐ Abnormal Pap Smear
- ☐ Acne
- ☐ ADD/ADHD
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Blood Clot
- ☐ Blood Transfusion
- ☐ Cancer (What kind)
- ☐ Chronic Bronchitis
- ☐ Crohn's Disease or IBS
- ☐ Colon Polyps
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Drug Abuse
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Emphysema
- ☐ Frequent UTI's
- ☐ Freq Sinus Infections
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Condition (specify)
- ☐ Hepatitis (specify A, B, C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Melanoma or Skin Cancer
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Positive TB Skin Test
- ☐ Prostate Problems
- ☐ Psoriasis
- ☐ Reflux (heartburn)
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Sexually Trans. Disease
- ☐ (specify)
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis
- ☐ Warts

Other medical problem(s) not on this list:_____

Please check or list any **SURGERIES** you have had:

Type of surgery:	**Year**	**Type of surgery:**	**Year**
☐ Appendectomy	_____	☐ Hysterectomy	_____
☐ Arthroscopy (joint)	_____	☐ Knee or Hip Replacement	_____
☐ Back or Neck Surgery	_____	☐ Mastectomy or Lumpectomy	_____
☐ Cataract Surgery	_____	☐ Mastectomy/Lumpectomy	_____
☐ Cesarean Section	_____	☐ Polyp Removal (colon)	_____
☐ Gallbladder Removal	_____	☐ Tonsillectomy/Adenoidectomy	_____
☐ Heart Surgery (specify)	_____	☐ Tubal Ligation or Vasectomy	_____
☐ Hemorrhoids	_____	☐ Plastic Surgery (specify)	_____
☐ Hernia	_____	☐ Other (specify)	_____

Please list all previous **HOSPITALIZATIONS**:

Reason for hospitalization:	**Date**
_____	_____
_____	_____
_____	_____
_____	_____

For Women:

Last menstrual period _____

Last pap smear _____

Last mammogram _____

Last bone density _____

Age of first period _____

# of days in cycle _____

# of days in flow _____

Are you menopausal Y N

Age at onset of menopause _____

# of pregnancies _____

# of live births _____

# of miscarriages _____

# of abortions _____

# of living children _____

Family Health History:

Have any of your family members had any of the following health problems?

Condition:	**Family Member:**	**Condition:**	**Family Member:**
☐ Heart Disease/attack	_____	☐ Osteoporosis	_____
☐ Stroke	_____	☐ Migraines	_____
☐ Diabetes	_____	☐ Breast Cancer	_____
☐ High Blood Pressure	_____	☐ Colon Cancer	_____
☐ High Cholesterol	_____	☐ Prostate Cancer	_____
☐ Thyroid Disease	_____	☐ Lung Cancer	_____
☐ Depression	_____	☐ Ovarian Cancer	_____
☐ Other Mental Illness	_____	☐ Uterine Cancer	_____
☐ Alcoholism	_____	☐ Skin Cancer	_____
☐ Asthma	_____	☐ Other Cancer	_____

Any other illness in the family not listed? _____

Mother's Health Condition(s): _____

Living? Y/N If no, age at death_____

Father's Health Condition(s): _____

Living? Y/N If no, age at death_____

Sibling's Health Condition(s): _____

Other: _____

Health Habits:

1. Do you smoke currently? Yes No

   If yes, how much? # of cigarettes per day _____ # of years smoking _____

   If no, did you smoke in the past? Yes No How many years? _____ How much? # of packs per day _____

   Are you exposed to smoke? Yes No

   Any other tobacco use? Yes No Type: Cigars Chewing Tobacco Snuff Other

2. Do you drink caffeine? Yes No If so, how much?
3. Do you drink alcohol? Yes No What kind? Beer Wine Liquor Other:_____

   If so, how many times per week? _____ month? _____ year? _____

   Have you ever had a problem with alcohol in the past? (legal or social) Yes No

4. Have you ever used street drugs? Yes No

   Which ones? Marijuana IV drugs Amphetamines Cocaine Heroin Downers Inhalants

   Other _____

   Are you still using? Yes No Which ones? _____
5. Are you sexually active (in the last year)? Yes No

   If yes, circle all that apply: 1 partner multiple partners Male partner(s) Female partner(s)

   Which birth control do you or your partner use? None Condoms Pill Vasectomy/tubal

   Other_____
6. Do you exercise? Yes No If so, what type and how often? _____
7. Do you eat out at restaurants weekly? Yes No Times per week _____
8. How many servings of fruits and vegetables do you get per day? 0 1 2 3 4 5 >5
9. Do you take a calcium supplement? Yes No Number of dairy servings per day: _____ (e.g. milk, cheese)
10. Do you wear a seatbelt while in a vehicle? Yes No
11. Do you have a living will (do not resuscitate, medical power of attorney)? Yes No

    If no, would you like information? Yes No
12. Is there concern for your safety (emotional, physical, or sexual abuse)? Yes No
13. Do you feel safe at home? Yes No

NO SHOW POLICY

This policy has been established to help us to serve you better.

Our goal is to provide quality individualized medical care in a timely manner. It is necessary for us to schedule appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient who is in need of medical care.

A "no show" is missing a scheduled appointment without providing our office notice. A "late cancellation" is cancelling an appointment without contacting our office at least 24 hours in advance of a scheduled office visit.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel, you may be preventing another patient from getting much needed treatment, due to a seemingly "full" schedule.

If an appointment is not cancelled at least 24 hours in advance:

1st Occurrence: You will be contacted and reminded of our no-show/ cancellation policy.

2nd Occurrence: You will no longer be permitted to schedule follow up appointments/ well visits during our "prime" extended hours of 4:00 - 8:00pm or on weekends.

3rd Occurrence: You may be discharged as a patient from our practice.

For your convenience, our Patient Fusion patient management system allows you to opt-in for appointment reminders via email. We encourage all of our patients to take advantage of this complimentary service.

Patient Name _____ Date _____

Signature of Patient_____

Signature of Parent or Legal Guardian _____