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New Patient Questionnaire

Personal Information	Date:	Date of Birth:
Last Name, First Name, Middle Initial:		
Preferred Name:		
Gender Assigned at Birth: □ Female □ Male □ Intersex	Last four digits of your social security #:	
Family Status:	□ S □ Sig Other □ Sep □ M □ D □ W	
Home Address:		
City, State and Zip Code:		
Mailing Address: □ Same as Above		
City, State and Zip Code		
Phone Number(s) *Check box representing preferred number for patient reminders, etc.*	□ Home □ Cell □ Work	
Email Address:		
Enable Patient Portal:	□ Yes □ No	
Contact Name and # In Case of Emergency / Relationship		
Name of Primary Care Provider: City and State of PCP		
Employer Name:		
Employer Address:		
City, State and Zip Code		
Your Occupation:		
Who may we thank for referring you?		
Insurance Information		
Primary Insurance Company:		
Telephone Number:	Policy Number:	Group Number:
Secondary Insurance Company:		
Telephone Number:	Policy Number:	

New Patient Questionnaire - Continued

Last Name, First, Middle Initial :	

Race:

□ American Indian

□ Asian

□ Native Hawaiian

□ Black or African American

□ White

□ Hispanic

□ Other Race

□ Other Pacific Islander

□ Unreported / Refused to Report

Ethnicity:

□ Hispanic or Latin

□ Not Hispanic or Latin

□ Refused to Report

Preferred Language:

□ English □ Spanish □ Creole

	Name & Address	Telephone Number
Name of Your Local Pharmacy		
Name of Your Mail Order Pharmacy		
What Lab Do You Use		

I hereby consent to Midway Specialty Care Center, Inc . obtaining my **Prescription History** from any/all sources.

Patient's Signature:

Medical Questionnaire

What date were you diagnosed with HIV?	
How did you get HIV?	**Please explain:**
Do you have any Drug or other Allergies?	
Sexual & Behavioral History:	
Do you consider yourself?	□ Heterosexual □ Homosexual □ Bisexual
Are you sexually active?	□ Yes □ No If so, how many partners have you had?
Sexual practices?	□ Vaginal □ Anal □ Oral
Do you use condoms or some type of barrier protection?	□ Yes □ No
Birth control method?	□ Oral Contraception □ IUD or other implant □ None □ N/A
Have you ever been in jail or prison?	□ Yes □ No When?
Do you smoke?	□ Yes □ No How long/much?
Do you use other tobacco products? pipe, cigar, snuff, chew	□ Yes □ No Circle kind?
Do you have a history of using IV drugs or "street" drugs?	□ Yes □ No What?
Do you drink alcohol? □ Beer/Wine □ Liquor	□ Yes □ No Frequency?
Do you have a history of alcohol or substance abuse?	□ Yes □ No Explain:
Do you drink coffee or other caffeine products?	□ Yes □ No How many cups per day?
What type of diet do you follow?	
Place of Birth? City/State?	

What is the lowest your Absolute CD4 count has been in the past?	

HIV Treatment History *(skip if you are newly diagnosed with HIV)*	
Please list your current HIV medication: How long have you been on these medications?	

Please circle any HIV medications that you were on in the past:

Sustiva Efavirenz	Viramune Nevirapine	Rescriptor Delavirdine	Zerit Stavidine (d4t)	Emtriva Emtricitabine	Epivir Lamivudine	Videx Didanosine	Hivid Zalcitabine
Retrivir Zidovudine	Trizivir	Truvada	Epzicom	Viread	Combivir	Ziagen Abacavir	Agenerase Amprenavir
Crixivan Indinavir	Fortovase saquinavir	Invirase saquinavir	Kaletra Lopinavir/Ritonavir	Lexiva Fosamprenavir	Norvir Ritonavir	Reyataz Atazanavir	Viracept Nelfinavir
Are you allergic to any HIV medications?				□ Yes □ No If so, which one(s)?			

Have you had any history of HIV related opportunistic diseases?			□ Yes □ No If so, please circle below:		
Mycobacterium Infection	Tuberculosis	Syphilis	Aspergillosis	Cryptococcosis	Histoplasmosis
Cryptosporidiosis	Pneumocystis Carinii Pneumonia (PCP)	Herpes Simplex lasting more than one month	Cytomegalovirus	Herpes Zoster (Shingles)	Prog Mult. Leukoencephalopathy (PML)
Cervical Cancer	Lymphoma	Kaposi's Sarcoma	Anal Cancer	Toxoplasmosis	Non PCP Pneumonia

Please list all medications you are currently taking (excluding HIV medications): Please include Over-The-Counter Medications and/or Supplements	

Please list any other symptoms or health concerns that you would like to discuss with your healthcare provider:	

Vaccination & Healthcare History:	**Approximate Date**
Flu shot	
Hepatitis A shot	
Hepatitis B shot	
Pneumonia vaccine	
Tetanus shot	
Tuberculosis PPD	
Have you ever had a positive PPD test?	
Meningitis	
MMR	
Varicella	
Pap smear	
Mammogram	
Eye exam	
Dental exam	
Colonoscopy	
Chest x-ray	
Dexa scan	
PSA	
Have you ever had a blood transfusion?	
Have you traveled out of the country	Where and when?

Past Medical History

Have you had any of the following sexually transmitted diseases or other issues?

STD's	Yes	No	Other Diagnoses	Yes	No	Unk
Syphilis			Hepatitis B			
Gonorrhea			Hepatitis C			
Venereal Warts			Psychological Disorder			
Genital Herpes						
Chlamydia						

Surgical History	Year

Hospitalizations / Facility	Year

Do you have any of the following symptoms?

Symptom	Yes	No	Symptom	Yes	No
Rash, itchy skin or skin disorder			Change in vision		
Sinus congestion			Difficulty swallowing		
Hearing loss			Dental problems		
Cough			Shortness of breath		
Fever			Night sweats		
Chest pain or palpitations			Nausea and/or vomiting		
Constipation or diarrhea			Blood in stool or hemorrhoids		
Vaginal or penile discharge			Painful urination		
Genital/Rectal warts or ulcers			Muscle weakness		
Muscle pain or joint swelling			Tingling, burning, pain or numbness in extremities		
Poor appetite			Sudden weight loss or gain		
Suicidal thoughts?			Suicide attempts		
Anxiety/stress			Unexplained fatigue/weakness		

Do you have or is there a family history of the following conditions? (Check those that apply)

Health Condition	Self	Family	Health Condition	Self	Family
Alcoholism			High Blood Pressure		
Anemia			Kidney Disease		
Bleeding Disorder			Mental Illness		
Cancer			Frequent Headaches or Migraines		
Diabetes			Osteoporosis		
Epilepsy/Seizures/Convulsions			Stroke		
Glaucoma			Thyroid Disease		
Hair Loss			Heart Disease		
Heart Problems			Lung Problems		
High Cholesterol or Triglycerides			Back or Joint Problems		
Neuropathy			Prostate or Cervical Problems		

Patient Self Determination Act Questionnaire

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745 of the Florida Statutes, Please answer the following questions by initialing the applicable response:

Declaration to decline Life-Prolonging Procedure (Living Will)

_____I have such a declaration

_____I have NOT made such a declaration

Health Care Surrogate

_____I have a designated health care surrogate

_____I have NOT designated a health care surrogate

Durable Power of Attorney

_____I have appointed a durable power of attorney

_____I have NOT appointed a durable power of attorney

24-Hour Cancellation & No-Show Policy

Each time a patient misses an appointment without providing proper notice, another patient is unable to receive care. Midway Specialty Care Center, Inc. reserves the right to charge a fee of $25.00 for all missed appointments ("no-shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour notice.

"No-Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple no-shows in any twelve (12) month period by result in discharge from the Practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have reviewed this notice and understand the policy.

Printed Name:	Date:
Signature	

CONSENTS

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) require that we ask your permission before disclosing certain healthcare information to certain people or entities.

In accordance with the Act, I _____

(Patient's signature)

Hereby authorize Midway Specialty Care Center, Inc. to release any information regarding my health to the following persons or entities:

Name	Date of Birth	Relationship

Leaving Messages for You

In the event that I am not available when Midway Specialty Care Center, Inc. calls with medical information:

*(Please check the applicable box **and** initial beside it.)*

□ Please DO leave messages on my answering machine or voicemail.

□ Please NO NOT leave messages on my answering machine or voicemail.

□ I DO NOT HAVE an answering machine or voicemail.

Insurance Authorization and Assignment

All Charges are payable at the time of service.

All professional services rendered are charged to the patient. Necessary forms will be complete to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage, it is also customary to pay for services when rendered unless other arrangements have been made in advance.

Insurance Authorization and Assignment: I hereby authorize Midway Specialty Care Center, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Furthermore, I am aware that if I have an HMO Plan a referral must be obtained from my primary care provider for EACH visit to Midway Specialty Care Center. If one is NOT obtained, I understand that I will be held responsible for all charges.

Patient's Name:	
Patient's Signature:	

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

I understand that under the Health insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and/or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notices of Privacy Practices** from time to time and that I may contact the organization at any time or go to the Company's website to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient's Name:	
□ Self or Relationship to Patient	
Patient's Signature:	
Date:	

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Additional Questionnaire

My gender identity is:	□ Female □ Male □ Transgender (MTF) □ Transgender (FTM) □ Other □ Decline
I live (please check all that apply)	□ Live alone □ Live with spouse □ Live with roommate(s) □ Live with parents/family □ Homeless □ Other
My sexual orientation is:	□ Bisexual □ Heterosexual □ Homosexual □ Other □ Not sure
My pronoun is:	□ She/her □ He/Him □ They/Them/Their □ Other
Thinking of the last two weeks: Have you been feeling down, depressed or hopeless?	□ Yes □ No
Thinking of the last two weeks: Have you had little interest or pleasure in doing things?	□ Yes □ No
Have you ever been non-consensually hit, slapped, kicked or otherwise been physically hurt by an intimate partner?	□ Yes □ No If yes, how long ago?
Have you ever been forced to have sexual activity against your will?	□ Yes □ No If yes, when did this happen? Was the incident reported to authorities? □ Yes □ No