NEW PATIENT *Forms*

The Villages Health®

www.TheVillagesHealth.com

Please do not complete these forms before scheduling an appointment.
If you would like to schedule an appointment, please call:

(844)TVH-WELL (844) 884-9355

Once this form has been completed, please return to _____ on or before _____.
Please bring a photo I.D., insurance card and all prescription medications in the original containers to your appointment.

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The Villages Health®

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

The Villages Health®

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.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS (CONT.)

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: (844) TVH-WELL (844-884-9355)

Address: Please deliver to your care center (see last page of this packet for address) Fax: (855) 604-6305

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 _____ _____

Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

_____

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.

The Villages Health®

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.

Date _____ / _____ / _____

SIGN HERE **Patient's Signature** _____ _____
PRINT NAME

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

Relationship to Patient _____

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:

Home Telephone ☐ Yes ☐ No ☐ OK to leave voice mail?

Work Telephone ☐ Yes ☐ No ☐ OK to leave voice mail?

Cell Phone ☐ Yes ☐ No ☐ OK to leave voice mail?

SMS/Text ☐ Yes ☐ No

E-mail ☐ Yes ☐ No

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:

Spouse ☐ Yes ☐ No _____ ( ) _____ _____
PRINT SPOUSE'S NAME | SPOUSE'S PHONE NUMBER | SPOUSE'S DOB

Other _____ _____ ( ) _____ _____
PRINT NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER | DOB

Other _____ _____ ( ) _____ _____
PRINT NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER | DOB

Other _____ _____ ( ) _____ _____
PRINT NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER | DOB

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** _____ _____
PRINT NAME

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: _____

Gender

☐ MALE ☐ FEMALE

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 ( ) _____

PATIENT DEMOGRAPHIC INFORMATION (CONT.)

Current or Previous Primary Care Physician

NAME _____ CITY/STATE _____ ( ) PHONE _____ ☐ CURRENT

Current or Previous Specialists

NAME _____ SPECIALTY _____ CITY/STATE _____ ( ) PHONE _____ ☐ CURRENT

NAME _____ SPECIALTY _____ CITY/STATE _____ ( ) PHONE _____ ☐ CURRENT

NAME _____ SPECIALTY _____ CITY/STATE _____ ( ) PHONE _____ ☐ CURRENT

NAME _____ SPECIALTY _____ CITY/STATE _____ ( ) PHONE _____ ☐ CURRENT

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.

SIGN HERE **Patient's Signature** _____ **Date** ___/___/___

SIGN HERE **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

Type of Medication	Type of Reaction
Example: Penicillin	*Rash*

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.

Name	Strength [Formulation]	Frequency	Refill required in the next 90 days?		
				Supply	**Supply**
Example: Lisinopril	*10 mg [tablets]*	*Once daily*			
			☐ No	☐ 90 day	☐ 30 day
			☐ No	☐ 90 day	☐ 30 day
			☐ No	☐ 90 day	☐ 30 day
			☐ No	☐ 90 day	☐ 30 day
			☐ No	☐ 90 day	☐ 30 day
			☐ No	☐ 90 day	☐ 30 day
			☐ No	☐ 90 day	☐ 30 day
			☐ No	☐ 90 day	☐ 30 day

Current Non-Prescription Medications

Name	Strength [Formulation]	Frequency	Purpose
Example: Advil	*200 mg [capsules]*	*1 capsule every 6 hours*	*Headaches*

Current Supplements

Name	Strength [Formulation]	Frequency	Purpose
Example: Fish Oil	*500 mg [tablets]*	*1 tablet twice daily*	*Heart Health*

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.

Name	Reason Discontinued
Example: Lisinopril	*My ankles became swollen*

Medical Supplies I Use

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

Name	Purpose
Example: Insulin Syringes	*To take insulin for diabetes*

IMMUNIZATIONS *Please indicate month, day and year last received.*

INFLUENZA VACCINE	PNEUMONIA VACCINE	PREVNAR VACCINE	TETANUS BOOSTER	TDAP	SHINGRIX (SHINGLES) VACCINE
/ /	/ /	/ /	/ /	/ /	/ /

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 Type: _____

Used smokeless tobacco in the past? ☐ Yes ☐ No Type: _____

Most Recent Tobacco or Smokeless Tobacco Use ____/____/____ Number of Years Tobacco Used _____

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 Exercise ☐ NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY

Type of Exercise _____ Hobbies/Activities _____

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/caregiver have any communication barriers? ☐ None ☐ Cognitive ☐ Vision ☐ Language ☐ Hearing

SURGICAL HISTORY

Please provide dates in the space below.

	YEAR OF SURGERY		YEAR OF SURGERY
Appendix Removal		Hernia Repair	
Breast Biopsy/Breast Surgery		Hysterectomy	
Cardiac Bypass		Ovarian Removal *(one or both)*	
Carotid Artery Surgery		Other *(Type _____)*	
Cataract Surgery		Other *(Type _____)*	
Gallbladder Surgery		Other *(Type _____)*	

IMPLANT HISTORY

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

Device Type _____ Date of Implant __/__/__ UDI _____ Site _____ Side ☐ Left ☐ Right ☐ Bilateral

Device Type _____ Date of Implant __/__/__ UDI _____ Site _____ Side ☐ Left ☐ Right ☐ Bilateral

Device Type _____ Date of Implant __/__/__ UDI _____ Site _____ Side ☐ Left ☐ Right ☐ Bilateral

OB/GYN HISTORY

Date of Last Pap Smear __/__/__ ☐ Normal ☐ Abnormal ☐ Unknown

Date of Last Mammogram __/__/__ ☐ Normal ☐ Abnormal ☐ Unknown

Date of Last Bone Density __/__/__ ☐ Normal ☐ Abnormal ☐ Unknown

Date of Last Menstrual Period __/__/__ ☐ Normal ☐ Abnormal ☐ Unknown

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 _____

	NORMAL	ABNORMAL	UNKNOWN
Last Colonoscopy (DATE OF LAST EXAM) _____	☐	☐	☐

Hepatitis C Screening in the past? ☐ Yes ☐ No

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

	NORMAL	ABNORMAL	UNKNOWN
Cervical Cancer Screening (Pap) (DATE OF LAST EXAM) _____	☐	☐	☐
Dexa (DATE OF LAST EXAM) _____	☐	☐	☐
Mammogram (DATE OF LAST EXAM) _____	☐	☐	☐

Menstrual Period (DATE OF LAST) _____
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.*

	YEAR OF SURGERY	REMISSION	ACTIVE		YEAR OF SURGERY	REMISSION	ACTIVE
Lung Cancer	_____	☐	☐	Colon/Rectal Cancer	_____	☐	☐
Breast Cancer	_____	☐	☐	Prostate Cancer	_____	☐	☐
Anemia	_____	☐	☐	Other (*Type* _____)	_____	☐	☐

Pulmonary

☐ Asbestos Exposure/Asbestosis ☐ Asthma ☐ COPD
☐ Emphysema ☐ Pulmonary Nodules ☐ 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.*

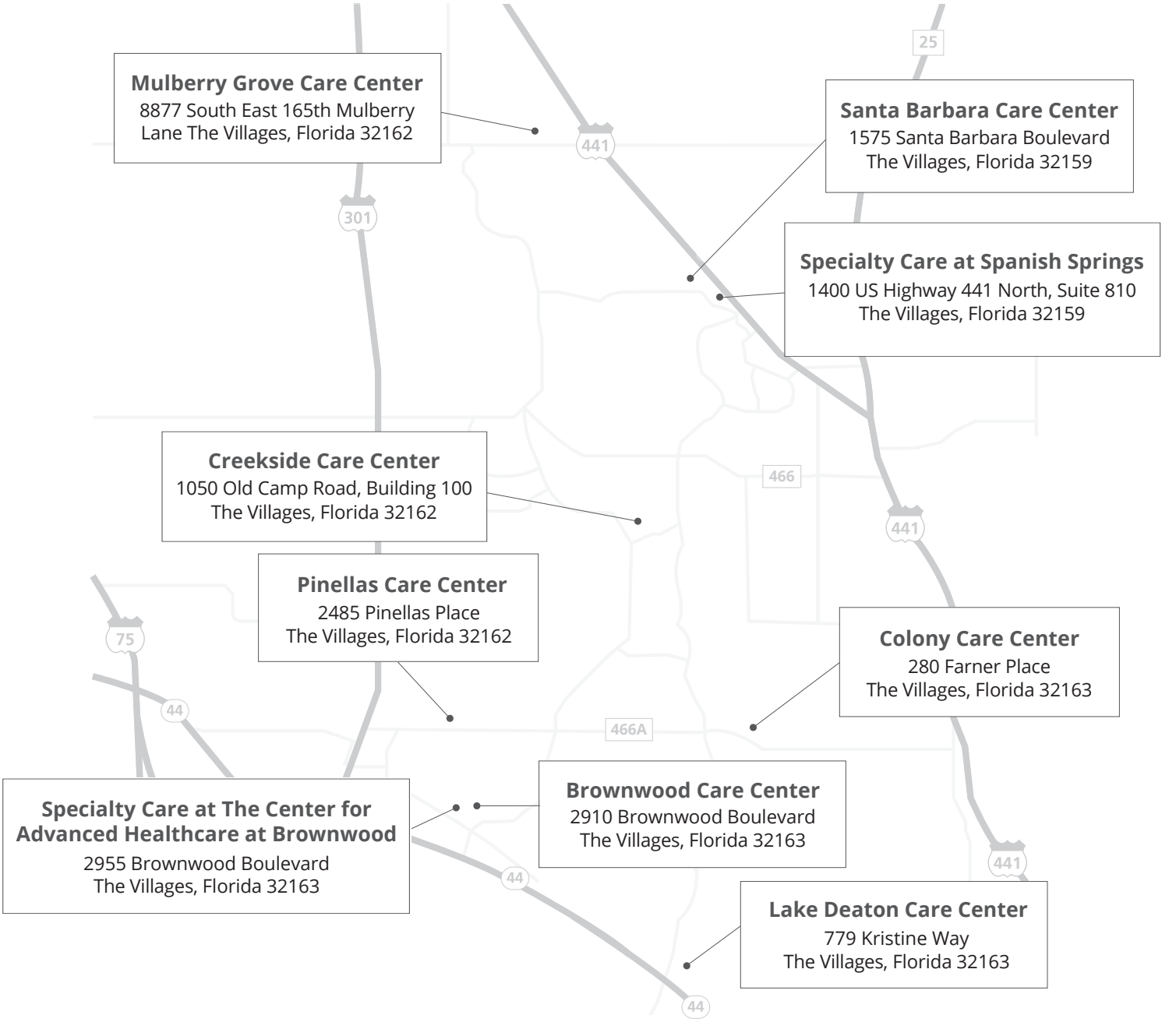
DATE OF HOSPITALIZATION	REASON FOR HOSPITALIZATION	COMPLICATIONS
/ /		
/ /		
/ /		
/ /		

Person completing this medical history is ☐ Patient ☐ Other _____
PRINT NAME

Relationship to Patient _____

9 CONVENIENT LOCATIONS

Need to contact your care center?
Give us a call at **844-TVH-WELL** (844-884-9355)



Mulberry Grove Care Center
8877 South East 165th Mulberry Lane The Villages, Florida 32162

Santa Barbara Care Center
1575 Santa Barbara Boulevard
The Villages, Florida 32159

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

Creekside Care Center
1050 Old Camp Road, Building 100
The Villages, Florida 32162

Pinellas Care Center
2485 Pinellas Place
The Villages, Florida 32162

Colony Care Center
280 Farner Place
The Villages, Florida 32163

Specialty Care at The Center for Advanced Healthcare at Brownwood
2955 Brownwood Boulevard
The Villages, Florida 32163

Brownwood Care Center
2910 Brownwood Boulevard
The Villages, Florida 32163

Lake Deaton Care Center
779 Kristine Way
The Villages, Florida 32163

For the latest information, please visit TheVillagesHealth.com

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