REVIVE & REMEDY, LLC.

Patient Information

Date: _____

Welcome to our office! Please fill out this form as completely as possible so that we will get to know you and be of greater assistance. Thank you.

Name:			Referred by: (If web search, please let us know which site or terms you searched under.)	Web Search (x) Current Patient ( ) Yellow Pages ( ) Brochure/Flyer ( ) Email/Newsletter ( ) Magazine Ad ( )	
SSN:	- -				
Address:			Family Doctor:		
City:	State:	Zip:	Sex:	Age:	
Permanent Address:	(If different from above)		Birth-date: (m/d/y)		
			Marital Status: (check one)	Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( )	
Cell Phone:			Driver's License #:		
Work Phone:			Employer name:		
If no phone how can we contact you?	Name:		Address:		
	Relation:		City:	State:	Zip:
	Phone #:		Occupation:		
E-mail:	(We will not sell or trade your e-mail address for any reason.)		Nearest Relative:	(Not living with you)	
Spouse Information:			Relationship:	Ph #	
Name:			Address:		
Social Sec #:			City:	State:	Zip:
Cell Ph #:			**In Case of Emergency Call:**		
Employer:			Name:		
Address:			Relationship:		
City:	State:	Zip:	Phone #:		
Work Ph #:			Address:		
Occupation:			City:	State:	Zip:

Patient Name: _____ Date: _____

AGREEMENTS & AUTHORIZATIONS

I understand that Terri Basken, FNP-C. and REVIVE & REMEDY, LLC. are separate business entities.

Patient Signature_____Date:_____

I agree that medical photographs may be taken in the course of the treatment.

Patient Signature_____Date:_____

I understand payment is due and payable to REVIVE & REMEDY, LLC. before any procedures/ services are rendered.

Patient Signature_____Date:_____

I understand that REVIVE & REMEDY, LLC. does not accept any checks as form of payment, only credit cards and correct cash for payment.

Patient Signature_____Date:_____

I authorize any holder of medical information about me to release full details of my medical history and treatment to REVIVE & REMEDY, LLC. I also authorize REVIVE & REMEDY, LLC., to release information to any hospital or physician I may be referred to by this office.

Patient Signature_____Date:_____

I understand if I use a credit card or financing company to pay for REVIVE & REMEDY, LLC. services, I therefore allow discussion of my medical case with the credit card or finance company, should any questions arise, and REVIVE & REMEDY, LLC. will not, therefore be in violation of any HIPAA requirements.

Patient Signature_____Date:_____

I have witnessed the above signatures: _____Date:_____
(Staff Member)

Medical History

Name:_____ **Date:**_____

1. Main reason you have come to see REVIVE & REMEDY, LLC.

_____

_____

2. Have you consulted another Provider about this? Yes ____ No ____ If yes, whom?

_____

3. Medication allergies (including tape): _____

4. Medications you are taking now, the dosage, and how often, including aspirin, birth control pills, eye-drops, Retin-A, medicated creams, vitamins and herbal meds:

Medication	Dosage	How often	Vitamins/Herbal Meds	Dosage	How often

5. Do/did you smoke? Yes _____ No _____ If yes, how much per day?_____
If you stopped, when?_____

6. Do/did you drink alcohol? Yes _____ No _____ If yes how much per day?_____
If you stopped, when? _____

7. List all surgical and non-surgical procedures and year: include cosmetic surgeries, wisdom teeth extractions, and non-surgical hospitalizations including child-births :

Description	Year	Description	Year

If you experienced any problems during any surgeries, please explain: _____

_____

_____

8. Previous major illness or injuries, not listed above: _____

_____

_____

9. Dominant hand: Right_____ **Left** _____

10. Your height: _____ **Your weight:** _____

Name:_____

	Yes	No
11. Have you ever had a bad reaction to a general anesthetic?……...	____	____
12. Has any blood relation ever had a bad reaction to an anesthetic?…	____	____
13. Have you ever had a bad reaction to a local anesthetic?(novocaine etc).	____	____
14. Do you wear contact lenses or glasses?……..…….....	____	____
15. Do you wear dentures?…….....	____	____
16. Have you ever taken cortisone-type medication by mouth?.....	____	____
17. Have you ever had any significant emotional problems?…….....	____	____
18. Have you ever been advised to see a psychiatrist?…….	____	____
19. Do you form thick scars or keloids?…….....	____	____
20. Are you overweight?.....	____	____
21. Women: Are you pregnant?…….....	____	____

22. Have you ever had: (check if yes and describe)

Condition	Yes	Description
Frequent headaches		
Eye, ear, nose or throat problems		
Sinus problems/ Hay-fever		
Bronchitis, asthma, or lung problems		
Shortness of breath while walking		
High cholesterol/ High triglycerides		
Heart disease/Chest pain		
Heart murmur		
Scarlet fever/Rheumatic fever		
High blood pressure		
Circulation problems		
Stomach/Bowel/Gall bladder problems		
Hepatitis or liver problems		
Mononucleosis		
Cold sores		
Kidney/Urine/Bladder/Prostate problems		
Breast disease/ Gynecological problems		
Slow or poor healing/ Frequent infections		
Diabetes		
Thyroid disease		
Anemia/Blood diseases/Easy bruising		
Arthritis/Joint pains/Fractures/Scoliosis		
Lupus/Scleroderma/Myasthenia/Fibromyalgia		
Stroke		
Seizures/ Epilepsy		
Pinched nerves/Numbness		
Cancer (including skin cancer)		
Blood transfusions		
Skin diseases (boils, hives, eczema, rashes)		

Name:_____

If yes to any of #22, please explain further: _____
_____
_____
_____
_____
_____
_____

23. Has anyone in your immediate family had: (list which side of family and who)

Condition	Side of Family/Who	Condition	Side of Family/Who
Cancer:		**Stroke:**	
(what type?)		**Heart disease:**	
Diabetes:		**Other family diseases:**	
High blood pressure:		**(what type?)**	

REVIVE & REMEDY, LLC.
Notice of Privacy Practice

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At **REVIVE & REMEDY, LLC.**, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to see and receive a copy of your health information, with a few exceptions. Upon receipt of written notice of permission from you, you have the right to transfer copies of your health information to another practice. Florida law allows us to charge you a reasonable fee to over costs for duplication costs. You have the right to request an amendment or a change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509-F, Washington, DC 20201. This notice goes into effect as of November 1,2021.

REVIVE & REMEDY, LLC.

Medical & Weight Loss Clinic

IMPORTANT - PLEASE READ CAREFULLY

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

This is an acknowledgement that _____,
(Print patient's name)

on _____received a copy from the office of REVIVE & REMEDY, LLC. notice of
(date)

Privacy Practices dated Nov 1,2021.

Permission has been given to notify patient of upcoming appointments and medical inquiries at

Phone number_____

Address_____

_____

By using a credit/debit card or a finance company for payment of services to REVIVE & REMEDY, LLC., I am allowing discussion of my medical case with the credit/debit card/ financing company, should any questions arise, and that REVIVE & REMEDY, LLC. will not, therefore, be in violation of any HIPAA requirements.

PATIENT SIGNATURE_____ DATE_____

REVIVE & REMEDY, LLC.

Medical & Weight Loss Clinic

PATIENT PRIVACY DISCLOSURE OF PERSONAL INFORMATION

PATIENT NAME_____

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

Name	Relationship	( ) Phone Number
Name	Relationship	( ) Phone Number

2. Please list family members or other persons allowed to pick up written prescriptions, samples, lab work results etc. related to your care:

Name	Relationship
Name	Relationship

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent **if other than your home**.

_____

_____

_____

I am fully aware that a cell phone is not a secure and private line, and that email is not a secure and private form of correspondence. If I do not wish either to be used, I will notify REVIVE & REMEDY, LLC. in writing.

PATIENT SIGNATURE_____ DATE_____