Family Choice Medical Clinic

Expert Health Care for Adults, Children and Adolescents

YOUR FIRST-VISIT HANDOUT

Your first visit

We welcome you to **Family Choice Medical Clinic,** and thank you for choosing us for your health care needs. During your first visit, you will meet our staff, complete a few brief forms and, of course, meet your Doctor, Dr. Mbaeri. As a family physician, he will try to solve your current medical problem and detect or prevent other health problems. We hope to make your first visit, not just an opportunity to deal with any medical concerns you may have, but also a time tof us to get acquainted with you.

The first examination

When you enter the exam room, you will be asked to fill out a health questionnaire by a staff member, and he or she will measure your height and weight, as well as take your temperature. The doctor will review the questionnaire with you further. After the examination, the doctor will suggest a treatment plan which may include laboratory and other testing, and future visits, if necessary.

We hope that after your visit you will feel confident that you have made a wise decision by choosing our practice for your health care needs.

Respectfully,

FAMILY CHOICE MEDICAL CLINIC

10111 FOREST HILL BLVD, SUITE 320, WELLINGTON, FL 33414

TELEPHONE: 561-623-0801 FAX: 561-469-1928

Family Choice Medical Clinic

Expert Health Care for Adults, Children and Adolescents

Dr. Chris C. Mbaeri, MD

THIS FACILITY PROVIDED A COPY OF THE NOTICES OF PRIVACY PRACTICES. I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW IT.

_____	_____
PRINTED NAME	**DATE OF BIRTH**
_____	_____
SIGNATURE OF PATIENT	**DATE**

Family Choice Medical Clinic

Expert Health Care for Adults, Children and Adolescents

In this office, Patient Confidentiality is a prime concern. Please indicate below whom our office may or may not leave a message or share your medical information with:

	YES	NO	N/A
Spouse			
Parent			
Children			
Home			
Work			
May we call you at work and state who is calling?			

Person(s) with whom we can discuss your information:

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

Signature: _____

Date: _____

FAMILY CHOICE MEDICAL CLINIC, P.A.

PATIENT REGISTRATION FORM

PATIENT INFO

FIRST/MIDDLE/LAST NAME			
HOME ADDRESS			
EMAIL ADDRESS			
HOME PHONE#		WORK PHONE#	MOBILE PHONE#
LANGUAGE	DOB	SOCAL SECURITY#	MARITAL STATUS
PRIMARY CARE PHYSICIAN		EMPLOYER	
EMERGENCY CONTACT		EMERGENCY PHONE#	
PHARMACY NAME		PHARMACY PHONE#	

RESPONSIBLE

PERSON RESPONSIBLE FOR PAYMENT IF PATIENT IS UNDER AGE 18		
FIRST/MIDDLE/LAST NAME		
HOME PHONE#	DOB:	SOCIAL SECURITY#
EMPLOYER NAME	EMPLOYER PHONE#	

INSURANCE INFO

PRIMARY INSURANCE		
PRIMARY INSURANCE NAME	PRIMARY INSURANCE ADDRESS	
SUBSCRIBER NAME	DOB	SEX
SUBSCRIBER ID#	GROUP#	RELATION TO PATIENT
SECONDARY INSURANCE		
SECONDARY INSURANCE NAME	SECONDARY INSURANCE ADDRESS	
SUBSCRIBER NAME	DOB	
SUBCRIBER ID#	GROUP #	

RELEASE

I understand and accept that I will be financially responsible for all deductibles, co-payments, co-insurances, and non-covered charges as provided by my insurance plan. If I fail to cancel my appointment at least 24 hours prior notice, a fee will charged. If my insurance requires a valid referral to receive medical care, I understand that it is my responsibility to provide such referral. If my referral is determined to be invalid by my insurance carrier, I understand that I will be financially responsible for balances on my account including non-covered items. If my insurance plan is not accepted by this office or is of the indemnity type, I understand that I am financially responsible for all balances remaining after payment, if any, made by my insurance plan. I hereby authorize and assign directly to Family Choice Medical Clinic all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the physician and/or their representative(s) to release any and all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient Signature _____ Date: _____

Family Choice Medical Clinic

Expert Health Care for Adults, Children and Adolescents

ADULT HEALTH HISTORY

Name: _____ Date: _____

DOB: _____ Age: _____ Sex: _____

Primary Language: _____

Need for Translator: Yes _____ No _____

Purpose of Visit: _____

ALLERGIES

Drug:

_____

_____

Food:

_____

_____

Other:

_____

_____

Current Medications:

Prescriptions:

_____

_____

Over- the- counter :

FAMILY HISTORY

Use Check Mark for Yes Answers	Father	Mother	Father Parents	Mother Parents	Sibling	Children
CANCER						
DIABETES						
EPILEPSY/CONVULSIONS						
HEART DISEASE						
HIGH BLOOD PRESSURE						
KIDNEY DISEASE						
MENTAL ILLNESS						
STROKE						
GLAUCOMA						
THYROID DISEASES						
DRUG ALCOHOL ADDICTION						
OTHER:						
HIGH CHOLESTEROL						

_____

PLEASE LIST AND SUPPLY THE DATES OF:

Operations: _____

Hospitalizations other than surgeries: _____

Transfusions: _____

IMMUNIZATION HISTORY—HAVE YOU HAD:

PNEUMOVAX IMMUNIZATION ☐ No ☐Yes When? _____ Hepatitis B ☐No ☐Yes When? _____

Tetanus ☐ No ☐ Yes When? _____ Flu immunization? ☐No ☐Yes When? _____ Other? _____

Past Medical History and Review of Systems

Please circle if you have had problems with or are presently complaining of any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain or tightness
6. Shortness of breath
7. Swollen ankles
8. Pneumonia
9. Persistent cough
10. Tuberculosis
11. Abdominal discomfort
12. Hay fever
13. Indigestion
14. Hemorrhoids
15. Gall bladder disease
16. Skin diseases
17. Blood disorders
18. Palpitations
19. Lightheadedness
20. Frequent urination
21. Rheumatic fever
22. Asthma
23. Bronchitis
24. Nausea
25. Vomiting
26. Constipation
27. Diarrhea
28. Blood in stool
29. Ulcers
30. Gout
31. Unexplained weight gain/loss
32. Colitis
33. Hepatitis or jaundice
34. Thyroid disease
35. Head or neck radiation
36. Kidney diseases
37. Kidney Stones
38. Difficulty urinating
39. Arthritis
40. Venereal disease
41. Gout
42. Anxiety
43. Depression
44. Anemia
45. Alcohol abuse
46. Drug abuse
47. Change in bowel habits
48. Low back problems
49. _____
50. _____

When was your last?

Complete physical	Date:_____	Results:_____	TB test	Date:_____	Results:_____
Cholesterol check	Date:_____	Results:_____	Pap smear	Date:_____	Results:_____
Eye Exam	Date:_____	Results:_____	Mammogram	Date:_____	Results:_____
Hearing	Date:_____	Results:_____	Breast exam	Date:_____	Results:_____
Stool check for blood	Date:_____	Results:_____	Prostate exam	Date:_____	Results:_____

FOR WOMEN ONLY (Gynecological and Obstetric History)

Age at first onset of period: _____ Frequency: _____ Length of period _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged abnormal bleeding	☐No ☐Yes	Please describe: _____
Leakage of urine:	☐No ☐Yes	Please describe: _____
Pelvic pain:	☐No ☐Yes	Please describe: _____
Abnormal discharge:	☐No ☐Yes	Please describe: _____
History of abnormal pap smear:	☐No ☐Yes	Type of treatment: _____

PREVENTION

Do you wear seat belts? ☐No ☐Yes If no, why not? _____

Do you wear a bike helmet? ☐No ☐Yes ☐N/A _____

Do you drink beverages with caffeine? ☐No ☐Yes If yes, how many per day? _____

Do you smoke? ☐No ☐Yes If yes, how many packs per day? _____

Do you use drugs?(Marijuana, cocaine, crack, etc.) ☐No ☐Yes If yes, explain: _____

If there is a gun in your home, do you keep it unloaded & out of children's reach? ☐No ☐Yes ☐N/A

Comments:

_____

_____

RISK HISTORY

Age at first intercourse: _____ How many partners? _____

Have you ever experienced?

Sex with a male? ☐No ☐Yes

Sex with a female? ☐No ☐Yes

Sex for drugs/money? ☐No ☐Yes

Vitim of sexual assault? ☐No ☐Yes

Sex injecting drug user? ☐No ☐Yes

Sex with person with other HIV/AIDS risk? ☐No ☐Yes

Contraceptive: Method Last used/now using: _____

Problem(s) with methods? _____

Have you been in contact with person with confirmed TB?	☐No	☐Yes If yes, explain:	
Are you from or have you recently traveled to regions of the world with TB prevalence?	☐No	☐Yes If yes, explain:	
Are you exposed to the following: • HIV+persons • Homeless persons • Migrant farm workers • IV/street drug users • Residents of nursing homes • Institutionalized/incarcerated persons?	☐No	☐Yes If yes, explain:	
Have you worked with chemicals, paints, asbestos, or other hazardous material?	☐No	☐Yes If yes, explain:	

Are you in a relationship in which you have been physically hurt (e.g. slapped, kicked punched, bruised) by your partner?	☐No	☐No	
Do you ever feel afraid of your partner	☐No	☐Yes	

Do you have "living will"? ☐Yes ☐No (If yes, please provide a copy) Do you have a donor card? ☐Yes ☐No

Signature _____

Family Choice Medical Clinic

Expert Health Care for Adults, Children and Adolescents

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Treatment dates from: _____ to _____

I authorize: (enter your current physician's information)

PREVIOUS DOCTOR'S NAME: _____

PHONE# _____ FAX# _____

ADDRESS: _____ CITY_____ STATE____ ZIP_____

To release copies of my medical records to (enter your new physician)

FAMILY CHOICE MEDICAL CLINIC, P.A. CHINYERE MBAERI, M.D._____

10111 FOREST HILL BLVD, SUITE 320_____

WELLINGTON, FL 33414____PHONE: 561-623-0801 FAX: 561-469-1928_____

I authorize release of information of the following portions of my medical record:

____Mental Health ____HIV/AIDS

____Substance Abuse ____Communicable Disease

____All ____Only the following: _____

I understand that this information shall be in effect for 180 days following the date of the signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

I hereby release Family Choice Medical Clinic from any and all liability which may arise as a result of my authorized release of records.

Should my case require review by a governing agency of another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Patient (or legal representative) _____ Date: _____

Relationship to patient: _____ Witness: _____

NOTICE: The information has been disclosed to you from records whose confidentiality has been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization is not sufficient for this purpose.

Adult ADHD Self-Report Scale (ASRS-V1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
0. How often do you misplace or have difficulty finding things at home or at work?					
1. How often are you distracted by activity or noise around you?					
2. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
3. How often do you feel restless or fidgety?					
4. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
5. How often do you find yourself talking too much when you are in social situations?					
6. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
7. How often do you have difficulty waiting your turn in situations when turn taking is required?					
8. How often do you interrupt others when they are busy?					

Part B

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	+

TOTAL: _____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Understanding your Health Record Information:

Each time you visit a hospital physician or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination, test results and diagnosis, treatment and 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 communicating with the many healthcare professionals who collaborate in 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 indication health professionals.
- A source of data for medical research.
- A source for informal or for public health officials with improving the health of the nation.
- A source of data for facility planning and marketing.
- A tool with which we can access and continually work to improve the care we render and the outcomes we achieve.
- Understanding of what is in your record and how your health information is used to help you to:

  Ensure its accuracy

  Better understand who, what, when, where, and why others may access your health information.

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

- Make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiles it, the information belongs to you. You have the right to:

- Request restriction on certain uses and disclosure of your information to provider by 45EFR.764.522
- Obtain a paper copy of the notice of information practices upon request.
- Inspect and copy your health record as provided in 45CFR.154.524.
- Obtain and accounting of disclosures of your health information as provided in 45CFR.164.525.
- Amend your health record as provided in 45CPR164.528.
- Request communication of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

This organization is required to:

- Maintain the privacy of your health information.
- Provide you with a notice of legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to requested restriction.
- Accommodate reasonable requests you may have and communicate health information by alternative means or at alternative location.

We reserve the right to change our practice and to make the new provisions effective for all protected health information. Should our changes, we will email revised notices to the address you have supplied to us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the director of health information at (561)969-7900.

If you believe your privacy rights have been violated, you can file a complaint with the director of health information management or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.