



Emmanuelle Allseits, MD, AAHIVS
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 (407) 745-1171 tele (407) 745-0712 fax
www.midwaycare.org

New Patient Questionnaire

| | |
|--|---|
| Personal Information | Date: |
| Last Name, First Name, Middle Initial: | |
| Preferred Name: | |
| Main reason for visit: | |
| Social security #: _____ | Date of Birth: _____ |
| Pronouns: | <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> He/Him/His <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Ze/Hir/Hirs <input type="checkbox"/> Other: _____ |
| Sex Assigned at Birth: | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other: _____ |
| What is your current gender identity | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male/Transgender Man/ Female-to-Male (FTM) <input type="checkbox"/> Transgender Female/Transgender Woman/Male-to-Female (MTF) <input type="checkbox"/> Non-binary/Genderqueer/Gender Fluid <input type="checkbox"/> Prefer to self-describe: _____ <input type="checkbox"/> Choose not to disclose |
| Relationship Status: | <input type="checkbox"/> S <input type="checkbox"/> Sig Other <input type="checkbox"/> Sep <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Other _____ |
| Home Address: | |
| City, State and Zip Code: | |
| Mailing Address: <input type="checkbox"/> Same as Above | |
| City, State and Zip Code | |
| Phone Number(s) <i>Check box representing preferred number for patient reminders, etc.</i> | <input type="checkbox"/> Home: _____ <input type="checkbox"/> Cell: _____ <input type="checkbox"/> Work: _____ |
| Email Address: | |
| Enable Patient Portal: | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | | |
|---|----------------|---------------|
| Contact Name and Phone Number 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: | | |
| 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: | | |

| | |
|--|---|
| <p>Race:</p> <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Haitian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Race <input type="checkbox"/> Decline to Specify | <p>Ethnicity:</p> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic of Latino <input type="checkbox"/> Other <input type="checkbox"/> Decline to Specify <p>Language:</p> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Other: _____ |
|--|---|

How did you hear about Midway Specialty Care Center? _____

| | Name & Address | Telephone Number |
|-----------------------|----------------|------------------|
| Name of Your Pharmacy | | |

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

Patient's Signature:



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Medical Questionnaire

Welcome to Midway. Please fill out the form to the best of your ability.

| | |
|--|--|
| -Last Name, First Name, Middle Initial: | |
| -Please list main reason for visit today: | |

| | |
|--|--|
| -Medications: Please list all medications you are currently taking (include Over-The-Counter Medications and/or Supplements) | |
| -Allergies: Do you have any Drug 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 past medical history: _____

Other family medical history: _____

| | |
|---|--|
| Social History: | |
| -Do you smoke cigarettes? | <input type="checkbox"/> Yes <input type="checkbox"/> No How long/much? |
| Are you interested in quitting smoking? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| If you are a former smoker, when did you quit? | |
| -Do you use other tobacco products? | <input type="checkbox"/> Yes <input type="checkbox"/> No ; Circle kind? pipe, cigar, snuff, chew |
| -Have you been sexually active in the past year? | <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how many partners in the past 1 year ? _____ |
| -Are you sexually active with... | <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both |
| -Do you use condoms? | <input type="checkbox"/> No <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Half the time <input type="checkbox"/> Some of time |
| -Have you ever had an STD (sexually transmitted disease)? Chlamydia, Gonorrhea, Syphilis, Herpes, Hepatitis B, Hepatitis C, Warts | <input type="checkbox"/> Yes <input type="checkbox"/> No Circle kind? |
| -Sexual orientation: (check all that apply) | <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Lesbian, Gay or Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer <input type="checkbox"/> Pansexual <input type="checkbox"/> Asexual <input type="checkbox"/> Don't Know <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other: _____ |
| -Sexual practices? (check all that apply) | <input type="checkbox"/> Vaginal <input type="checkbox"/> Anal <input type="checkbox"/> Oral |
| -Birth control method? | <input type="checkbox"/> Oral pills <input type="checkbox"/> Depo shot <input type="checkbox"/> IUD or other implant <input type="checkbox"/> None <input type="checkbox"/> N/A |
| Pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> N/A |
| -Have you ever used any substances? (Crystal Meth, Heroin, Opioids, Fentanyl, Ecstasy, Mushrooms, LSD, Cocaine, Crack) | <input type="checkbox"/> Yes <input type="checkbox"/> No Circle kind? <input type="checkbox"/> Other _____ |
| Have you ever injected? | <input type="checkbox"/> Yes <input type="checkbox"/> No What? |
| Are you still using ? | <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, drug of choice: _____ |
| Have you ever been in a substance use rehab program? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Have you ever been on Suboxone or Methadone? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Circle kind? |
| Are you interested in quitting substances? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| -Do you drink alcohol? <input type="checkbox"/> Beer/Wine <input type="checkbox"/> Liquor | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency? |
| -Any history of alcohol dependence? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| -Do you have any children? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| -Place of Birth? City/State? | |
| -Do you have any problems with your housing, such as unsafe/unclean conditions, temporary living, or no place to live? | <input type="checkbox"/> Yes <input type="checkbox"/> No Circle kind? |
| In the past 12 months, did you ever worry that your food would run out before you had money to buy more ? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| In the past 12 months, did your food ever not last and you didn't have money to get more? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| In the past 12 months, did you have trouble paying for: (check all that apply) | <input type="checkbox"/> Food <input type="checkbox"/> Rent/Mortgage <input type="checkbox"/> Medical Care <input type="checkbox"/> Prescriptions <input type="checkbox"/> Insurance <input type="checkbox"/> Gas/Electricity <input type="checkbox"/> Childcare <input type="checkbox"/> Other: _____ |
| Is it difficult for you to get transportation to your appointments? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

| | |
|---|--|
| When were you diagnosed with HIV? | Date: |
| 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: |
| Is your viral load currently undetectable ? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |
| What is your current HIV medication? | Medication: |
| Who was your HIV provider? (please provide contact info) | Prior provider info: |

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 | Norvir | Odefsey | Prezcobix | Prezista | Reyataz |
| Rukobia | Retrovir | Tivicay | Trogarzo | Triumeq | Temixys | Truvada | Tybost |
| Norvir | Symtuza | Stribild | Symfi and Symfi Lo | Selzentry | Viread | Vocabria | Ziagen |
| Other meds not listed above: | | | | | | | |
| Are you allergic to any HIV medications? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which one(s)? | | | |
| Any history of medication resistance? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which one(s)? | | | |

| | | | | | |
|---|---|--|-----------------|--|---|
| Have you had any history of HIV related opportunistic diseases? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> 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 |

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: | |
| <input type="checkbox"/> Self or Relationship to Patient | |
| Patient's Signature: | |
| Date: | |



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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

or sent electronically via secure fax to (407)745-0712.

I understand that my medical records may contain copies of information received from another health care facility or doctor. I also authorize release of the following to Midway Specialty Care Center, Inc.

Type of information to be disclosed:

| | | |
|--|---|---|
| <input type="checkbox"/> Entire medical record | <input type="checkbox"/> Radiology reports | <input type="checkbox"/> All Hospital records |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Billing statements | <input type="checkbox"/> Discharge summary |
| <input type="checkbox"/> Dental records | <input type="checkbox"/> Pathology reports | <input type="checkbox"/> Laboratory reports |
| <input type="checkbox"/> Office chart notes | <input type="checkbox"/> Emergency Department reports | <input type="checkbox"/> Other: |

In addition, I authorize and I am aware that this information may include health information relating to :

| | | | |
|---|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> HIV/AIDS Infection | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Genetic Test | <input type="checkbox"/> Psychiatric |
| Patient Name: | | | DOB: |
| Patient's Signature | | | Date: |
| Last 4 digits of social: | | Expiration Date: | |