

New Patient Paperwork Introduction:

Dear Patient: You must fill out this paperwork completely. This is very important information that we must have **prior** to your office visit. Not only will it allow our medical staff to prepare your chart ahead of time for the doctor and/or nurse practitioner, but it will also shorten any wait time you could have. We will need this paperwork turned in to our office **before** we can schedule your appointment. THANK YOU VERY MUCH.

***** Due to the overflow of new patient paperwork coming into the office, if you do not fill out the form in its entirety, the office is not responsible for calling you for an appointment. *****

NOTE:

If a section is not applicable to you or your child or guardian, please write "N/A" on the page.

Please make sure to sign and date all appropriate pages.

We typically call new patients and re-establishing patients on Monday afternoons to schedule your visit.

PLEASE READ AND INITIAL: *I understand that if I do not fill out the new patient paperwork fully I will not receive a phone call from Dr. Anthony Williamitis' office (Initials) _____*

WELCOME to the practice. We look forward to seeing you!

Dr. Anthony Williamitis & Staff

REGISTRATION FORM
Anthony J. Williamitis, MD

9200 Bonita Beach Rd. SE, Suite 105
 Bonita Springs, Florida 34135
 Ph: 239-947-6808
 Fax: 239-947-9625

3900 Broadway, Suite A1
 Fort Myers, Florida 33901
 Ph: 239-790-9025
 Fax: 239-931-0498

Bonita Office Appointment *(check one)* Fort Myers Office Appointment

Today's Date: _____ PCP: _____

PATIENT INFORMATION

Patient's Last Name: _____ First: _____ Middle: _____

Is this your legal name? If not, what is your legal name? _____

Date of Birth: / / Sex: M or F Age: Marital Status:

Home Phone: _____ Cell Phone: _____
 Email Address: _____

Mailing Address: P.O. Box: _____ Street Address: _____
 City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Social Security Number: _____

Other family member's seen here? Please list name and relationship:

I was referred by: _____

INSURANCE INFORMATION

You must bring your insurance card and ID to each office visit and provide it upon check in.
 Please circle one: Self-pay Insured
 Insurance Company Name: _____ Insurance Policy #: _____
 Group #: _____ Insurance Claims Address: _____
If patient is a child, who is the subscriber on the card and their DOB?

IN CASE OF EMERGENCY:
 Name of local friend / family member: _____

The above information is true to the best of my knowledge. I authorize insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Anthony Williamitis, MD Inc. or insurance company to relate any information required to process my claim: Signature: _____ Date: _____

Health History Questionnaire

Childhood Illness you had: (Check any that apply)

- Measles
- Mumps
- Rubella
- Chickenpox
- Polio
- Rheumatic Fever

Immunizations and dates: (Check all that apply)

- Tetanus: Date: _____
- Hepatitis: Date: _____
- Influenza: Date: _____
- Pneumonia: Date: _____
- Chickenpox: Date: _____
- MMR: Date: _____

List any medical problems that other doctors have diagnosed for you:

List Surgeries and year completed:

List other Hospitalizations (and year):

Have you ever received a blood transfusion? YES or NO (Circle one)

If YES, when and why?

Your Medication (Prescribed and Over the Counter):

Name of Medication	Dosage Strength	Frequency Taken
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____

List your allergies to medications:

Name of Medication	Reactions
1 _____	_____
2 _____	_____
3 _____	_____

HEALTH AND PERSONAL SAFETY:

Exercise:	Do you exercise? If YES, how often?	YES or NO (<i>circle one</i>) _____
Diet:	Are you dieting? Number of meals you eat per day?	YES or NO (<i>circle one</i>) _____
Caffeine:	Circle all that apply: None Number of cups / cans per day?	Coffee _____ Tea _____ Soda _____
Alcohol:	Do you drink alcohol? If YES, what kind? Beer Wine Liquor How many drinks per week:	YES or NO (<i>circle one</i>) (<i>circle any that apply</i>) _____
Tobacco:	Do you use tobacco products? Which? Cigarettes Chewing Tobacco Pipe Cigars How many per day? _____ If you are a former smoker, how long did you smoke? What year did you quit? _____	YES or NO (<i>circle one</i>) _____

Drugs: (Circle answer)

Do you currently use recreational or "street" drugs? YES or NO
Have you ever injected yourself with a needle? YES or NO

Sexual Relations: (Circle answer)

Are you sexually active? YES or NO

If yes, are you trying to get pregnant? YES or NO

If not trying to get pregnant, list contraceptive or barrier method used:

Do you experience any discomfort with sexual relations? YES or NO

Would you like to speak to your provider regarding the risk of HIV or AIDS? YES or NO

Personal Safety: (Circle answer)

Do you live alone? YES or NO If NO, list people in your home: _____

Do you have frequent falls? YES or NO
If YES, when was your last fall? _____

Do you use a wheelchair, walker or cane? _____

Do you have vision or hearing loss? YES or NO

Do you have an Advanced Directive or Living Will? YES or NO
If NO, would you like information about these? YES or NO

Physical and mental abuse have become major health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue confidentially with your provider? YES or NO

Medical Marijuana (Circle One)

Are you currently using Medical Marijuana? If not, are you interested in information?
__YES, CURRENT USER __I AM INTERESTED __NOT INTERESTED

Want to Decrease Your Pain? Acoustic Therapy is Your Answer

We have added a new service. "Acoustic Therapy" is a unique, non-invasive solution for pain that treats pain in the back, lumbar area, feet, wrist, shoulder, elbow, pelvic area, hip and knee. **Are you interested? YES or NO** _____

FAMILY HEALTH HISTORY

Relationship	Father	Mother	Grandmother (Maternal)	Grandfather (Maternal)	Grandmother (Paternal)	Grandfather (Paternal)	Other
Arthritis							
Asthma							
COPD							
Dementia							
Depression							
Diabetes							
Heart Disease							
Hypertension							
High Cholesterol							
Obesity							
Osteoporosis							
Stroke							
Substance Abuse							
Breast Cancer							
Colon Cancer							
Lung Cancer							
Skin Cancer							
Stomach Cancer							
Thyroid Cancer							
Ovarian Cancer							
Prostate Cancer							
Testicular Cancer							

Mental Health (circle your answers)

Is stress a major problem for you?	YES or NO
Do you feel depressed?	YES or NO - Sometimes
Do you panic when stressed?	YES or NO
Do you cry frequently?	YES or NO
Have you ever attempted suicide?	YES or NO
Do you have trouble sleeping?	YES or NO
Do you have problems with eating or appetite?	YES or NO
Have you ever seriously thought about hurting yourself?	YES or NO
Have you ever seen a mental health counselor?	YES or NO

Other Problems

Circle any significant issues you have:

Skin	Chest / Heart	Weight Loss
Weight Gain	Head / Neck	Ears
Back (Chronic)	Back (Acute)	Intestinal
Nose	Bladder	Energy Level
Throat	Bowel	Lungs
Circulation	OTHER: _____	

If we offered PT and / or Chiropractic Care in our offices, would you use this service? YES or NO _____

WOMEN ONLY

Please answer all items below that apply to you:

Age of onset of menstruation: _____
Date of last period: _____ Period every ____ days.
Heavy periods, irregularity, spotting, pain or discharge? YES or NO
Number of pregnancies? _____ Number of live births? _____
Are you pregnant or breast feeding? YES or NO
Have you had a D&C, hysterectomy or C-Section? YES or NO
Have you had urinary tract, bladder or kidney infections in the last 12 months? YES or NO
Do you have blood in your urine? YES or NO
Do you have any problems with the control of urination? YES or NO
Are you experiencing Hot Flashes or sweating at night? YES or NO
During the time of your period, do you have menstrual pain, bloating, irritability or other symptoms? YES or NO
When was your last mammogram? ___/___/_____
Any new lumps, tenderness or swelling since your last mammogram? YES or NO
What was the date of last pap smear or rectal exam? ___/___/_____

MEN ONLY

Please answer all items below that apply to you:

Do you usually wake up to urinate during the night? YES or NO
If YES, # of times you get up? _____
Do you feel pain or burning with urination? YES or NO
Do you have any blood in your urine? YES or NO
Do you feel a burning / discharge from your penis? YES or NO
Has the stream of your urination decreased? YES or NO
Have you had any kidney, bladder or prostate infections in the last year? YES or NO
Do you have problems emptying your bladder? YES or NO
Do you have any difficulty with erections or ejaculations? YES or NO
Do you experience any testicular pain or swelling? YES or NO
What was the date of your last prostate or rectal exam? ___/___/_____
Were there any lumps or changes since then? YES or NO

Anthony J Williamitis, M.D.

Consent for Use of PHI

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Anthony J. Williamitis, M.D. Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Primacy Practices provided by Anthony J. Williamitis, M.D. Inc. describes such uses and disclosures more completely.)

I have the right to review the Notice of Primacy Practices prior to signing this consent.

Anthony J. Williamitis, M.D. Inc.

9200 Bonita Beach Rd., #105, Bonita Springs, FL 34135

3900 Broadway, Ste A-1, Fort Myers, FL 33901

With this consent, Anthony J. Williamitis M.D. Inc. may mail my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are marked "Personal and Confidential."

With this consent, Anthony J. Williamitis M.D. Inc. may call my home or other alternative location and leave a message on my voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Anthony J. Williamitis M.D. Inc. may send email my to home or other alternative location in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements. I have the right to request that Anthony J. Williamitis, M.D. Inc. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Anthony J. Williamitis M.D. Inc. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Anthony J. Williamitis, M.D. Inc. may decline to provide treatment to me.

Signature of Patient / Legal Guardian

Date

Print Patient / Legal Guardian's Name

Anthony J. Williamitis, M.D.

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PATIENT CONFIDENTIALITY AGREEMENT

Today's Date: ____/____/____

Patient Name: _____

DOB: ____/____/____

I hereby authorize:

Name: _____

Relationship: _____

Phone Number: _____

... To discuss on my behalf anything pertaining to my medical health with Dr. Williamitis or his medical staff.

(** If patient is of minor age, please make sure to put both parent's names if it is okay to speak with them on the child's behalf. **)

Parent #1: _____ Date of Birth: _____

Parent #2: _____ Date of Birth: _____

Patient Signature: _____

OR

If you do not wish to authorize anyone to speak upon your behalf, sign declaration below:

I decline: _____

Medical Records - CONFIDENTIAL

From: Anthony J. Williamitis, M.D.

9200 Bonita Beach Rd. SE, Suite 105
Bonita Springs, Florida 34135
Ph: 239-947-6808
Fax: 239-947-9625

3900 Broadway, Suite A1
Fort Myers, Florida 33901
Ph: 239-790-9025
Fax: 239-931-0498

I, the undersigned, hereby authorize you to release my medical records:

Printed Name: _____

Date of Birth: _____

Patient Signature: _____

This information may be used by the person I authorize to receive it and may be used for medical treatment, consultation or the purposes as I may direct.

Clinical Documents

This fax may contain sensitive and confidential personal health information that is being sent for the sole use of the intended recipient. Unintended recipients are directed to securely destroy any materials received. You are hereby notified that the unauthorized disclosure or other unlawful use of this fax or any personal health information is prohibited. To the extent patient information contained in this fax is subject to 42 CFR Part 2, this regulation prohibits unauthorized disclosure of these records.

If you have received this fax in error, please visit www.anthonywilliamitismd.com to notify the sender and confirm that the information will be destroyed. If you do not have internet access, please call 239-947-6808 to notify sender. Thank you for your cooperation.

Please send the following:

- Last two (2) office visit notes or any other information needed for continuing care.
- CT scans, MRI's, X-Rays, Lab work and any other diagnostic scans.

Responsibility Form **INSURANCE COVERAGE**

It is your responsibility to be aware of and understand your own medical insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is obtained by contacting your insurance carrier. We attempt to verify that your coverage is valid at the time of service. However, if your coverage is not in effect at the time of your visit, the financial responsibility for payment is yours. If you have had any changes in your insurance coverage - even if it is only a small change in the co-payment amount or change in the expiration date of the policy - you must notify us. Even a small discrepancy on the claim form can lead to a claim denial.

NON-PARTICIPATING INSURANCE COMPANIES: There are certain insurance plans that we do NOT accept. Regarding BCBS - we accept ALL with one exception: BCBS MyBlue. In addition, If your insurance carrier is one of the following: Medicaid, Humana-Medicaid, Cigna EPO, Aetna EPO, you will be responsible for the total amount of charges for your visit and treatment. ALSO: if you have an HMO insurance that we do participate in, it is your responsibility to make sure that Dr. Williamitis is your Primary Care Provider (PCP). This may change every year that you are enrolled.

CO-PAYMENTS, CO-INSURANCES AND DEDUCTIBLES

Co-payments and co-insurances are your responsibility. Your insurance company expects us to collect them from you at the time of service. Understand that you will be expected to pay your co-pay for every date of service. You are also responsible for your deductibles. The deductible is determined by your individual contract with your insurance carrier. We do not have information about each patient's deductible amount, and how much of that deductible has been met.

INSURANCE PAYMENTS SENT TO YOU

If insurance payments are sent to you by mistake, you are responsible for forwarding them to our office.

NON-COVERED SERVICES

All patients are responsible if their insurance carrier denies payment for services rendered because they were "non-covered services." These non-covered services may include certain treatment types, supplies or equipment, etc. To avoid this, please check with your insurance carrier prior to receiving any treatment.

COLLECTION CHARGES

Payment is due at the time of service. If there remains a balance due after an insurance payment, we may send a statement for the balance due. If you do not pay your balance in a timely manner, then we have the right to send it to a collection agency and you will be liable for both the balance due and the fee that the collection agency charges us to collect your balance. This fee may add up to fifty percent (50%) of your balance.

BAD CHECKS

If a check bounces you will be liable for \$25.00 in addition to the fees that the bank charges against Anthony J. Williamitis, M.D. Inc.

NO SHOW POLICY

Patients who do not show up for a scheduled appointment will be charged a \$25.00 fee unless the appointment was cancelled 24 hours in advance.

I have read and fully understand this Financial Responsibility Form on page 12 above. I acknowledge my personal financial responsibility and I consent to these terms and to continue with treatment.

Patient Printed Name: _____

Patient Signature: _____ Date: _____