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www.midwaycare.org/ormond-beach

New Patient Questionnaire

Personal Information	Date of Birth:
Last Name, First Name, Middle Initial:	
Preferred Name:	
Main reason for visit:	
Social security #:	

Pronouns:
- □ She/Her/Hers
- □ He/Him/His
- □ They/Them/Theirs
- □ Ze/Hir/Hirs
- □ Other: ______

Sex Assigned at Birth: □ Female □ Male □ Other: _______________

What is your current gender identity?
- □ Male
- □ Female
- □ Transgender Male/ Transgender Man/ Female-to-Male (FTM)
- □ Transgender Female/ Transgender Woman/ Male-to-Female (MTF)
- □ Non-binary/Genderqueer/Gender Fluid
- □ Prefer to self-describe: __________
- □ Choose not to disclose

Relationship status: □ S □ Sig Other □ Sep. □ M □ D □ W □ Other ________

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

Emergency Contact / Relationship

Name of Primary Care Provider:
Phone number of PCP:

Employer Name:

Employer Address:

City, State and Zip Code

Your Occupation:

Insurance Information

Primary Insurance Company:

Telephone Number: Policy Number:	Group Number:

Secondary Insurance:
Telephone Number:
Policy Number:
Group Number:

Policy Holder / Subscriber's Name

Financially Responsible Party:

How did you hear about Midway Specialty Care Center?

□ Advertising Online
□ Google/Search Engine
□ Another Patient Referred Me
□ Outreach
□ Other ____

Race: □ Alaska Native □ American Indian □ Asian □ Asian Indian □ Black or African American □ Haitian □ Native Hawaiian □ Other Pacific Islander □ White □ Other Race □ Decline to Specify	**Ethnicity:** □ Hispanic or Latino □ Not Hispanic or Latino □ Other □ Decline to Specify **Language:** □ English □ Spanish □ Creole □ Other: _______

	Name & Address	Telephone Number
<u>Name of Your Local Pharmacy</u>		
I hereby consent to Midway Specialty Care Center, Inc. obtaining my Prescription History from any/all sources. **Patient's Signature:_X**____		

Medical Questionnaire

Medications: Please list all medications you are currently taking (including Over-The-Counter medications and/or supplements)	
Allergies: Do you have drug allergies or other allergies?	

Surgical History: If any, list month/year and what procedure. **Hospitalizations:** If any, list month/year and what reason.	

Past Medical History, Family History: Do you have or is there a family history of the following? Check those that apply

Health Condition	Self	Family	Health Condition	Self	Family
Alcoholism			HIV		
Anemia			Kidney Disease		
Bleeding Disorder			Mental Health Condition		
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		
High Blood Pressure			Prostate or Cervical Problems		
Other					

Other past medical history: ____

Other family medical history: ____

Vaccination & Healthcare History:	Approximate Date
Flu Shot	
COVID vaccine	
Hepatitis A shot	
Hepatitis B shot	
HPV vaccine	
Pneumonia 23 vaccine	
Pneumonia 13 vaccine	
Tetanus shot (TDAP)	
Tuberculosis PPD or QuantiFERON Tuberculosis Test	
Have you ever had a positive PPD test?	
Meningitis vaccine	
MMR	
Varicella	
Pap smear	
Mammogram	
Eye exam	
Dental exam	
Colonoscopy or FIT test – circle kind? DEXA scan Have you ever had a blood transfusion? Have you traveled out of the country?	Where and when?

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 pain or joint swelling			Muscle weakness **Suicidal thoughts** **Suicide attempts**		
Tingling, burning, pain or numbness in extremities			Anxiety/stress Unexplained		
Poor appetite Sudden weight loss or gain			fatigue/weakness		

If yes to any of those symptoms, please notify the provider. (FOR OFFICE USE ONLY)

Social History

Do you smoke cigarettes?	□ Yes □ No, how long/much?
Are you interested in quitting smoking?	□ Yes □ No □ N/A
If you are a former smoker, when did you quit?	
Do you use other tobacco products? (Pipe, cigar, snuff, chew)	□ Yes, circle kind. □ No
Have you been sexually active in the past year?	□ Yes □ No If so, how many partners in the past year? ____________
Are you sexually active with…	□ Men □ Women □ Trans Male □ Trans Female □ All of the above

Do you use condoms?	□ No □ All the time □ Most of the time □ Half of the time □ Some of the time
Have you ever had an STD (Sexually Transmitted Disease)?	□ Yes, circle kind. □ No Chlamydia, Gonorrhea, Syphilis, Herpes, Hepatitis C, Warts.
Sexual orientation: (check all that apply) Do you have any tattoos? Have you ever been in jail or prison? Sexual practices? (check all that apply) Birth control method?	□ Straight or Heterosexual □ Pansexual □ Lesbian, Gay or Homosexual □ Asexual □ Bisexual □ Don't Know □ Queer □ Choose not to disclose □ Other: ________________ □ Yes □ No □ Yes □ No □ Vaginal □ Anal □ Oral □ Oral pills □ Depo shot □ IUD or other implant □ None □ N/A
Pregnant?	□ Yes □ No □ Don't know □N/A
Have you ever used any substances? (Crystal Meth, Heroin, Opioids, Fentanyl, Ecstasy, Mushrooms, LSD, Cocaine, Crack)	□ Yes, circle kind. □ No □ Other: _________________
Have you ever injected any drug?	□ Yes □ No
Are you still using any drugs?	□ Yes, drug of choice: _____________ □ No
Have you ever been in a substance use rehab program?	□ Yes □ No □ N/A
Have you ever been on Suboxone or Methadone?	□ Yes, circle kind. □ No □ N/A
Are you interested in quitting substances?	□ Yes □ No □ N/A
Do you drink alcohol? □ Beer/Wine □ Liquor	□ Yes, frequency? □ No
Any history of alcohol dependence?	□ Yes □ No □N/A
Do you have any children?	□ Yes □ No

Is it difficult for you to get transportation to your appointment?	□ Yes □ No

Do you have any problems with your housing such as unsafe/unclean conditions, temporary living, or no place to live?	□ Yes, circle kind. □ No
In the past 12 months, did you ever worry that your food would run out before you had money to buy more?	□ Yes □ No
In the past 12 months, did your food ever not last and you didn’t have money to get more?	□ Yes □ No
In the past 12 months, did you have trouble paying for: (check all that apply)	□ Food □ Rent/Mortgage □ Medical Care □ Prescriptions □ Insurance □ Gas/Electricity □ Childcare □ Other: ______

Additional Questionnaire

Have you ever been on a non-consensually hit, slapped, kicked, or otherwise been physically hurt by an intimate partner?	□ Yes, how long ago? □ No
Have you ever been forced to have sexual activity against your will?	□ Yes, when did this happen? Was the incident reported to authorities? □ No

If HIV positive, please answer the questions below. If HIV negative, skip this page.

When were you diagnosed with HIV?	**Date: State of diagnosis:**
How do you think you may have gotten HIV?	Please explain:
What is the lowest CD4 count (T-cell) you ever had? What is your latest CD4 count?	□ Lowest CD4 count: □ Last CD4 count: □ Don’t know
Is your viral load currently undetectable?	□ Yes □ No □ N/A
What is your current HIV medication?	**Medication:**
Who was your HIV provider? (Please provide contact info)	**Prior provider info: Name: Phone: Address:**

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

Atripla Biktarvy	Cabenuva Cimduo	Complera	Combivir	Delstrigo	Dovato
Descovy Emtriva	Epivir Epzicom	Edurant	Evotaz	Genvoya	Intelence
Juluca Kaletra	Isentress Trogarzo	Odefsey	Prezcobix	Prezista	Reyataz
Rukobia Retrovir	Tivicay Symfi	Triumeq	Temixys	Truvada	Tybost
Norvir Symtuza	Stribild Symfi Lo	Selzentry	Viread	Vocabria	Ziagen
Other meds not listed above:					
Are you allergic to any HIV medications?	☐ Yes. If so, which one(s)? ☐ No				
Any history of medication resistance?	☐ Yes. If so, which one(s)? ☐ No				

Have you had any history of HIV related opportunistic diseases?			**☐ No** **☐ Yes. 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

Answer these questions if you are a Hepatitis C patient. If not, please skip these questions.

Are you seeking Hepatitis C treatment?	☐ Yes ☐ No
If yes, have you ever been treated before?	☐ No ☐ Yes, which drug and when?
When were you diagnosed?	Date: ___________________________

How did you get exposed?	
Do you know your last viral load?	
Are you on the liver transplant list?	
Do you have Cirrhosis?	□ Yes □ No

If you are on hormone replacement therapy, answer the questions below. If not, please skip these questions.

Are you currently seeking hormone replacement therapy (HRT)?	□ Yes □ No
If so, are you currently on HRT?	□ No □ Yes, for how long? Prescribed by whom?
Do you have a letter of support?	□ Yes □ No
Did you have a legal name change?	□ Yes □ No
Are you planning on having any surgery?	□ Yes, please describe. □ No
Have you had any of the following?	
Hysterectomy (Removal of uterus surgery)	□ Yes. Total, or partial hysterectomy? □ No
Mastectomy (Breast removal surgery)	□ Yes □ No
Orchiectomy (testicular removal surgery) Vaginoplasty	□ Yes □ No □ Yes, when? □ No
Phalloplasty	□ Yes, when?
Facial surgery	□ Yes Name of procedure and when? □ No
Total laryngectomy (Voice box surgery)	□ Yes □ No
Please describe any surgery not listed above:	

CONSENTS

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we ask your permission before disclosing certain healthcare information to certain people or entities and treating you in office or through telehealth visits. In accordance with the Act, I 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

Patient's name:____

Signature:____

☐ **Self** or Relationship to Patient:____

Date: ___________/_______/_____________

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.)*

- Do you give permission to our office to send you text messages? □ Yes □ No Initials: _______
- Do you give permission to our office to leave voicemails? □ Yes □ No Initials: _______
- Do you give permission to our office to send you emails? □ Yes □ No Initials: _______

Name:____

Signature:__________________________________

□ **Self** or Relationship to Patient:____

Date: __________/______/____________

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:____

Signature:_____________________________________

□ **Self** or Relationship to Patient:______________________________________

Date: __________/______/____________

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:____

Signature:____

□ **Self** or Relationship to Patient:____

Date: ___________/_______/_____________

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

Patient's name:____

Signature:____

□ **Self** or Relationship to Patient:____

Date: ___________/_______/_____________

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 canceled 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 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.

Patient's name:____

Signature:____

□ **Self** or Relationship to Patient:____

Date: ___________/_______/_____________

	Daniel Warner, MD PA AAHIVS ***570 Memorial Circle, STE 140*** ***Ormond Beach, FL 32174*** ***Phone: (904) 687-1164*** ***Phone: (386) 220-9886*** ***Fax:(386) 220-9638*** *www.midwaycare.org/ormond-beach*

Authorization for Release of Medical Records

I hereby request and authorize release copies of my medical records to Midway Specialty Care Center, Inc.

Records can be sent to the address above. I understand that my medical records may contain copies of information received from another health care facility or doctor. I also authorized the release of the following to Midway Specialty Care Center, Inc.

Type of information to be disclosed:

□ Entire medical record	□ Radiology reports	□ All Hospital records
□ Consultation	□ Billing statements	□ Discharge summary
□ Dental records	□ Pathology reports	□ Laboratory reports
□ Office chart notes	□ Emergency Department reports	□ Other:

In addition, I authorize, and I am aware that this information may include health information relating to (check if applicable):

□ HIV/AIDS Infection	□ Drug/Alcohol Abuse	□ Genetic Test	□ Psychiatric
Patient Name:			DOB:
Patient's Signature			Date:
Last 4 digits of social:		(FOR OFFICE USE ONLY) Expiration Date:	