Please do not complete these forms before scheduling an appointment. If you would like to schedule an appointment, please call 352-205-4032.
# Table of Contents

Notice of Privacy Practices ................................................................. 2

**SIGNATURE REQUIRED**  
Patient Financial Responsibility ....................................................... 5

**SIGNATURE REQUIRED**  
Universal Patient Authorization Form .............................................. 7

**SIGNATURE REQUIRED**  
Consent to Medical Treatment .......................................................... 9

**SIGNATURE REQUIRED**  
Acknowledgement of Receipt of Privacy Practices .......................... 10

Patient Demographic Information ...................................................... 11

**SIGNATURE REQUIRED**  
Insurance Information ................................................................. 12

**SIGNATURE REQUIRED**  
Prescription History and Medication Information ............................ 13

Family History .................................................................................. 14

Social History .................................................................................. 15

Surgical History | Implant History | OB/GYN History ......................... 16

Past Medical History ......................................................................... 17
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At The Villages Health, we are committed to handling and using your protected health information with care. This Notice of Privacy Practices (“Notice”) describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information (“PHI”). This Notice is effective August 2019.

Understanding Your Health Record/Information

A record of your visit is made each time you visit The Villages Health. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

• Basis for planning your care and treatment
• Means of communication among the many health professionals who contribute to your care
• Legal document describing the care you received
• Means by which you or a third-party payer can verify that services billed were actually provided
• A tool in educating health professionals
• A source of data for medical research
• A source of information for public health officials charged with improving the health of this state and the nation
• A source of data for our planning and marketing
• A tool we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of The Villages Health, the information belongs to you.

You have the right to:

• Obtain a paper copy of this Notice
• Inspect and copy your health record, or request that we share it with a third party
• Request an amendment to your health record
• Obtain an accounting of certain disclosures of your health information
• Request communications of your health information by alternative means or at alternative locations
• Request a restriction of PHI regarding care and services you pay for out-of-pocket (in writing)
• Request a copy of your health record in an electronic format if applicable
• Request a restriction on certain uses and disclosures of your information
• Revoke your authorization to use or disclose health information, except to the extent that action has already been taken
• Be notified of a breach of your PHI

Our Responsibilities

The Villages Health System is required to:

• Maintain the privacy of your health information
• Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
• Abide by the terms of this Notice as currently in effect
• Notify you following a breach of your unsecured PHI
• Notify you if we are unable to agree to a requested restriction
• Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change this Notice and to make the new Notice effective for all PHI we maintain. We will not use or disclose your health information without your authorization, except as described in this Notice. The current version of this Notice in effect will be posted on our website and at our office. You may also contact the Privacy Officer for a copy.

Required Authorization

We will not disclose your health information without your authorization except as provided for in this Notice or provided by law. Additionally, we will require your written authorization for the following disclosures:

• Disclosing of psychotherapy notes
• Use of PHI in marketing
• Sales of PHI

You have the right to revoke your authorization by submitting your revocation in writing to the practice where you signed your authorization or to our Privacy Officer. However, your revocation does not apply to actions already taken based on your authorization or disclosures already made.

Examples of Disclosures for Treatment, Payment and Health Operations (TPO)

We will use your health information for treatment.

For example, information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will
know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used or other information as needed for payment purposes.

We will use your health information for regular health operations. For example, members of the medical staff, the risk or quality improvement manager or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates
There are some services provided to our organization through contracts with Business Associates. Examples include an Electronic Medical Record (EMR) system, billing company, or legal services. When these services are contracted, we may disclose your health information to our Business Associate so that they can perform the job we've asked them to do. To protect your health information, we require the Business Associate to agree to safeguard your information.

Notification
We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care. If your information is used for such notification, it would typically be limited to your name, general condition, and location.

Communication from Offices
We may call your home or other designated location and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements. If you choose to provide an email account to us or communicate with us via email, we will reply to you via email or communicate other information needed to assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements. Before using email to communicate with us, you should understand that there are certain risks associated with the use of email. It may not be secure and messages can easily be misdirected. Text messaging presents similar risks. If you choose to contact us via text messaging, we may respond to you in the same manner or choose to refrain from text messaging with you, or otherwise limit the information included if we are not able to verify your identity. Additionally, you should understand that use of email and/or other electronic communications is not intended to be a substitute for professional medical advice, diagnosis or treatment and should never be used in a medical emergency.

Communication with Family
Unless you object or in the health professional’s best judgment, we may disclose your health information to a family member or friend to the extent of their involvement in your care or payment related to your care.

Health Information Exchanges
The Villages Health participates in one or more health information exchanges ("HIE") that allow us to share information that we obtain or create about you with other health care providers or other health care entities, for your treatment or otherwise as permitted by law. For example information about your past medical care and current medical conditions and medications can be available to us or to your other health care providers, if they participate in the same HIE. You will have the chance to opt-in to participate in the HIE before your information is shared.

Open Treatment Areas
We will implement reasonable safeguards to protect your information. However, sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, some patient information may be incidentally overheard by others while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer or your health care provider.

Research
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors
We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations
Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Marketing & Fundraising
We may contact you to provide information about treatment alternatives or other health-related benefits and services that we provide that may be of interest to you. However, for services that are not provided by us and are not related to your treatment, or that are otherwise considered “marketing” under HIPAA, we would first obtain your authorization for this type of communication. We may also use your information for fundraising purposes. If we do contact you for fundraising activities, you will have an opportunity to opt out of such communications. If you prefer to opt-out now and not be contacted for fundraising efforts, you may submit your request to opt-out in writing to the practice where you signed your authorization, or to our Privacy Officer at the address listed at the end of this Notice.
Food and Drug Administration (FDA)
We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers’ Compensation
We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For More Information or to Report a Problem
If you have questions and would like additional information, you may contact the Practice’s Privacy Officer at (352) 674-8905. If you believe that your privacy rights have not been followed as directed by applicable law or as explained in this Notice, you may file a complaint with us. Please send any complaint to The Villages Health Privacy Officer at the address provided below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

The Villages Health
Attention: Privacy Officer
1020 Lake Sumter Landing
The Villages, FL 32162

Telephone: (352) 674-8905
Email: tvhprivacyofficer@thevillageshealth.com
FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

Patient Financial Responsibility. I understand that in consideration of the services provided, I am directly and primarily responsible to pay for services and procedures rendered at The Villages Health. I understand that I am responsible for any applicable deductible or co-payments.

Assignment of Insurance Benefits. I hereby authorize The Villages Health to file a claim for payment with my insurance company and/or Medicare (if applicable) for services provided to me and I request that payments for such services be made directly to The Villages Health and/or any physician providing services to me. If the insurance company fails to pay for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to The Villages Health.

Responsibility to Provide Proof of Insurance. I understand that it is my responsibility to provide The Villages Health with a copy of my current insurance card. I will notify The Villages Health immediately upon any change in my insurance.

Insurance Waiver and Non-Covered Services Waiver. There may be a service I desire, suggested or provided that is not covered under my insurance plan or Medicare ("Non-Covered Services"). I understand I must pay for "Non-Covered Services". If feasible, a waiver will be completed for each "Non-Covered Service."

Release of Information. I authorize The Villages Health, any physician examining and/or treating me, and their business associates to release to any third party payer (such as UnitedHealthcare or Blue Cross) any medical and psychiatric information and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment. I specifically consent to the release of any material in your possession, including, if any exists, results of HIV (AIDS) tests, and any that might address chemical dependence, depression or other psycho-emotional issues. I understand that if I do not consent to the release of information for payment purposes, The Villages Health and other health care providers will not be able to bill my insurance other third party and I may be billed directly for these services.

Medicare — Patient’s Certification/Authorization to Release Information and Payment Request. I certify that the information given by me in applying for payment under title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby certify all insurance pertaining to the treatment shall be assigned to the physician treating me. I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at The Villages Health Care Center’s office.
The Villages Health accepts payments in: Cash, Check and Credit Cards. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to The Villages Health, and send to The Villages Health.

By signing, I acknowledge understanding the above patient information.

Patient’s Name
First Name ___________________________ MI _____ Last Name ______________________________

Patient’s Date of Birth
_______ — ______ — ______
MONTH DAY YEAR

SIGN HERE Patient’s Signature ___________________________ Date _________ / _________ / _________

SIGN HERE Guardian/Power of Attorney Signature ______________________________

Person responsible for payment if different than above
Please sign as self if you are the responsible party. If not, please have responsible party sign, such as parent, guardian, etc.

First Name ___________________________ MI _____ Last Name ______________________________

Relationship to Patient ______________________________

Address ________________________________ City ________________ State ________ Zip ________

SIGN HERE Responsible Party’s Signature ________________________________
UNIVERSAL PATIENT AUTHORIZATION FORM FOR
FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

***PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW***

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): ________________________________

Date of Birth (mm/dd/yyyy): ______________________________

Address: ______________________________ City: __________ State: _______ Zip: _______

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: _____________________________ The Villages Health _____________________________ Phone: (352) 674-8905

Address: __________________________________________________________________________________________

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in “To Whom.”

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- I have read all pages of this form and agree to the disclosures above from the types of sources listed.

X ____________________________________________ Date Signed (mm/dd/yyyy)

Signature of Patient or Patient’s Legal Representative

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

☐ Parent of minor
☐ Guardian
☐ Other personal representative (explain: ________________________________)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.
Explanation of Form Florida AHCA FC4200-004
“Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care”

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

“Of What”: includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:
   a. Drug, alcohol, or substance abuse
   b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes “psychotherapy notes” as defined in HIPAA at 45 CFR 164.501)
   c. Sickle cell anemia
   d. Birth control and family planning
   e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
   f. Genetic (inherited) diseases or tests

2. Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.

3. Information created before or after the date of this form.

“From Whom” includes: All information sources including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker’s compensation programs, state Medicaid, Medicare and any other governmental program.

“To Whom”: For those health care providers listed in the “TO WHOM” section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization’s facility or that person’s office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

“Purpose”: Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

“Revocation”: You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

“Re-disclosure of Information”: Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the “From Whom” or “To Whom” section to seek out the information you specified in the “Of What” section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.
CONSENT TO MEDICAL TREATMENT

Consent to Treatment. I, or my authorized representative, consent to providers at The Villages Health, to evaluate and treat my medical condition as may be deemed necessary or advisable in the judgment of my physician or other provider. Absent an emergency, if the treatment has significant risks, then an additional consent would be obtained by The Villages Health. I understand that providing medical care is not an exact science and no guarantees have been given to me by anyone as to the results or outcomes that may be obtained from examinations, treatments or other healthcare services.

Communications About My Treatment. I agree that by providing my landline or cell phone number(s), I am giving express consent for The Villages Health, its staff, employees, independent contractors, assignees, successors, and agents, to contact me at these numbers, or any number that is later acquired for me and to leave live or pre-recorded messages or text messages regarding my healthcare-related matters, my account, or my bill related to any services I receive. I confirm that any phone number I provide is associated with me and not a third-party. For greater efficiency, calls may be delivered by an auto-dialer. Providing a telephone or cell phone number is not a condition of receiving services.

Consent to Obtain Prescription History. I authorize The Villages Health and its affiliated providers to view my external prescription history via the RX History service. I understand that my history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff of TVH, and it may include prescriptions back in time for several years. My signature certifies that I have read and understand the scope of my consent and I authorize access.

Consent to Obtain Vaccination History. I authorize the Villages Health and its affiliated providers to view my vaccination history via Florida Shots. I understand that my history from multiple other unaffiliated medical providers or pharmacies may be viewable by my providers and staff and TVH, and it may include vaccination history back in time for several years. My signature certifies that I have read and understand the scope of my consent and I authorize access.

I certify that I have read the forgoing, received a copy thereof and I am the patient or am duly authorized by the patient as patient’s authorized representative to execute this Consent to Medical Treatment.

SIGN HERE

Patient's Signature

SIGN HERE

Guardian/Power of Attorney Signature

Relationship to Patient

Date ______________________
**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND COMPLIANCE WITH HIPAA STANDARDS**

**Notice to Patient**
We are required to provide you with a copy of our Notice of Privacy Practices (pages 2 and 3), which states how we may use and/or disclose your health information. Your signature on this form is to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I authorize The Villages Health to leave medical information pertaining to my care by the following methods:

<table>
<thead>
<tr>
<th>Method</th>
<th>Yes</th>
<th>No</th>
<th>OK to leave voice mail?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Telephone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Telephone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cell Phone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMS/Text</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E-mail</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I authorize The Villages Health, and hospitals where I may be a patient, to leave medical information pertaining to my care with the following people:

<table>
<thead>
<tr>
<th>Spouse</th>
<th>PRINT SPOUSE'S NAME</th>
<th>SPOUSE'S PHONE NUMBER</th>
<th>SPOUSE'S DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>PRINT NAME</td>
<td>RELATIONSHIP TO PATIENT</td>
<td>PHONE NUMBER</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>PRINT NAME</td>
<td>RELATIONSHIP TO PATIENT</td>
<td>PHONE NUMBER</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>PRINT NAME</td>
<td>RELATIONSHIP TO PATIENT</td>
<td>PHONE NUMBER</td>
</tr>
</tbody>
</table>

I acknowledge that I have been offered and/or received a copy of this office’s Notice of Privacy Practices. I understand that at the discretion of The Villages Health I may be asked to update this information periodically.

**SIGN HERE** Patient’s Signature

**SIGN HERE** Guardian/Power of Attorney Signature

Relationship to Patient  Date / / 

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this Patient. It could not be obtained because:

- [ ] The Patient refused to sign.
- [ ] Due to an emergency situation it was not possible.
- [ ] We could not communicate with the Patient.
- [ ] Other. Explain

EMPLOYEE’S PRINTED NAME  EMPLOYEE SIGNATURE  DATE
PATIENT DEMOGRAPHIC INFORMATION

General Information
Last Name ___________________________ First Name ___________________________ MI _________
Nickname/Preferred Name ___________________________ Previous Name ___________________________
Date of Birth ______/____/____ Social Security Number ______-____-____ Driver’s License Number ___________________________
Driver’s License State ___________________________ Driver’s License Expiration Date ______/____/____
Mailing Address ___________________________ City ______ State ______ Zip ______
Home Phone (______) ___________________________ Cell Phone (______) ___________________________ SMS/Text ☐ Yes ☐ No
Work Phone (______) ___________________________ Email ___________________________
Preferred Contact Method ☐ HOME PHONE ☐ WORK PHONE ☐ MOBILE PHONE ☐ MAIL ☐ PORTAL

Race
☐ WHITE/CAUCASIAN ☐ BLACK/AFRICAN AMERICAN ☐ ASIAN ☐ OTHER ___________________________ ☐ DECLINED TO ANSWER

Ethnicity
☐ HISPANIC/LATIN ☐ NOT HISPANIC/LATIN ☐ DECLINED TO ANSWER Preferred Language: ___________________________

Marital Status
☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ PARTNER

Seasonal
If Seasonal, Enter Dates ____________ Seasonal Address ___________________________ Seasonal City ___________________________
Seasonal State ______ Seasonal Zip ______ Villages ID ______ Villages Neighborhood ___________________________

Miscellaneous Information
How Did You Hear About Us? ___________________________ Guardian ___________________________
Emergency Contact ___________________________ Relationship ___________________________
Home Phone (______) ___________________________ Cell Phone (______) ___________________________
Next of Kin ___________________________ Relationship ___________________________ Phone (______) ___________________________
Occupation: Employer Name ___________________________ Phone (______) ___________________________ ☐ RETIRED ☐ DISABLED
Current or Former Occupation ___________________________ Current or Former Industry ___________________________
Guarantor (Person to Whom Statements are Sent) ___________________________
Guarantor DOB ___________________________ Relationship to Patient ___________________________
Guarantor Mailing Address ___________________________ City ______ State ______ Zip ______

Pharmacy Contact
Primary Pharmacy Name ___________________________
Primary Pharmacy Phone (______) ___________________________ Primary Pharmacy Fax (______) ___________________________
Primary Pharmacy Address ___________________________ City ______ State ______ Zip ______
Secondary Pharmacy Name ___________________________
Secondary Pharmacy Phone (______) ___________________________ Secondary Pharmacy Fax (______) ___________________________
Secondary Pharmacy Address ___________________________ City ______ State ______ Zip ______
Referring Provider Name ___________________________ Referring Provider Phone (______) ___________________________
Current or Previous Primary Care Physician

<table>
<thead>
<tr>
<th>NAME</th>
<th>CITY/STATE</th>
<th>PHONE</th>
<th>CURRENT</th>
</tr>
</thead>
</table>

Current or Previous Specialists

<table>
<thead>
<tr>
<th>NAME</th>
<th>SPECIALTY</th>
<th>CITY/STATE</th>
<th>PHONE</th>
<th>CURRENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
<td>SPECIALTY</td>
<td>CITY/STATE</td>
<td>PHONE</td>
<td>CURRENT</td>
</tr>
<tr>
<td>NAME</td>
<td>SPECIALTY</td>
<td>CITY/STATE</td>
<td>PHONE</td>
<td>CURRENT</td>
</tr>
<tr>
<td>NAME</td>
<td>SPECIALTY</td>
<td>CITY/STATE</td>
<td>PHONE</td>
<td>CURRENT</td>
</tr>
</tbody>
</table>

INSURANCE INFORMATION

Primary Insurance

REQUIRED INFORMATION: PLEASE NOTE: Insurance is considered a method of reimbursing the member fees paid by you to the doctor and it is not a substitute for payment, unless our office is a provider for your insurance company.

Insurance Company _______________ Member ID# _______________ Group Number _______________

Group Name __________________________ Issue Date ______/______/______ Expiration Date ______/______/______

Policy Holder's

Last Name ___________________________ First Name ________________________ MI __________

Mailing Address ___________________________ City ___________ State ___________ Zip __________

Social Security Number _____ – ____ – _____ Date of Birth ____/____/______ Relationship to Patient ________________

Secondary Insurance

Insurance Company _______________ Member ID# _______________ Group Number _______________

Group Name __________________________ Issue Date ______/______/______ Expiration Date ______/______/______

Policy Holder's

Last Name ___________________________ First Name ________________________ MI __________

Mailing Address ___________________________ City ___________ State ___________ Zip __________

Social Security Number _____ – ____ – _____ Date of Birth ____/____/______ Relationship to Patient ________________

Prescription Drug Coverage Plan Name __________________________ Medicare Part D Plan Name ________________

All co-pays, coinsurance, and deductibles are expected to be paid in full at the time of your visit. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney’s fees and/or cost of collection. If this account is assigned to a collection agency, an administrative fee will be applied.

Patient's Signature ___________________________ Date ______/______/______

Guardian/Power of Attorney Signature __________________________________________
### MEDICATION INFORMATION

Note: Please bring **ALL** medications you are currently using (in their original containers) to your **FIRST** appointment.

#### Allergies/Intolerances

<table>
<thead>
<tr>
<th>Type of Medication</th>
<th>Type of Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Penicillin</td>
<td>Rash</td>
</tr>
</tbody>
</table>

#### Current Prescription Medications

This may include ointments, creams, inhalers or any items for which you would need a prescription. This may include items that are used only rarely.

<table>
<thead>
<tr>
<th>Name</th>
<th>Strength [Formulation]</th>
<th>Frequency</th>
<th>Refill required in the next 90 days?</th>
<th>Supply</th>
<th>Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Lisinopril</td>
<td>10 mg [tablets]</td>
<td>Once daily</td>
<td>□ No □ 90 day □ 30 day</td>
<td>□ No</td>
<td>□ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ No □ 90 day □ 30 day</td>
<td>□ No</td>
<td>□ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ No □ 90 day □ 30 day</td>
<td>□ No</td>
<td>□ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ No □ 90 day □ 30 day</td>
<td>□ No</td>
<td>□ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ No □ 90 day □ 30 day</td>
<td>□ No</td>
<td>□ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ No □ 90 day □ 30 day</td>
<td>□ No</td>
<td>□ No</td>
</tr>
</tbody>
</table>

#### Current Non-Prescription Medications

<table>
<thead>
<tr>
<th>Name</th>
<th>Strength [Formulation]</th>
<th>Frequency</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Advil</td>
<td>200 mg [capsules]</td>
<td>1 capsule every 6 hours</td>
<td>Headaches</td>
</tr>
</tbody>
</table>

#### Current Supplements

<table>
<thead>
<tr>
<th>Name</th>
<th>Strength [Formulation]</th>
<th>Frequency</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Fish Oil</td>
<td>500 mg [tablets]</td>
<td>1 tablet twice daily</td>
<td>Heart Health</td>
</tr>
</tbody>
</table>
Discontinued Medications
It would be helpful for us to know of any medication you have previously used that has been stopped for any reason, besides those you have listed under the “allergies/intolerances” section above, such as those that may have been ineffective, or simply no longer needed.

<table>
<thead>
<tr>
<th>Name</th>
<th>Reason Discontinued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Lisinopril</td>
<td>My ankles became swollen</td>
</tr>
</tbody>
</table>

Medical Supplies I Use
These are items for which you may need a prescription, such as diabetic shoes, oxygen, prosthetics, etc.

<table>
<thead>
<tr>
<th>Name</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Insulin Syringes</td>
<td>To take insulin for diabetes</td>
</tr>
</tbody>
</table>

IMMUNIZATIONS  Please indicate month, day and year last received.

<table>
<thead>
<tr>
<th>INFLUENZA VACCINE</th>
<th>PNEUMONIA VACCINE</th>
<th>PREVNAR VACCINE</th>
<th>TETANUS BOOSTER</th>
<th>TDAP</th>
<th>SHINGRIX (SHINGLES) VACCINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td></td>
<td>/</td>
</tr>
</tbody>
</table>

FAMILY HISTORY
Family Member with a History of (Please define who had history and what age if applicable):

- Abdominal Aortic Aneurysm
- Breast Cancer
- Colon Cancer
- Coronary Artery Disease
- Diabetes Mellitus
- Other
- Other
- Hypertension
- Mental Illness
- Ovarian Cancer
- Prostate Cancer
- Stroke
- Other
- Other
SOCIAL HISTORY

Please complete the following social history information. Please check all that apply. If in doubt, leave blank.

Advance Directives

Note: Please bring a copy of these documents to your **FIRST** appointment.

- DNR
- FIVE WISHES
- GUARDIAN
- HEALTH CARE SURROGATE
- LIVING WILL
- POWER OF ATTORNEY
- NONE

If none, would you like additional information explaining what these mean?  
- Yes
- No

Tobacco Use

- NEVER SMOKED
- FORMER SMOKER
- CURRENT SMOKER
- EVERY DAY
- SOME DAYS

How much do you or did you smoke?  
- Packs Per Day
- Week

Do you currently use smokeless tobacco?  
- Yes
- No

Used smokeless tobacco in the past?  
- Yes
- No

Most Recent Tobacco or Smokeless Tobacco Use  

E-Cigarette/Vape Use  
- CURRENT
- FORMER
- NEVER USED

Passive Smoke Exposure  
- Yes
- No

Are you interested in quitting?  
- Yes
- No

Ready to quit?  
- Yes
- No

General

Total Number in Household

Are you currently employed?  
- Yes
- No

Occupational Exposures  
- Yes
- No

Current/Former Occupation

Education  
- LESS THAN 8th GRADE
- 8
- 9
- 10
- 11
- 12
- 2 YEAR COLLEGE
- 4 YEAR COLLEGE
- POST GRADUATE

Where are you from?  

City/Neighborhood In Which You Live

Do you have local family?  
- Yes
- No

Number of Children

Pets?  
- Yes
- No

Able to care for self?  
- Yes
- No

General Stress Level  
- LOW
- MEDIUM
- HIGH

Caregiver  
- FAMILY
- FRIENDS
- OTHER
- NONE

Sexually Active  
- Yes
- No

Sexual Orientation  
- HETEROSEXUAL
- HOMOSEXUAL
- BISEXUAL
- DECLINE TO ANSWER

Caffeine Intake  
- NONE
- OCCASIONAL
- MODERATE
- HEAVY

Type of Exercise

Exercise

Type:  

Diet  
- REGULAR
- VEGETARIAN
- VEGAN
- GLUTEN FREE
- CARDIAC
- DIABETIC
- OTHER:  

Smoke Alarm In Home  
- Yes
- No

Seat Belts Used Routinely  
- Yes
- No

Sunscreen Used Routinely  
- Yes
- No

Domestic Violence  
- Yes
- No

Religious Preference

Drugs/Alcohol

Alcohol Intake  
- NONE
- OCCASIONAL
- MODERATE
- HEAVY

During the past 4 weeks, how many drinks of wine, beer, or other alcoholic beverages have you consumed?  

Illicit/Recreational Drug Use  
- NEVER
- IN PAST
- CURRENT
- TYPE:  

-
**Medication Adherence**

Do you understand all the medications as you are taking them?  □ Yes  □ No

Do you have any financial concerns related to the medication you are taking?  □ Yes  □ No

Do you have any other barriers related to the medications you are taking?  □ Yes  □ No

**Communication Provisions**

Do you have any communication barriers?  □ None  □ Cognitive  □ Vision  □ Language  □ Hearing

Does the family/caretaker have any communication barriers?  □ None  □ Cognitive  □ Vision  □ Language  □ Hearing

---

**SURGICAL HISTORY**

*Please provide dates in the space below.*

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Year of Surgery</th>
<th>Procedure</th>
<th>Year of Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix Removal</td>
<td></td>
<td>Hernia Repair</td>
<td></td>
</tr>
<tr>
<td>Breast Biopsy/Breast Surgery</td>
<td></td>
<td>Hysterectomy</td>
<td></td>
</tr>
<tr>
<td>Cardiac Bypass</td>
<td></td>
<td>Ovarian Removal <em>(one or both)</em></td>
<td></td>
</tr>
<tr>
<td>Carotid Artery Surgery</td>
<td></td>
<td>Other <em>(Type _________)</em></td>
<td></td>
</tr>
<tr>
<td>Cataract Surgery</td>
<td></td>
<td>Other <em>(Type _________)</em></td>
<td></td>
</tr>
<tr>
<td>Gallbladder Surgery</td>
<td></td>
<td>Other <em>(Type _________)</em></td>
<td></td>
</tr>
</tbody>
</table>

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**IMPLANT HISTORY**

*List any implants, date implanted, and the UDI for the device.*

<table>
<thead>
<tr>
<th>Device Type</th>
<th>Date of Implant</th>
<th>UDI</th>
<th>Site</th>
<th>Side</th>
<th>Left</th>
<th>Right</th>
<th>Bilateral</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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**OB/GYN HISTORY**

<table>
<thead>
<tr>
<th>Date of Last Pap Smear</th>
<th>□ Normal □ Abnormal □ Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Last Mammogram</td>
<td>□ Normal □ Abnormal □ Unknown</td>
</tr>
<tr>
<td>Date of Last Bone Density</td>
<td>□ Normal □ Abnormal □ Unknown</td>
</tr>
<tr>
<td>Date of Last Menstrual Period</td>
<td>□ Normal □ Abnormal □ Unknown</td>
</tr>
</tbody>
</table>

Age at First Period  ___  Age at First Child  ___  Age at Menopause  ___  Current Birth Control Method  ______________________

Number of Pregnancies  ___  Number of Living Children  ___
**PAST MEDICAL HISTORY**

Please complete the following in as much detail as possible. If you cannot recall certain information, that is okay.

**DIAGNOSES/CONDITIONS** Please check all that apply.

### Cardiovascular
- □ Heart Disease
- □ Heart Attack
- □ Cardiac Catheterization
- □ Heart Valve Disorder
- □ Atrial Fibrillation
- □ Stent Placement/Angioplasty
- □ Pacemaker
- □ Implantable Defibrillator
- □ High Blood Pressure
- □ Elevated Cholesterol
- □ Vascular Disease
- □ Peripheral Arterial Disease
- □ Palpitations
- □ Blood Clotting Disorder
- □ Deep Venous Thrombosis
- □ Abdominal Aortic Aneurysm Screening [AAA Ultrasound] (DATE OF LAST EXAM)
- □ Other

### Endocrine
- □ Diabetes (Type 2)
- □ Diabetes (Type 1)
- □ Osteoporosis (weak bones)
- □ Overactive Thyroid
- □ Underactive Thyroid
- □ Fractures (please specify date and type of fracture)
- □ Other

### Gastrointestinal
- □ Heartburn/Reflux
- □ Ulcer
- □ Cirrhosis
- □ Hepatitis A
- □ Hepatitis B
- □ Hepatitis C
- □ Diverticulosis
- □ Colon Polyps
- □ Inflammatory Bowel Disease
- □ Irritable Bowel
- □ Constipation
- □ Other

### Genitourinary
- □ Overactive Bladder/Incontinence
- □ Urinary Tract Infections
- □ Kidney Stones
- □ Chronic Kidney Disease
- □ Kidney Cysts
- □ Enlarged Prostate
- □ Erectile Dysfunction
- □ PSA Screen (DATE OF LAST EXAM)

Are you sexually active? □ Yes □ No
- □ Sexually Transmitted Diseases (Chlamydia, Gonorrhea, Genital Herpes)

### Gynecological
- □ Cervical Cancer Screening (Pap) (DATE OF LAST EXAM)
- □ Urinary Tract Infections
- □ Dexa (DATE OF LAST EXAM)
- □ Chronic Kidney Disease
- □ Mammogram (DATE OF LAST EXAM)
- □ Enlarged Prostate
- □ Menstrual Period (DATE OF LAST)
- □ PSA Screen (DATE OF LAST EXAM)
- □ Number of Pregnancies □□ Number of Deliveries □□

### Neurologic/Psychiatric
- □ Dementia
- □ Parkinson’s Disease
- □ Anxiety
- □ Post-Traumatic Stress Disorder
- □ Stroke
- □ Neuropathy
- □ Transient Ischemic Attacks (TIA)
- □ Depression
- □ Other
**Oncologic (Cancer) and Hematologic (Blood Disorders)**

*Please provide year of diagnosis and check if disease is in remission or active.*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Year of Surgery</th>
<th>Remission</th>
<th>Active</th>
<th>Year of Surgery</th>
<th>Remission</th>
<th>Active</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung Cancer</td>
<td></td>
<td></td>
<td></td>
<td>Colon/Rectal Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer</td>
<td></td>
<td></td>
<td></td>
<td>Prostate Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td></td>
<td>Other (Type _____)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pulmonary**

- Asbestos Exposure/Asbestosis
- Emphysema
- Asthma
- Pulmonary Nodules
- COPD
- Other

**Rheumatologic/ Joint Disease**

- Cervical Disc Disease
- Gout
- Lumbar Disc Disease
- Osteoarthritis
- Rheumatoid Arthritis

**HOSPITALIZATIONS**

*Please list all dates, reasons and complications for hospitalizations below.*

<table>
<thead>
<tr>
<th>Date of Hospitalization</th>
<th>Reason for Hospitalization</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
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<td></td>
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<tr>
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<td></td>
</tr>
</tbody>
</table>

**Person completing this medical history is**

- Patient
- Other

Relationship to Patient

PRINT NAME
8 CONVENIENT LOCATIONS

Mulberry Grove Care Center
8877 South East 165th Mulberry Lane
The Villages, Florida 32162
352-674-1750

Santa Barbara Care Center
1575 Santa Barbara Boulevard
The Villages, Florida 32159
352-674-1740

Specialty Care at Spanish Springs
1400 US Highway 441 North, Suite 810
The Villages, Florida 32159
352-674-8700

Colony Care Center
280 Farner Place
The Villages, Florida 32163
352-674-1710

Brownwood Care Center
2910 Brownwood Boulevard
The Villages, Florida 32163
352-674-1790

Pinellas Care Center
2485 Pinellas Place
The Villages, Florida 32162
352-674-1760

Creekside Care Center
1050 Old Camp Road, Building 100
The Villages, Florida 32162
352-674-1760

Specialty Care at the Center for Advanced Healthcare at Brownwood
2955 Brownwood Boulevard
The Villages, Florida 32163
352-674-8700

For the latest information, please visit TheVillagesHealth.com