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Phone: 561-249-2279
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www.midwaycare.org

New Patient Questionnaire

Personal Information

Today's Date: _____

Last Name, First Name, Middle Initial: _____ Date of Birth: _____

Preferred Name: _____ Social Security Number: _____

Gender Assigned at Birth: Female Male Intersex Prefer not to answer
Relationship Status: Single Sig Other Separated Married Divorced Widowed

Home Address: _____ City, State and Zip Code: _____

Mailing Address: Same as Above

City, State and Zip Code: _____

Phone Number(s) Home: _____ Cell: _____ Work: _____
Check box representing preferred number for patient reminders, etc.

Email Address: _____ Enable Patient Portal: Yes No

Emergency Contact: _____ Phone: _____ Relationship: _____

Name of Primary Care Provider: _____

Address: _____ City, State and Zip Code: _____

Employment Status: Full time Part time Retired Self None
Student Status: Full time Part time None

Employer Name/School Name: _____

Address: _____ City, State and Zip Code: _____

Occupation: _____

Who may we thank for referring you: _____

Insurance Information

Primary Insurance Company: _____ Policy Holder: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____ Policy Holder: _____

Policy Number: _____ Group Number: _____

Financial Responsible Party: _____



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New Patient Questionnaire – Continued

Race:

- American Indian
- Asian
- Native Hawaiian
- Black or African American
- White
- Other Race
- Other Pacific Islander
- Decline to answer

Ethnicity:

- Hispanic or Latin
- Not Hispanic or Latin
- Decline to answer

Preferred Language:

- English
- Spanish
- Portuguese
- Other: _____

Name of Your Local/Mail Order – Check the preferred one

Pharmacy	Address	Telephone Number
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____

Use of 340B Contract Pharmacy

Contract pharmacies offer a range of customizable clinical and operational services that enhance the safety, quality, and affordability of care for our patients. Our 340B network of pharmacies was chosen based on a wide variety of performance and cost-saving criteria. We review each pharmacy that we add to our network to determine their true capabilities and services before entrusting our patients to their care. Using our 340B program helps to provide funds for increased client services such as a case manager and in-house lab and mental health and help us provide care for uninsured patients.

- Yes, Sign me up No, not at this time I would like more information

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

Patient's Signature: _____



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Current/Past Medical History

Do you currently have any of the following symptoms? *(Check those that apply)*

- | | |
|--|--|
| <input type="checkbox"/> Rash, itchy skin or skin disorder | <input type="checkbox"/> Change in vision |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Chest pain or palpitations | <input type="checkbox"/> Nausea and/or vomiting |
| <input type="checkbox"/> Constipation or diarrhea | <input type="checkbox"/> Blood in stool or hemorrhoids |
| <input type="checkbox"/> Vaginal or penile discharge | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Genital or rectal warts or ulcers | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Muscle pain or joint swelling | <input type="checkbox"/> Tingling burning, pain or numbness in extremities |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Sudden weight loss or gain |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Suicide attempts |
| <input type="checkbox"/> Anxiety/stress | <input type="checkbox"/> Unexplained fatigue/weakness |

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

_____	_____
_____	_____
_____	_____

Do you have any of the following conditions? *(Check those that apply)*

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Rheumatic fevers |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rhinitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Back or joint problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD/reflux | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Prostate problem |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> cervical problem |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> CAD/heart disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Cancer, type: _____ | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Thyroid disease | |



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

- Syphilis, If yes, what was your most recent titer and when? _____
- Gonorrhea
- Chlamydia
- Venereal warts
- Genital herpes
- Hepatitis A, B, or C, if yes, which one(s) and most recent viral load if chronic? _____

Any other conditions you are followed by a doctor or take any medication for? _____

Vaccination & Healthcare History:

BOTH MEN AND WOMEN

- Flu Shot, if yes when? _____
- Hepatitis A Shot, did you complete the series and when? (2 shots) _____
- Hepatitis B Shot, did you complete the series and when? (3 shots) _____
- Measles, Mumps Rubella (MMR) shot, did you complete the series and when? _____
- Varicella Shot, if yes when? _____
- Pneumonia Vaccine, if yes which one (s) _____
- Tetanus Booster, if yes when? _____
- Tdap/TD, if yes when? _____
- HPV, if yes did you complete series and when (3shots)? _____
- Tuberculosis (PPD) test, if yes when? _____

Have you ever had a positive PPD test? Yes, Explain: _____ No

Have you ever had Meningitis? Yes, Explain: _____ No

Last Cholesterol testing: _____

Last eye exam: _____

Last dental exam: _____

Last Colonoscopy: _____

Last Dexa scan: _____

Have you ever had a blood transfusion? Yes, Year: _____ Explain: _____ No

WOMEN ONLY

Last Pap Smear: _____

Last Mammogram: _____

Last menstrual cycle: _____

MEN ONLY

Last PSA (Prostate blood test): _____

Digital rectal exam: _____



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Sexual and behavioral Questionnaire

My gender identity is: Female Male Transgender (MTF) Transgender (FTM) Other _____ Decline

I live: alone with spouse with roommate(s) with parents/family am homeless Other _____

My sexual orientation is: Bisexual Heterosexual Homosexual Other _____ Not sure

My pronoun is: She/her He/Him They/Them/Their Other _____

Do you currently have sex? Yes No

Sexual practices? Vaginal Anal Oral Other, _____

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 When? _____ No

Do you use tobacco products? Yes, Smoke Chew Vape Other: _____ No

If yes, what are they? _____ And how often? _____ Are you ready to quit? Yes No

If no, have you ever smoked? _____ How long ago did you quit? _____

Do you have a history of using IV drugs or "street" drugs? Yes No

If yes, which one(s): _____ How long ago did you quit? _____

Do you drink alcohol? Yes No

If yes, how many drinks per day? _____ How many times a week? _____

Did you ever have a problem with alcohol or other substances? Yes No

If yes, please explain: _____

Do you drink coffee or other caffeine products? Yes No

If yes, which _____ How many cups per day? _____

Place of Birth? City, State, Country _____

Have you traveled out of the country? Yes No

If yes where and when? _____

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



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Surgical History

Surgery Name	Year
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalization History

Hospital/Facility	Reason	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



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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 (Please provide a copy)
- I have NOT made such a declaration

Health Care Surrogate

- I have a designated health care surrogate Name: _____
- I have NOT designated a health care surrogate

Durable Power of Attorney

- I have appointed a durable power of attorney (Please provide a copy)
- 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 may 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: _____

Self or Relationship to Patient: _____

Signature: _____

Date: _____



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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.

In accordance with the Act, I _____ Hereby authorize Midway Specialty
(Patient signature)

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

Name	Date of Birth	Relationship	Phone Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 DO 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.

Printed Name: _____

Self or Relationship to Patient: _____

Signature: _____

Date: _____



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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.

Printed Name: _____

Self or Relationship to Patient: _____

Signature: _____

Date: _____