



**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 118<sup>th</sup> St.
2. Make a right on 72<sup>nd</sup> St.
3. Turn left on 112<sup>th</sup> Ave.
4. Take 1<sup>st</sup> left into parking lot
5. We are building just to your left.

#### Directions from St. Petersburg Area

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



**PAST MEDICAL HISTORY**

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

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 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 charge. 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 charges. **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

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Patient/Guardian Signature

Date

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Print Name of Person Signing

Date

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**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 eating, 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.

Patients, family members, and/or visitors are strictly prohibited from video/audio recording or photography within this practice without consent of a medical provider.

Print Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient or Patient's Legal Representative: \_\_\_\_\_

Print Name of Legal Representative (if applicable): \_\_\_\_\_



**AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS**

|                               |                   |
|-------------------------------|-------------------|
| <b>NAME OF PATIENT:</b> _____ | <b>DOB:</b> _____ |
|-------------------------------|-------------------|

**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: \_\_\_\_\_



