MIDWAY SPECIALTY CARE CENTER

Emmanuelle Allseits, MD, AAHIVS
Moti Ramgopal, MD FIDSA FACP CPI
1685 Lee Road, Suite 110
Winter Park, Florida 32789
(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:	□ 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

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:		

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 of Latino □ Other □ Decline to Specify **Language:** □ English □ Spanish □ Creole □ 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?	□ 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?	□ Yes □ No ; Circle kind? pipe, cigar, snuff, chew
-Have you been sexually active in the past year?	□ Yes □ No If so, how many partners in the past 1 year ? ___
-Are you sexually active with…	□ Men □ Women □ Both
-Do you use condoms?	□ No □ All the time □ Most of the time □ Half the time □ Some of time
-Have you ever had an STD (sexually transmitted disease)? Chlamydia, Gonorrhea, Syphilis, Herpes, Hepatitis B, Hepatitis C, Warts	□ Yes □ No Circle kind?
-Sexual orientation: (check all that apply)	□ Straight or Heterosexual □ Lesbian, Gay or Homosexual □ Bisexual □ Queer □ Pansexual □ Asexual □ Don't Know □ Choose not to disclose □ Other: _____
-Sexual practices? (check all that apply)	□ Vaginal □ Anal □ Oral
-Birth control method?	□ 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 □ No Circle kind? □ Other _____
Have you ever injected?	□ Yes □ No What?
Are you still using ?	□ No □ Yes If yes, drug of choice: _____
Have you ever been in a substance use rehab program?	□ Yes □ No □ N/A
Have you ever been on Suboxone or Methadone?	□ Yes □ No □ N/A Circle kind?
Are you interested in quitting substances?	□ Yes □ No □ N/A
-Do you drink alcohol? □ Beer/Wine □ Liquor	□ Yes □ No Frequency?
-Any history of alcohol dependence?	□ Yes □ No □ N/A
-Do you have any children?	□ Yes □ 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?	□ Yes □ 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 ?	□ 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: _____
Is it difficult for you to get transportation to your appointments?	□ Yes □ 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 ?	□ Yes □ No □ 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?				□ Yes □ No If so, which one(s)?			
Any history of medication resistance?				□ 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

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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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:

□ 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 :

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