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 #:
Insurance Claims Address:
If patient is a child, who is the subscriber on the card?

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? YES or NO *(circle one)*
If YES, how often? ______________________________

Diet: Are you dieting? YES or NO *(circle one)*
Number of meals you eat per day? __________

Caffeine: Circle all that apply: None Coffee Tea Soda
Number of cups / cans per day? _______ ____ _____

Alcohol: Do you drink alcohol? YES or NO *(circle one)*
If YES, what kind? Beer Wine Liquor *(circle any that apply)*
How many drinks per week: ________

Tobacco: Do you use tobacco products? YES or NO *(circle one)*
Which? Cigarettes Chewing Tobacco Pipe Cigars
How many per day? _______ How many years have you used tobacco? _________
If you are a former smoker, how long did you smoke? _____
What year did you quit? _______

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 selling 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 prostrate 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: ________________________________

(** 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. **)

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

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 herby 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 discourse 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.

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.

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

Patient Printed Name: ____

Patient Signature: ____ Date: ____________