Welcome:

Please arrive 30 minutes prior to your scheduled appointment time.

Please bring the following to your first appointment:

- **New patient paperwork completely filled out!**
- **License or ID card**
- **Insurance card (if applicable)**
- **Lab work from the last 6 months (if applicable)**
- **Medical records pertaining to your current or past diagnosis'**

We will call to confirm your new patient appointment 2 days in advance. If we do not reach you, we must receive a call back within 24 hours of the appointment to confirm that you wish to keep your appointment.

Young Foundational Health Center
7241 Bryan Dairy Rd.
Largo, FL 33777
(727)545-4600

*If utilizing GPS for directions, use the city of Pinellas Park.

Directions from Tampa/I275

1. Take I275 S towards St. Petersburg. Take Exit to 118th St.
2. Make a right on 72nd St.
3. Turn left on 112th Ave.
4. Take 1st left into parking lot
5. We are building just to your left. Neon green columns on brick building.

Directions from St. Petersburg Area

1. Head North on US 19 / 34th St.
2. Make a left turn on 118th / Bryan Dairy Rd.
3. Bryan Dairy Business Park is on the North side of Bryan Dairy.
4. Continue past 66th St. and make a right turn onto 72nd St. (Wheelchair store on rt. called Custom Mobility)
5. Make a left at the first street on your left 112th Ave.
6. Take first left into parking lot. Our office is to the left next to law office.

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INITIAL HEALTH ASSESSMENT

The following information is CONFIDENTIAL. It is used to evaluate your health profile and risk factors.

IDENTIFICATION DATA DATE:_____

Full name: _____ ☐ Male ☐ Female
First Middle Last

Address: _____ ☐ Single ☐ Divorced
Street Apt#

_____ ☐ Married ☐ Separated
City State Zip

Social Security Number: _____ DOB: _____ Driver's License#: _____
Home Phone#: _____ Cell Phone#: _____ Work Phone#: _____
E-mail: _____ Employer: _____
How did you hear about us? _____
What Pharmacy do you use? _____Pharmacy Phone#: _____
Emergency Contact/Relation: _____Phone#:_____

PRESENT ILLNESSES

Please list all illnesses or concerns that you would like to address with the doctor today:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

CURRENT MEDICATIONS:

Please list ALL medicines you are taking, including any over the counter medicines and vitamins.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

DRUG ALLERGIES

List all drug, food and environmental allergies:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Name: _____ DOB:_____

PAST MEDICAL HISTORY

List all serious medical problems you have had such as diabetes, cancer, heart disease, lung disease etc...

1._____ 4. _____

2._____ 5. _____

3._____ 6. _____

PERSONAL HISTORY Please list who lives with you:

Name, First & Last	Age	Relation to You	Name, First & Last	Age	Relation to You
1.			**4.**		
2.			**5.**		
3.			**6.**		

Have you ever smoked? ☐ Yes ☐ No How long? _____

Do you presently smoke? ☐ Yes ☐ No How much? _____

Do you use alcoholic beverage? ☐ Yes ☐ No How much? _____

Do you use recreational drugs? ☐ Yes ☐ No Type? How often? _____

Do you have pets? ☐ Yes ☐ No If so, what type? _____

Is religion or spiritual belief important to you? ☐ Yes ☐ No If so, what religion? _____

Do you exercise at least 3 times a week? ☐ Yes ☐ No What type? _____

Have you had a colonoscopy? ☐ Yes ☐ No When? _____

How would you describe your overall health? (check one) ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HEALTH SCREENING QUESTIONS FOR WOMEN

Have you had a mammogram? ☐ Yes ☐ No Date of last mam _____

Do you do self-breast exams? ☐ Yes ☐ No

Have you had a pap smear? ☐ Yes ☐ No Date of Last Pap_____

Any history of abnormal Pap smear? ☐ Yes ☐ No When? _____

Please list dates of any pregnancy and outcomes _____

Have you ever been a victim of sexual or physical abuse? ☐ Yes ☐ No When? _____

HEALTH SCREENING QUESTIONS FOR MEN

Do you examine your testicles for lumps? ☐ Yes ☐ No

Have you had a prostate exam? ☐ Yes ☐ No When? _____

Have you had a PSA test? ☐ Yes ☐ No When/Results? _____

Have you had trouble achieving or maintaining an erection? ☐ Yes ☐ No

Name: _____ DOB:_____

IMMUNIZATIONS & TESTS

Please give the date of your last immunization/test:

Tetanus: _____ Flu shot: _____ Shingles Vaccine: _____ COVID 19 Vaccine: _____

Pneumonia Vaccine: _____ Colon Cancer Screening: Colonoscopy: _____

Stool Test: _____

FAMILY HISTORY Please check or list any diseases that your relatives have now or have had:

	Age if Alive	Age at Death	Diabetes	High Blood Pressure	Heart Disease	Cancer	Other
Mother							
Father							
Brother(s)							
Sister(s)							
Grandparents (Maternal)							
Grandparents (Paternal)							

SURGICAL HISTORY

Please list all surgeries you have had and dates performed.

Operation	Year	Operation	Year
1.		4.	
2.		5.	
3.		6.	

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient's Signature: _____ **Date:** _____

INSURANCE INFORMATION: ☐ INSURANCE ☐ SELF-PAY

Primary Carrier: _____Secondary Carrier: _____

ID/Policy #: _____ID/Policy #: _____

Group#: _____Group#:_____

Ins Party's Date of Birth: _____Ins Party's Date of Birth: _____

Ins Party's SSN#: _____Ins Party's SSN#: _____

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures and others pay a percentage of the change. Please remember it is your responsibility to pay any deductible amount, co-insurance and any other balance not paid for by your insurance. If your insurance company does not respond to our billing within 60 days, you are responsible for the changes. **Self-pay and co-pays are due at the time of service**. If this account is assigned to an attorney for collection and or suit, the prevailing party shall be entitled to reasonable Attorney's fees and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize the Providers (and its entities) to furnish information to the insurance carriers, and I hereby assign to all physicians all payment for medical services. I understand that I am responsible for non-covered fees.

Signed: _____ Date: _____DOB:_____

NUTRITIONAL ADJUNCTIVE SUPPORT FOR ACUTE & CHRONIC DISEASES

To Our Patients:

In order to make it possible for you to choose from all effective health care options available to you. Including those that complement or substitute for prevailing conventional treatments, we are making the following information available to you. You have the right of access to any mode or treatment that in your and our judgement is in your best interests.

Although much evidence exists supporting the belief that Orthomolecular Therapy is effective. Orthomolecular Therapy is not generally recognized as proven by various professional medical organizations, governmental agencies such as FDA (Food and Drug Administration), and the medical establishment at large. Therefore, Orthomolecular Therapy is considered experimental, investigative, and medically unnecessary by these entities and third party payers (insurance companies, Medicare, Worker's Compensation, etc.). Thus, not all of our programs may be covered by insurance or reimbursable.

Our facility practices alternative medicine and he or she recommends that I maintain other physicians to oversee and coordinate my various healthcare needs.

PLEASE SIGN BELOW

_____

Patient/Guardian Signature Date

_____

Print Name of Person Signing Date

Name: _____ DOB: _____

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Compliance Consent Form

I _____understand that the success of any treatment plan we offer; including Weight management, Hormone therapy, Diabetes, Thyroid, Chronic Disease etc. depends on my active participation, compliance and full disclosure of lifestyle, eating habits, medications, etc. Full disclosure and compliance is the utmost importance to my success. If I omit something or am not completely transparent with the doctors about what I am easting, medications I'm taking or about something in my life, it may throw off my success. My compliance with the treatment plan advised is also vital. I understand that the doctors cannot guarantee or assure treatment success or any definite outcomes. I understand that many issues, i.e. Hormone problems, Diabetes, Thyroid, Weight problems, etc. are considered chronic conditions that may require permanent changes in my eating habits, treatment and lifestyle to attempt symptom relief.

Print Patient's Name: _____Date:_____

Signature of Patient or Patient's Legal Representative:_____

Print Name of Legal Representative (if applicable):_____

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS, PER HIPAA REGULATIONS

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care of treatment. I understand this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care, such as referrals,
- A source of information for applying my diagnosis and treatment information to my bill,
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I have been provided with a "Notice of Patient Practices" that provides a more complete description of information uses and disclosures. I understand that I have the rights and privileges:

- The right to review the "Notice" prior to acknowledging this consent.
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

Restrictions: (Please Print)
**I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

****Please tell us with whom we may discuss your protected health information:**
Example: spouse name, children name(s), other relatives name(s), friends or caregivers name(s).

Name:	**Relationship:**
Name:	**Relationship:**
Name:	**Relationship:**

****Messages or Appointment Reminders:**

May we leave a message at your home using doctor's/practice name: ◯ Yes ◯ No
May we leave a message at your work using doctor's/practice name: ◯ Yes ◯ No
Messages will be of a non-sensitive nature, such as, appointment reminders.

We require 24 hour notice for cancellations or changes to appointment date / time or a $25 fee will be charged.

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and ☐ accept ☐ decline (please check one) the information in this consent.

_____
Patient/Guardian Signature Date

_____
Print Name of Person Signing Date

*If other than the patient (Patient Name) _____is signing, are you the legal guardian, custodian or do you have Power of Attorney for this patient, for treatment, payment or healthcare operations? ☐ Yes ☐ No

Name: _____ DOB:_____

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

NAME OF PATIENT:	**DOB:**

Requesting Office

Name: Young Foundational Health Center Phone: 727-545-4600 Fax: 727-545-4611

Address: 7241 Bryan Dairy Road

City/State/Zip Largo, Florida 33777

RECORDS FROM: (Who is releasing the records?)

Name: _____ Phone #: _____

Address: _____Fax #:_____

City/State/Zip_____

For the Following Purposes:

☐ **Continued Medical Care** ☐ Personal Information ☐ Legal Follow-up

☐ Disability Insurance ☐ Other:

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, if such information And/or Records Exist:

☐ Please send the entire Medical Record (all information) to the above named recipient.

☐ **Office Notes and Reports** ☐ **Most recent one-year history** ☐ Most recent 3-year history

☐ Rx History ☐ Transcribed hospital reports ☐ **Laboratory reports**

☐ Billing Statements ☐ **Diagnostic Reports** ☐ Diagnostic Films

☐ Others Listed Here:

The Following Items Must Be initialed to Be Included in the Use and/or Disclosure:

_____HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases

_____Mental Health information and/or Records

_____Domestic Violence

_____Genetic Testing information and/or records

_____Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:_____

_____

I understand that, if the person entity receiving the information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality requirements. Authorization will expire in Six (6) Months from date of signing.

Print Patient's Name: _____Date: _____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

Relationship to patient: _____