DISCOVER HEALTH

Patient Information Form

Last Name: _____ **First Name:** _____ **MI:** _____

Status: ☐ S ☐ M ☐ W ☐ D

Address: _____

Home Phone: _____ **Cell Phone:** _____

Work: _____

DOB: _____ **Age:** _____ **SEX:** ____ **Social Security #:** _____

Email Address: _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other ☐ Decline

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Native Islander or another Pacific Native ☐White ☐Other

Out Of Sate Address _____
City ,State ,Zip: _____ **Home Phone:** _____

Emergency Contact name: _____ **Phone Number:** _____
Relationship to the Patient: _____

PLEASE GIVE THE FRONT DESK YOUR INSURANCE CARDS / PHOTO ID TO COPY FOR YOUR FILE

Referring Physician: _____ **Primary Physician:** _____
Primary Insurance: _____ **Policy Number:** _____
Insured's Name: _____ **Relationship to patient:** _____
Date of Birth: _____ **SS #:** _____
Secondary Insurance: _____ **PolicyNumber:** _____

ASSIGNMENT OF BENEFITS: *(Allows us to file for your insurance) I hereby assign all medical, to include major medical benefits which I am entitled including Medicare and private insurance and any other health plans to: Discover Health. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is valid as the original. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. I authorize Discover Health to download my medication history and RX benefits into my account from an RX clearinghouse.*

Signed: _____ **Date:** _____

PREVIOUS SURGERIES/DATES: 1) _____ 3) _____

2) _____ 4) _____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING? *(Place ☑ by applicable items)*

- ☐ Headache
- ☐ Earache
- ☐ Sore throat
- ☐ Sinus trouble
- ☐ Hoarseness
- ☐ Eye problems
- ☐ Chest pain/pressure
- ☐ Short of breath
- ☐ Sleep w/ head elevated
- ☐ Swollen ankles
- ☐ Rapid or irregular pulse
- ☐ Cough Abdominal pain
- ☐ Nausea/Vomiting
- ☐ Trouble swallowing
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Weight gain
- ☐ Weight loss
- ☐ Urine burns
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Difficulty w/ stream
- ☐ Urinary incontinence
- ☐ Excessive thirst
- ☐ Excessive appetite
- ☐ Double vision
- ☐ Trouble walking
- ☐ Trouble talking
- ☐ Numbness anywhere
- ☐ Weakness
- ☐ Dizzy spells
- ☐ Blackouts
- ☐ Joint pain
- ☐ Back pain
- ☐ Muscle aches
- ☐ Abnormal bruising
- ☐ Abnormal bleeding

YOUR PAST HISTORY Please ☑ *if you have ever had:*

- ☐ Heart rhythm problem
- ☐ Heart attack
- ☐ Heart failure
- ☐ Angina
- ☐ High blood pressure
- ☐ Blood clots in legs
- ☐ Blood clots in lungs
- ☐ Heart valve problem
- ☐ TB
- ☐ Emphysema
- ☐ Asthma
- ☐ Anemia
- ☐ Ulcer
- ☐ Hepatitis
- ☐ Head injury
- ☐ Glaucoma
- ☐ Pancreatitis
- ☐ Gallbladder trouble
- ☐ Cancer
- ☐ Colitis
- ☐ Kidney trouble
- ☐ Prostate trouble
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Diabetes
- ☐ Arthritis
- ☐ Lupus
- ☐ Abnormal bleeding
- ☐ Diverticulitis

YOUR CURRENT MEDICINES, INCLUDING DOSAGE AND FREQUENCY: *(May attach a list)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

WHAT DRUG OR ENVIRONMENTAL ALLERGIES DO YOU HAVE? _____

SOCIAL HISTORY: *(Please Check All That Apply)*

Tobacco Use

- ☐ Never
- ☐ Quit–*When*_____
- ☐ Cigarettes–*Pack/Day*____
- ☐ Pipe
- ☐ Cigars
- ☐ Chewing Tobacco

*How many years?*_____

Alcohol Use

- ☐ None
- ☐ Socially
- ☐ Daily

Drug Use

- ☐ None
- ☐ Marijuana
- ☐ Amphetamines
- ☐ Other

Caffeine Use

- ☐ None
- ☐ Occasional
- ☐ Daily

Exercise

- ☐ None
- ☐ 1 - 2x week
- ☐ 3 - 4x week
- ☐ 5 - 7x week

FAMILY HISTORY: Does any direct relative have:

- ☐ Asthma
- ☐ Emphysema
- ☐ Allergic condition
- ☐ Diabetes
- ☐ Lung cancer
- ☐ High blood pressure
- ☐ TB
- ☐ Sleep disorders
- ☐ Heart problem before age 60

PHARMACY: _____

Address: _____ Phone: _____ Fax: _____

Print: **Date:**

Sign: _____

No Show/Late Cancellation Policy

We strive to provide excellent medical care to all our patients. To do so effectively and efficiently, we have an appointment cancellation policy that applies to new and existing patients of the practice.

We understand that situations arise in which you must cancel your appointment. It is, therefore, requested that if you must cancel your appointment, give our office at least 24-hour's notice for the appointment and 48- hours' notice for testing. This will allow us to offer that time to another patient on our waitlist.

To remain consistent with our mission, we have instituted the following policy.

- A "No-Show," "No-Call," or missed appointment without proper 24-hour 48-hour notification may be assessed a fee.
    1. **First missed appointment** – You will receive a phone call informing you of your missed appointment with the opportunity to reschedule.
    2. **Second missed appointment** - Any established patient who fails to show or cancels/reschedules an appointment with no 24-48-hour notice will be charged a $50.00 fee.
    3. **Third missed appointment** - If a third, No Show or cancellation/reschedule with no 24–48-hour notice will be charged a $50.00 fee.
    4. **Fourth missed appointment** - You will be notified of your fourth missed appointment and may be subject to dismissal from the practice at the physician's discretion.

- This fee is NOT billable to your medical insurance.
- If you are 15 or more minutes late, the appointment may be canceled and rescheduled.
- As a courtesy, we make reminder calls for appointments one or two days in advance. Please note that if a reminder call or message is not received, the cancellation policy remains in effect.

Follow-up appointment: $50
New Patient Sleep/Weight Consultation: $100
Sleep Study: $250
Sleep Study and MSLT: $500
Home Sleep Test: $100

Financial Responsibility

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and pay in full for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Florida Sleep Specialist/Discover Health for services rendered. I authorize Florida Sleep Specialists/Discover Health representatives to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.
This signature will act as a lifetime authorization for Medicare.

I have read and understood the above Financial Policy and agree to meet all financial obligations.

Patient Name (Please Print)	Patient Signature	Date of Birth	Today's Date

Patient Name (Please Print) (If other than the patient)	Patient Signature	Date of Birth	Today's Date

HIPAA Disclosure Agreement & Disclosure information

Do we have permission to leave the following on your Phone, E-mail, or text message?

*Appointment Information	☐ YES	☐ NO
*Medical Information	☐ YES	☐ NO
*Billing Information	☐ YES	☐ NO
*Contact you at work	☐ YES	☐ NO

Other than my physicians, I authorize the following person(s) to receive information regarding my medical condition, appointments, and billing:

_____

_____

I would like to receive information/sign up for the Patient online Healthcare Portal: ☐ YES ☐ NO

I understand that the person or entity receiving authorized information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this (HIPPA) authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits.

I hereby acknowledge that I received Discover Health's Notice of Privacy Practices.

Name of Patient (please print): _____

Patient Signature: _____

Date: _____

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941-667-2796

RECORDS RELEASE

Name:_____

D.O.B:_____

Date: _____

I hereby authorize use or disclosure of protected health information about me as described below for the purpose of continuity of care:

____ Past Sleep Studies ____ X-ray ____ CT Scans

____ Office Notes ____Labs

_____ Other:

Facility/Physician Name: _____

I understand this authorization may be revoked by me at any time except to the extent the information has already released.

_____

Signature

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DISCOVER HEALTH

Weight Management History

Name: _____ Date: _____

- Purpose of visit: *Why are you seeking this visit?* (for example, I am seeking help to lose weight because of weight related complications, inability to lose weight by other means, desire for professional guidance to lose weight in a healthy manner).

  _____

  _____

  _____

  _____

  _____

  _____

- When did your weight become a problem (year/age of onset)?

  _____

- What were the circumstances at that time? *(for example: following childbirth, new job, a particular life stress)*

  _____

  _____

- Do you have (have you had) any of the following complications/comorbid conditions (circle those that apply):

Diabetes	High Blood Pressure	High Cholesterol	Heart Disease
Arthritis	Depression	Anxiety	Sleep Apnea
GERD	Stroke/mini-stroke	Blocked Arteries	Heart Attack
Pre-diabetes	Dementia	Cancer	Migraine
Gall Bladder	Gout	Varicose Veins	Blood Clots
Low testosterone	PCOS	Heavy Periods	

- Have you dieted to lose weight? Yes/No

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DISCOVER HEALTH

- Are you currently dieting? ☐Yes/No☐
- What type of eating plan works well for you? (*low carb, vegetarian, balanced reduced calorie, low fat, Paleo, meal replacements)*

_____

_____

- Do you have any religious or personal food restrictions, including food allergies/ sensitivities)? (*kosher, vegan, lacto-ovo vegetarian, gluten free, lactose intolerance):*

_____

_____

- Have you lost more than 20 pounds through dieting at any time in your life? If so, list when, weight lost, method, and long-term result:

  For example: 1989, lost 60# by diet and exercise, kept off for 3 years.

_____

_____

_____

- Have you ever taken weight loss prescription medication? If so please list when, and what was the effect, and any side effects.

_____

_____

- Have you had weight loss surgery? If so, what procedure, and when. If you have not had surgery, but have contemplated surgery, please describe:

_____

_____

- Did you have trouble with your weight as a child? As a teen?:

_____

- Is there any history of physical, sexual, or emotional abuse? _____
- Have you ever been diagnosed with an eating disorder? _____

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- On a scale of 0-10, how do you rate your desire to make changes in your weight and health? (0= I don't want to make change, 10= I am 100% motivated to make changes).

  _____

- On a scale of 0-10, how to you rate your readiness to make changes at this time: (0= not at this time, 10= I am 100% ready to do what it takes). _____
- Do you ever eat in excess, beyond what you know is healthy, and feel compelled to do so or have difficulty stopping? _____
  - Do you do so in secret? _____
  - Do you feel guilty or remorse later? _____
- On a scale of 1-10, please indicate to degree to which each of the following applies to you:
  - Hunger is a strong motivator of my eating habits: _____
  - Once I start eating, I have difficulty stopping: _____
  - I cannot resist temptation to eat certain foods: _____
  - I have strong cravings for certain foods: _____
  - I cannot have certain foods in my home / environment: _____
  - I give in easily to temptation to eat: _____
  - When in social environments, I have trouble adhering to my plan: _____
  - Family events, holidays, and traditions are trigger times: _____
  - I eat out of boredom: _____
  - I eat due to stress, or to help calm anxiety: _____
  - I eat out of fear of getting hungry: _____
  - I have trouble limiting my intake if I haven't eaten in several hours: _____
  - I have increased craving in the evening: _____
  - I can tell the difference between true hunger vs. want to eat: _____
  - I often eat even though I am not hungry: _____

DISCOVER HEALTH

- Are you frustrated with yourself that you cannot control your weight? _____
- If appropriately recommended for you, do you have any reservations about weight loss medication? _____
- What is your weight loss goal?

  _____
- Sleep quality *(Skip this section if you we are treating you for sleep disorders).*
  - What is your typical bedtime? _____
  - What is your typical wake time? _____
  - How long does it take to fall asleep? _____
  - How many times do you awaken in the night? _____
  - Is your sleep refreshing? _____
  - Do you snore? _____
  - Have you been told you stop breathing in your sleep? _____
  - Do you kick or move in your sleep? _____
- Have you had routine bloodwork in the last 6 months? If so, can we request these results? _____
- Do you have any of the following conditions that are known to contribute to weight gain, or make weight loss more difficult (circle all that apply):

☐ Diabetes ☐ Pre-diabetes ☐ Hypothyroid ☐ Low Testosterone

☐ Depression ☐ Sleep Apnea ☐ Sleep Problems ☐ Menopause

☐ Anti-depressant use ☐ Beta Blocker use ☐ Allergy medication ☐ Hormone Therapy

☐ Steroids

- Do you currently exercise? If so, how many days per week, and for how long? *(4x/week-walking 1 hour):*

  _____

Signature: _____ Date: _____

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