

Phone 727-322-4227
Fax 727-322-4656



**Affiliated Health
Clinics**

www.affiliatedhealthclinics.com
professional experienced care with a personal touch

3600 Central Avenue
St. Petersburg, FL 33711

Dear: _____

Account #:

Thank you for choosing Affiliated Health Clinics, LLC for your Internal medicine / Sports Medicine / Hospital / and

Nursing Home needs. On Date: _____ at: _____

Your appointment is scheduled at our 3600 Central Avenue
St. Petersburg, FL 33711
location.

Please complete all of the enclosed forms and return them to us when you check in for your appointment. You may drop these off before your appointment to expedite the check in process

If you are unable to keep this appointment, please notify our office as soon as possible. We reserve the right to charge for any missed appointments not kept with less than 24 hours notification.

Our strength lies in our ability to provide both the simple and the most advanced treatments in a cost effective manner. Our dedicated staff of skilled professionals are here to guide you through your evaluation and treatment process.

Spouses, guardians, and/or partners are encouraged to attend for mutual understanding of the problems and reasons for different diagnostic and therapeutic procedures.

Since our patients deal with sensitive issues, it is not recommended that small children accompany you during appointment times at our facility.

Please be sure to bring the Following to your appointment:

Your photo ID

Your Insurance card, co-payment, and/or deductible if applicable.

A referral if required by your insurance

All pertinent medical records from your previous physicians

Please have all the enclosed forms completed before you check in for your appointment.

Affiliated Health Clinics, LLC

PATIENT INFORMATION

Last Name		First Name		Middle Initial	Nickname/AKA	
Date of Birth	Age	Social Security Number			Gender ☐ Male ☐ Female	
Marital Status	☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other	Language other than English				
Race	☐ Black – Non Hispanic ☐ American Indian/ Alaskan Native ☐ Hispanic ☐ Asian/Pacific Islander ☐ White – Non Hispanic ☐ Other					
Home Address		Apt #	City	State	Zip Code	
Home Phone		Work Phone		Other Phone ☐ Cell ☐ Pager ☐ Fax		
Email Address	Employment Status	☐ Active Duty Military ☐ Employed Full-Time ☐ Not Employed ☐ Student Full-Time ☐ Child ☐ Employed Part-Time ☐ Retired ☐ Student Part-Time ☐ Disabled ☐ Homemaker ☐ Self Employed ☐ Other				
Employer	Occupation	Employer Phone				

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician Referring Physician

How did you hear about us?

SPOUSE / PARTNER INFORMATION

Relationship to Patient	☐ Self (If self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent ☐ Other			
Last Name	First Name	Middle Initial		
Date of Birth	Age	Social Security Number		
Home Address	Apt #	City	State	Zip Code
Home Phone	Work Phone	Other Phone ☐ Cell ☐ Pager ☐ Fax		
Employer	Employment Status	☐ Active Duty Military ☐ Employed Full-Time ☐ Not Employed ☐ Student Full-Time ☐ Child ☐ Employed Part-Time ☐ Retired ☐ Student Part-Time ☐ Disabled ☐ Homemaker ☐ Self Employed ☐ Other		
Employer Phone	Occupation			

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name	First Name	Relationship to Patient		
Address	Apt #	City	State	Zip Code
Home Phone	Work Phone	Other Phone ☐ Cell ☐ Pager ☐ Fax		

Signature of Patient or Guardian

Date

Relationship to Patient

Witness Signature

Affiliated Health Clinics, LLC
Internal Medicine / Sports Medicine / Family Medicine

INSURANCE INFORMATION

Please present proof of insurance and valid identification upon completion of this form

Insurance Company: _____

Claims Address: _____

Street / PO Box

City

State

Zip

Telephone Number: _____

Policy #: _____ **Group # :** _____

Insured Person: _____ **Relationship to Patient:** _____

Insured Person's Address: _____

Street

City

State

Zip

Insured DOB: _____ / _____ / _____ **Insured S.S.# :** _____ - _____ - _____

Insured Employer : _____ **Phone:** _____
~~**Lifetime Assignment of Benefits and Information Release**~~

Patient Initials

I affirm that the billing and insurance information I have provided is correct to the best of my knowledge and I accept responsibility for keeping Affiliated Health Clinics informed of any changes to this information.

Patient Initials

I authorize the release of my medical information including, without limitation of information related to psychiatric care, drug abuse, alcohol abuse, STD, or HIV/AIDS, confidential information that is needed for the submission to my insurance carrier in order to process a claim or for utilization review or quality assurance activities.

Patient Initials.

I assign any and all medical and/or surgical benefits billed by Affiliated Health Clinics or one of their provider to which I am entitled to Affiliated Health Clinics. A photocopy of this authorization shall be considered as valid as the original.

Patient Initials

I agree to accept full responsibility for any copayments, deductible, coinsurance, and balances remaining after my insurance has processed claims, or for any services not covered or denied by my insurance company. If I do not have insurance coverage, I agree to pay in full for services provided at the time of service. I agree to be responsible for payment of any legal fees, court cost, and any and all other expenses incurred by or on behalf of Affiliated Health Clinics in pursuit of collecting fees due for services rendered.

Patient Initials

I acknowledge and agree that copayments, deductible, coinsurance, and non-covered charges are due when services are rendered. I understand and agree to pay Affiliated Health Clinics a charge of \$35 for failing to cancel an appointment without 24 hour notice or a no show to an appointment, and \$50 above the value of a returned check plus any and all fees associated with collecting on the returned check.

Patient Signature: _____ **Date:** _____

Representative Signature: _____ **Date:** _____

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Detailed Message

Dear Patient,

In accordance with the providers contracted by Affiliated Health Clinics blood may be drawn or other tests ordered and performed. We may contact you after your appointment with the results of your tests or to follow up on your care. We may also need to call in reference to your appointments and financial matters. In accordance with HIPAA regulations, we need your authorization to leave a detailed message or email for you with your results or questions in order to follow up on your care and financial matters, if we are unable to speak with you directly. Please select an option below.

___ I do not want you to leave a detailed message.

___ You can leave a detailed message at (___) - ___ - ___

or (___) - ___ - ___

You can email me at: _____

You can text appointment confirmations at (___) - ___ - ___

If there are any changes to the information above, you must notify our office in writing as soon as possible.

If you would like someone else to have access to your medical information and financial obligations to the office you may list their names below.

Authorized Person

Relationship to Patient

_____	_____
_____	_____
_____	_____

Patient Name _____ (Please Print)

Signature _____ Date _____

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HIPAA PRIVACY POLICY ACKNOWLEDGE STATEMENT

I have been informed that Affiliated Health Clinics has a privacy policy in place according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a patient or parent / guardian of a patient at Affiliated Health Clinics, I understand the following:

1. Affiliated Health Clinics has a privacy policy in effect in our office.
2. Affiliated Health Clinics has made this policy readily available to me.
3. Affiliated Health Clinics has made me aware that I am entitled to a copy of this privacy policy if I desire a copy for my personal records.

After reading these statements please sign at the bottom of this sheet, acknowledging that you have been advised of the privacy policy implemented by Affiliated Health Clinics and have read and understand the acknowledgement form. If you would like a copy of the privacy policy please ask for one at the front desk or print it from our website www.affiliatedhealthclinics.com

_____ No, I do not want a copy of the policy, but I do acknowledge that it exists

_____ Yes, I have requested and been given a copy of the privacy policy.

Patient Name: _____ Acct #: _____

Patient Signature: _____

Parent / Guardian Signature: _____

For more information, please contact Affiliated Health Clinics Compliance and Privacy Officer at (727) 322-4227.

Affiliated Health Clinics, LLC

NEW PATIENT HISTORY

1. IDENTIFYING INFORMATION

Name: _____ DOB: ____/____/____ Date: ____/____/____

Reason for visit: ☐ Preventative/ Well-Woman exam ☐ Other: _____

Age: _____ Marital Status: _____ Occupation: _____

Who referred you? _____

Name of internist or family doctor: _____

Name of last gynecologist: _____

2. MEDICATION HISTORY

List all medications and non-prescription medication that you take with the dose and timing, including vitamins, herbs, and anti-inflammatory medications: ☐ None

DRUG	DOSE	FREQUENCY	REASON FOR MEDICATION

Do you take hormone therapy or birth control pills? Please list dose and timing: ☐ None

Allergies: List all adverse reactions or allergies you have to medications and what happened ☐ None

3. MEDICAL HISTORY ☐ None

Please list any medical problems that you have, the physician taking care of you and how they are being treated.

DATE	MEDICAL PROBLEM	MEDICATION / TREATMENT	PHYSICIAN

Check if you currently have or have ever had:

Alcohol Abuse ☐	Depression / Anxiety ☐	Kidney Stones ☐
Anesthetic reaction ☐	Drug/Substance Abuse ☐	Lupus/Autoimmune Disorder ☐
Anemia ☐	Eating Disorder ☐	Mitral Valve Prolapse ☐
Asthma ☐	Heart Disease ☐	Rheumatic Fever ☐
Bleeding Disorder ☐	Hepatitis/Jaundice ☐	Seizure Disorder ☐
Blood Clots ☐	High Blood Pressure ☐	Stomach Ulcers ☐
Cancer ☐	High Cholesterol ☐	Stroke ☐
Chronic Lung Condition ☐	Hypothyroidism ☐	Transfusion Reaction ☐
Diabetes ☐	Irritable Bowel Syndrome ☐	Tuberculosis ☐

Please explain: _____

4. SURGICAL HISTORY ☐ None

List all surgeries you have had including but not limited to breast biopsies, breast augmentation, tonsillectomy, appendectomy, tubal ligation, wisdom teeth.

DATE	OPERATION	DIAGNOSIS	HOSPITAL/ M.D.

5. GENERAL HEALTH

Date/Place of last pap smear: ☐ None _____
Date/Place of last mammogram: ☐ None _____
Date/Place of last blood work: ☐ None _____
Your Height _____feet _____inches Your weight _____lbs. Your blood type: _____

How much alcohol do you drink/week? ☐ None ☐ Avg. less than one daily ☐ Avg. one daily ☐ Avg. more
Do you smoke? ☐ Yes ☐ No Amount/Day _____ How many years? _____
If you quit smoking, when did you stop? _____
Have you used marijuana or other drugs in the last 5 years? ☐ Yes ☐ No Type: _____
Are you currently dieting or do you have a non-traditional diet? ☐ Yes ☐ No
Please Explain: _____

Do you perform self-breast examinations monthly? ☐ Yes ☐ No
Have you been immunized or had the following? Hepatitis A ☐ Yes ☐ No Hepatitis B ☐ Yes ☐ No

6. GYNECOLOGIC HISTORY (Women Only)

Age of first menstrual cycle: _____ Date of last period:_____/_____/_____ ☐ Menopausal ☐ Hysterectomy
How frequently do you bleed? _____ How many days do you bleed? _____

What do you use to keep from getting pregnant? ☐ Nothing

☐ Abstinence	☐ Diaphragm	☐ Rhythm
☐ Birth Control Pills	☐ IUD	☐ Tubal Ligation
☐ Condoms	☐ Patch	☐ Vasectomy

Please check if you have had or currently have the following:

Abnormal Pap Smear ☐	Herpes ☐	Pelvic Adhesions ☐
Chlamydia ☐	HPV ☐	PMS ☐
Condyloma (Warts) ☐	HPV Gardasil Vaccine ☐	Recent Change in Period ☐
Cramps ☐	Incontinence of Urine ☐	Recurrent Vaginitis ☐
Endometriosis ☐	Laser/Freezing Cervix ☐	Syphilis ☐
Fibroids ☐	Mycoplasma/Ureoplasma ☐	Trichomonas ☐
Gonorrhea ☐	Ovarian Cyst ☐	

Sexual History:

Are you sexually active? ☐ Yes ☐ No Do you have pain with intercourse? ☐ Yes ☐ No

Infertility History: (complete if indicated)

How long have you been trying unsuccessfully to become pregnant? _____
How long have you been trying without any form of contraception? _____

Please describe any test/diagnosis/treatments you have had performed: _____

Patient Name: _____

Pregnancy History: ☐ No Pregnancies

Number of times pregnant _____ Full term births _____ Premature births _____

Elective termination _____ Miscarriage _____ Ectopic pregnancies _____

Early pregnancy loss: Please list date and length of pregnancy with outcome (less than 20 weeks)

DATE	Miscarriage/# WEEKS	ELECTIVE ABORTION/#WEEKS	HOSPITAL/M.D.
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Deliveries: Please list date and length of pregnancy with outcome (lasting more than 20 weeks)

DATE	# WEEKS	VAGINAL/C-SECTION	SEX/WEIGHT	HOSPITAL/M.D.	COMPLICATIONS
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Family History: ☐ Adopted

Which of your 1st degree family members have the following:

Anesthesia Problems _____	Heart Disease _____
Breast Cancer _____	High Blood Pressure _____
Colon Cancer _____	Ovarian Cancer _____
Diabetes _____	Other Cancer _____

7. SYSTEMS REVIEW

Please check if you have had or currently have the following:

<u>HEENT</u>	CURRENT	PAST	N/A	<u>NEUROLOGIC</u>	CURRENT	PAST	N/A
Migraines	☐	☐	☐	Any Neurological Disorders	☐	☐	☐
Chronic Headaches	☐	☐	☐	Fainting	☐	☐	☐
Visual Changes	☐	☐	☐	Numbness	☐	☐	☐
Hearing Loss	☐	☐	☐	Weakness	☐	☐	☐
Dizziness	☐	☐	☐	Head/Nerve Injury	☐	☐	☐
<u>CARDIOVASCULAR</u>				Anxiety/ Depression	☐	☐	☐
Chest Pain	☐	☐	☐	<u>BREAST</u>			
Chronic Cough	☐	☐	☐	Breast Lump	☐	☐	☐
Abnormal Chest X-Ray	☐	☐	☐	Breast Tenderness	☐	☐	☐
Leg Swelling	☐	☐	☐	Breast Secretion	☐	☐	☐
Heart Murmur/Mitral Valve Prolapse	☐	☐	☐	Bleeding from Nipples	☐	☐	☐
Take Antibiotics for Dental Work	☐	☐	☐	Breast Implants	☐	☐	☐
Wheezing/Heart Palpitations	☐	☐	☐	<u>URINARY</u>			
<u>GASTROINTESTINAL</u>				Recurrent Urinary Tract Infections	☐	☐	☐
Chronic Abdominal Bleed	☐	☐	☐	Blood in Urine	☐	☐	☐
Frequent Nausea/Vomiting	☐	☐	☐	Painful Urination	☐	☐	☐
Chronic Constipation	☐	☐	☐	Kidney Stones	☐	☐	☐
Persistent Diarrhea	☐	☐	☐	<u>HEMATOLOGY</u>			
Bloody Stools	☐	☐	☐	Frequent Bruising	☐	☐	☐
Hemorrhoids	☐	☐	☐	Cuts that Do Not Stop Bleeding	☐	☐	☐
				Enlarged Lymph Nodes	☐	☐	☐

Please explain: _____

Patient Name: _____