AMANA MEDICAL CENTER -- REGISTRATION INFORMATION

PATIENT INFORMATION

First Name:_____ MI: _____ Last Name:_____ Social Security:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Sex: ☐ M ☐ F Date of Birth: _____Age:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer and Employer's Address: _____

Cell Phone: _____ Work Phone: _____ Email:_____

Student Status: ☐ Full Time:☐ Part Time Name of School:_____

Emergency Contact Name:_____ Telephone Number:_____

Relationship to You: ☐Spouse/Partner ☐Parent ☐Other:_____ Permission to Contact in Case of Emergency? ☐Yes or ☐No

**At which telephone number should we leave reminder calls (CHOOSE ONE)? ☐Cell ☐Home ☐ Email ☐Other _____

INSURANCE INFORMATION

Insurance Company:_____ Phone number: _____ Claims Address: _____

Group/Policy Number:_____ Subscriber or I.D. Number:_____

Secondary Insurance Company:_____ Phone number: _____ Claims Address: _____

Group or Policy Number:_____ Subscriber or I.D. Number:_____

MEDICAL HISTORY

Current Medical Conditions:_____

Hospitalization & Surgeries:_____

Current Medications:_____

_____

Drug Allergies: _____

Family history of medical conditions:_____

Your Pharmacy Name & Number:_____

Personal history of past medical condition: Have you ever been told you had one of the following?

Medical Condition	Yes	No	Comments / Notes	Medical Condition	Yes	No	Comments / Notes
Anxiety, Depression, ADHD				Heart trouble			
Arthritis				Hepatitis			
Any form of cancer				Lung disorder			
Blood disorder				Life-threatening conditions			
Diabetes				Nervous disorder			
Defect or deformity				Spine disorder			
Digestive Disease /Colon				STDs or Contagious disease			
Disease of the kidney				Thyroid Disease			
High blood pressure				Vision or hearing disorders			
Smoking or marijuana			____ Pk/Day ___ yrs	Alcohol			
Other Conditions							

ASSIGNMENT AND RELEASE

I hereby assign, transfer, and set over to **Amana Medical Center** all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits.
I give complete permission for Amana Medical Center providers to treat my children if they are under the age of 18.
This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's (or Responsible Party/Guardian) Signature: _____ **Date:** _____

How did you find about us? ___Internet ___Friend ___Insurance company ___Ad ___Business Card ___Walk In ___Others _____

AMANA MEDICAL CENTER

FAMILY & URGENT CARE MEDICINE

www.AmanaMedicalCenter.com

Email: wecare@amanamedicalcenter.com

220 Alafaya Woods Blvd. Ste 1000, Oviedo, FL 32765

Tel: 321-765-7065 Fax: 321-765-7061

Date: ---/---/------

Medical Records Release Form

I hereby authorize the use & disclosure of my protected health information as follow:

Patient Name: **Date Of Birth:**

This authorization applies to all health information pertaining to any medical history, physical condition, mental, HIV results, Sexual abuse, Alcohol / Drug treatment & Psychotherapy notes.

I have some Limitations on the information you may release:

_____

The reasons or purposes for this release of information are as follows:

_____

Persons/ Doctors/ Clinics/ organizations authorized to use or disclose the information:

NAME: _____

Tel Number: _____ Fax Number: _____

Persons/ Doctors/ Clinics/ organizations authorized to use or receive the information:

Name: Amana Medical Center

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).
Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.

Patient Signature [or parent, guardian or legal representative]:

_____ **Date:** _____

I understand that you will provide this information within 1-5 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Florida Medical Board.

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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AMANA MEDICAL CENTER

MEDICAL CARE FOR THE ENTIRE FAMILY

Allergy Questionnaire and Order Form

PATIENT NAME: _____ DATE OF BIRTH: _____ SEX: ___M ___F

PATIENT PHONE #: _____ PROVIDER'S NAME: _____

Do you experience any of the following symptoms?	Yes	No	Frequency: D = Daily, W = Weekly, M = Monthly, S = Seasonally, Y = Yearly
Runny/ Stuffy Nose, Frequent Sneezing, Post-Nasal Drip			
Joint pain			
GI disturbance (bloating, cramping, loose stool)			
Coughing | Sneezing			
Seasonal Allergies			
Sinus Problems			
Food Allergies			
Restless, Poor Sleep, or Snoring			
Fatigue or Irritability due to Restlessness or Poor Sleep			
Have you ever been told you have Asthma, Reactive Airway Disease, or COPD?			
Have you ever used Albuterol (inhaler)?			
Itchy | Dry | Watery Eyes Itchy, Dry Mouth, Throat or Ears			
Several episodes of acute bronchitis in a short period of time?			
Does your family have a history of Allergies?			

Please answer the following questions:

1. Do you take prescription or OTC (over the counter) medications to control your allergy symptoms? ☐ Yes ☐ NO

2. If yes, name of medication and last date taken? _____

Please indicate symptoms/conditions that you have experienced over the past 1-2 years:

☐ Sinus related issues (pain/pressure, congestion, headaches, sinusitis	☐ Restless sleep, snoring, challenges sleeping through the night
☐ Re-occurring seasonal colds	☐ Consistent or Re-occurring coughing
☐ Chronic colds lasting longer two months	☐ Dizziness or brain fog
☐ Migraine headaches	☐ Asthma, COPD, Chronic Bronchitis
☐ Skin conditions (dry and/or itchy skin, etc.)	☐ Shortness of breath

To be filled out by the doctor's office:

I hereby confirm that I will refer the above listed patient for:

Allergy Testing: ____ Yes ____ No ***Pulmonary Function Testing***: ____Yes ____ No

Print Provider Name: _____ Date: _____

Provider Signature: _____