**INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.,**
5535 GRAND BLVD., SUITE C, NEW PORT RICHEY, FL 34652
Phone (727) 841-0700

# PATIENT REGISTRATION FORM

(Please Print Clearly)

Today's date: EMAIL:

## **PATIENT INFORMATION**

Patient's last name: First: M ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.

Marital status ❑ Single ❑ Mar ❑ Div ❑ Sep ❑ Widowed

Is this your legal name? ❑ Yes ❑ No

Date of Birth: / /

Age:

Sex: ❑ M ❑ F

Street address:

Social Security #

Primary phone # Home /Cell ( )

P.O. box: City: State: ZIP Code:

Employer: Occupation: Work phone # ( )

**Ethnicity:** ❑ Hispanic or Latino ❑ Not Hispanic or Latino

**Race:** ❑ American Indian or Alaska Native ❑ Asian Indian
❑ Asian Other ❑ Black or African American ❑ Chinese ❑ Filipino
❑ Guamanian or Chamorro ❑ Hawaiian Native ❑ Japanese
❑ Korean ❑ Multiple ❑ Other ❑ Pacific Islander ❑ Samoan
❑ Unknown ❑ Vietnamese ❑ White

**Primary Language:**
❑ English ❑Spanish
❑Other

## **INSURANCE INFORMATION**

(Please give your insurance card to the receptionist along with a Photo ID)

Policy Holder Name:

Relationship to Patient: ❑Spouse ❑Mother ❑ Father ❑ Other

Policy Holder's Date of Birth: / /

Policy Holder Address (If different than patient):

Policy Holder Phone # ( )

Policy Holder ID:

Policy Holder Sex : ❑Male ❑ Female

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance: ❑ MEDICARE ❑ COMMERCIAL ❑SELF PAY ❑ OTHER (Please Specify)

Preferred method of notification:
❑ Home Phone ❑ Cell Phone ❑ Email

# Florenda L. Fortner, M.D.

**Patient Name:** **DOB:**

**IN CASE OF EMERGENCY**

| Name of local friend or relative (not living at same address): | Relationship to patient: | Phone # | Work phone # |
|---|---|---|---|
| | | ( ) | ( ) |

**I Authorize discussion and release of my health care conditions and diagnosis, including billing and medical records with the following individuals: (List any additional individuals on the back of this form)**

**Name:**________________________ **Phone number:** ________________ **DOB:**__________ **Relationship:**____________

**Name:**________________________ **Phone number:** ________________ **DOB:**__________ **Relationship:**____________

**Name:**________________________ **Phone number:** ________________ **DOB:**__________ **Relationship:**____________

- The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.**,or insurance company to release any information required to process my claims. The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable by **INTERNAL MEDICAL & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.**

- I give **INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.**, permission/ authorization to obtain medical information, pharmacy information, personal and billing information from other facilities, companies, physicians, etc. via Electronic, Email, Fax, Mail, Text Message, Phone/ Cell Phone.

- I authorize **INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.** to collect Insurance benefits on my behalf, and to release any information in my medical chart to my Insurance Company.

- **INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.** Collects All Patient Payments prior to seeing the physician on the day of your appointment. **All** Co-pays, deductibles, co-insurance, and prior balances must be collected via **Cash or Credit Card.**
- We no longer accept Personal Checks in our office. If you receive a Bill from our office, you may pay by check, but **All Returned Checks will be charged a $50.00 Returned Check Fee added to your total balance.**

- **INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.** will charge a **$25.00 NO SHOW FEE** for any No-Show Appointments. The patient must call our office and give us a 24 hour notice to cancel their appointments. This Fee is not billable to your insurance company, and will be the patient's responsibility to pay the no-show fee before being seen in our office. It is the patient's responsibility to provide our office with current and accurate billing information. Failure to provide the updated information will result in the patient being liable for all charges. **In the event that your account is placed with an outside Collection Agency, the patient / guarantor will be held responsible for ALL Incurred Fees.**

- **INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D. charges $25.00 for work / disability forms.**

- **INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.** also charges for other letters/ forms. These fees can be obtained by contacting our office.

- **I have received a copy of INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D.'s Notice of Privacy Practices for Protected Health Information (HIPPA).**

- **I authorize INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D. to release my medical records and related information to authorized representatives of my third party payer or physicians / facilities related to my care.**

- **Permission for Treatment is granted to INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC ~ FLORENDA L. FORTNER, M.D to treat the patient as deemed medically necessary.**

***Patient/Guardian signature*** ***Date***

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# Health History Questionnaire

**All questions contained in this questionnaire are strictly confidential and will become part of your medical record.**

**Patient Name:** ______________________ **Date of Birth:** ____________

**Allergies:** ______________________ **Age:** ________ ☐ New patient ☐ Established patient

**Reason for today's visit?**

______________________________________________

**Height:** ____________ **Weight:** ____________

Previous Primary Care Physician: ____________________ Specialists you see: ____________

| Name of Medication | Strength | Daily Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Pharmacy Name: | Phone #: | Address: |
|---|---|---|
| | | |

| Mail away Pharmacy | Phone #: | Address: |
|---|---|---|
| | | |

**Patient's Signature/ POA:** ______________________ **Date:** ____________

**Physician's Signature:** ______________________ **Date:** ____________

**Florenda L. Fortner, M.D.**

**Patient Name:** ______________________________ **Date of Birth:** ______________

## Medical History

Have you ever had or been diagnosed to have (check all that apply)

- ❑Alzheimer's disease
- ❑Anemia
- ❑Anxiety
- ❑Arthritis
- ❑Asthma
- ❑Atrial fibrillation
- ❑Bleeding disorder
- ❑Blood transfusion
- ❑Cancer (specify) ____________
- ❑Cataracts
- ❑Colon Polyps
- ❑Depression
- ❑Diabetes
- ❑Fracture
- ❑Glaucoma
- ❑Heart attack
- ❑Heart Disease
- ❑Heart failure
- ❑Heart murmur
- ❑Heartburn
- ❑Hemorrhoids
- ❑High blood pressure
- ❑High cholesterol
- ❑Irritable bowel syndrome
- ❑Jaundice/ Liver Disease
- ❑Kidney Disease
- ❑Migraines/ Headaches
- ❑Osteopenia
- ❑Osteoporosis
- ❑Pneumonia
- ❑Prostate problems
- ❑Rheumatic fever
- ❑Seizures / epilepsy
- ❑Stroke
- ❑Syphilis
- ❑TB / Lung disease
- ❑ Thyroid disease
- ❑ Ulcers
- ❑ Urinary incontinence
- ❑ Other: ____________

## Health Maintenance

(List date when last done) Month / Day / Year

- ❑ Bone Density Test _____/_____/_____
- ❑ Cholesterol Screen _____/_____/_____
- ❑ Colonoscopy _____/_____/_____
- ❑ Diabetes Screen _____/_____/_____
- ❑ Eye Exam _____/_____/_____
- ❑ Flu Vaccine _____/_____/_____
- ❑ HIV Testing _____/_____/_____
- ❑ Mammogram _____/_____/_____
- ❑ Pap smear _____/_____/_____
- ❑ Pneumonia Vaccine _____/_____/_____
- ❑ PSA _____/_____/_____
- ❑ Shingle Vaccine _____/_____/_____
- ❑ Tetanus Vaccine _____/_____/_____
- ❑ Covid-19 Vaccine _____/_____/_____
- ❑ Covid-19 Booster _____/_____/_____
- ❑ Echocardiogram _____/_____/_____
- ❑ Stress Test _____/_____/_____
- ❑ CABG _____/_____/_____

**Patient's Signature/ POA:**
Date:

**Physician's Signature & Date:**

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# Health Information Questionnaire

**Patient Name:** ______________________ **DOB:** __________

**List any medical problems that you have been diagnosed with:**

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

**Past Surgical History: (Include Reason, Hospital, & Year)**

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

**Hospitalizations: (Include Reason, Hospital, & Year)**

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

**Family History: (Include Age & Diagnosis) example: cancer, high blood pressure, diabetes**

- Father: ______________________
- Mother: ______________________
- Siblings: ______________________
- Children: ______________________
- Grandparents: ______________________

**Patient's signature/ POA:** ______________________ **Date:** __________

**Physician's signature:** ______________________ **Date:** __________

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# Social History

**Patient's Name:** ______________________ **Date of Birth:** ____________

Do you currently work? ❑ Yes ❑ No Occupation: ______________________ Retired? ❑ Yes ❑ No

Do you drink alcohol? ❑Yes ❑ No If yes, what kind? ______________________ If Yes, how many drinks per day? _____

Do you Smoke? ❑ Yes ❑ No How many packs per day? ______________ How many years did you smoke? __________
Former Smoker? ❑ Yes ❑ No when did you quit? ______________
Never Smoked ❑ Smoke rarely/occasionally ❑ Current every day smoker ❑ Current some day smoker ❑
Are you interested in quitting? ❑ Yes ❑ No

Caffeine intake:
❑ None ❑ Coffee ❑ Tea ❑ Cola Number of cups per day? _______

Diet: Are you dieting? ❑ Yes ❑ No What type of Diet Plan are you on? ______________

Exercise:
❑ Sedentary (No Exercise)
❑ Mild exercise
❑ Occasional exercise
❑ Regular vigorous exercise

Do you currently use recreational drugs? ❑ Yes ❑ No

Are you sexually active? ❑ Yes ❑ No

Do you live alone? ❑ Yes ❑ No

Do you have frequent falls? ❑ Yes ❑ No

Do you have vision or hearing loss? ❑ Yes ❑ No

Do you feel Depressed? ❑ Yes ❑ No are you under a lot of stress? ❑ Yes ❑ No

Do you have panic attacks? ❑ Yes ❑ No Do you cry frequently? ❑ Yes ❑ No

Do you have trouble sleeping? ❑ Yes ❑ No

Do you have an Advanced Directive or Living Will? ❑ Yes ❑ No (Please provide us with copies)

Do you have a Durable Power of Attorney? ❑ Yes ❑ No Name & # ______________________

Patient's Signature or POA: ______________________ Date: ______________

Physician's signature: ______________________ Date: ______________

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# Notice of Privacy Practices for Protected Health Information (HIPAA)

**"This Notice Describes How Medical Information About You May Be Used And Disclosed And How You May Get Access To This Information". Please Review It Carefully!**

## We Safeguard Information about Your Health and Person:

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations.

## Typical Uses and Disclosures of Medical Information:

We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for which you authorize disclosure such as other healthcare providers (doctors, nurses, and extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors.
- Organ and tissue donation
- Research, provided authorization is IRB-approved or privacy board-approved
- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Worker's compensation
- Disaster Relief

**We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.**

# Patient Privacy Rights:

## You Have The Right To:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days. You may also get an electronic copy if we have one available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last six years, starting April 14, 2003. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supersede the typical disclosures noted above. You may revoke or restrict the consent.
- Restrict certain disclosures of PHI to a health plan when you pay out of pocket in full for the healthcare item or service.
- Request confidential communications. All communications in our office are confidential. You may specifically-request that all communications be confidential with a written request directed to our office.
- Not to have your protected health information sold for marketing purposes.
- Opt out of receiving fund-raising communications.
- Be notified following a breach of your unsecured protected health information.
- Receive a copy of this notice by printing it or with a written request directed to this office, and a copy of this notice will be given with all new patient packets.

We May Contact You for Appointment Reminders and we may provide you with information about health-related or product benefits and services.
Forms of communication can be made with you via Landline phone, Cell phone, Electronic Health Records (EHR), Email, Fax, Text messages, etc.

Each patient is given a copy of the Privacy Notice and an opportunity to review and understand it.

## Our Responsibilities under HIPAA:

We are required by Law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice.

We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be made available.

**You can submit a complaint about our privacy policy or its execution either verbally or in writing to our <u>PRIVACY OFFICER</u> at our office.**

If you get no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services.
Effective Date of Notice: February 2015
Amended Dates: September 2015