



Hermann Wellness

3040 W. Cypress Street, Suite 103 Tampa, Florida 33609
6387 Central Avenue, St. Petersburg, Florida 33710
Phone (813) 902-9559 (727) 278-3992 Fax (813) 315-6611

Contact@DoctorHermann.com

REGISTRATION

PLEASE PRINT

Name: _____

Date of Birth: _____ Age: _____

Address: _____

Marital Status: M S D W

City: _____ State: _____ Zip: _____

Social Security#: _____ - _____ - _____

Home Phone: () _____

Employer: _____

Work Phone: () _____ Ext. _____

Occupation: _____

Cell Phone: () _____

Student: () Yes () No () Fulltime () Part time

E-Mail Address: _____

Primary Care Physician: _____

How did you hear about us: Family/Friend /Dr./ Yellow Pages /

Primary Care's Phone: () _____

Other: _____

Pharmacy: _____

Pharmacy Phone : () _____

EMERGENCY CONTACT

Name: _____

INFORMATION ON SPOUSE/PARENT

Name: _____

Address: _____

Social Security #: _____

City: _____ State: _____ Zip: _____

Employer: _____

Home Phone: () _____

Occupation: _____

Work Phone: () _____

Phone Number: () _____

Relationship: _____

Date of Birth: _____

I understand that I am financially responsible for any and all balances not covered and for any required authorization for service. A copy of this signature is as valid as the original

SIGNATURE: _____

DATE: _____



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name and date here

Signature

Telephone number for messages: () _____
(please check below for consent)

- _____ May we leave a message for an appointment reminder?
- _____ May we leave a message on your answering machine?
- _____ May we leave a message with your spouse/significant other or family member?
Please list whom: _____
- _____ May we discuss your medical records with your spouse/significant other or family member?
Please list whom: _____
- _____ May we place you on our email / text message list for listings of events, special promotions, and educational opportunities presented by Dr. Hermann?
- _____ I give permission for my photos to be taken for purpose of evaluating treatment effectiveness for office use only.
- _____ Circle One: I do/ do not consent to allow before/after pictures to be used in promotional materials.

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*



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Hermann Wellness Patient Evaluation Form

Patient Name _____ Date _____

Are you interested in treatment for the following?

- | | |
|--|--|
| <input type="checkbox"/> Anti-wrinkle Injections | <input type="checkbox"/> Brown Spot / Redness Reduction |
| <input type="checkbox"/> Dermal Fillers | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Fat-dissolving Injections | <input type="checkbox"/> Spider Vein Reduction |
| <input type="checkbox"/> Skin Tightening | <input type="checkbox"/> Laser Hair Reduction |
| <input type="checkbox"/> Microneedling | <input type="checkbox"/> Anti-Aging and Wellness IV Therapy |
| <input type="checkbox"/> PRP Facials / Injections | <input type="checkbox"/> Weight Management |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Fatigue / Low Energy |
| <input type="checkbox"/> Chemical Peel | <input type="checkbox"/> Nutritional & Food Sensitivity Testing |
| <input type="checkbox"/> Skin Brightening Facial | <input type="checkbox"/> Bio-Identical Hormone Replacement Therapy |
| <input type="checkbox"/> Skin Care Consultation | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Large Pores / Poor Skin Texture | |

If applicable, please list the cosmetic treatments / products you have had in the past / currently use and whether or not you were satisfied with the results.



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YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

INITIAL PATIENT VISIT

Patient Name _____ Date of Service _____ Age _____

Please state your reason for coming in today. List any current concerns / complaints regarding your health.

PAST MEDICAL HISTORY	CURRENT MEDICATIONS

LIST ANY ALLERGIES TO MEDICATIONS	Please list any SURGICAL PROCEDURES that you have had.

FAMILY HISTORY
Please list any illness that the following relatives have:
Mother
Father
Sister(s)
Brother(s)
Grandparents
Aunts and uncles



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Name _____ Date of Service _____

SOCIAL HISTORY		
Do you smoke?	If so, how many packs per day?	
Do you drink alcohol?	If so, how many per day?	How often?
Do you drink caffeine?	What kind?	How often?
What do you do for a living?		
Do you exercise?		

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- Changes in vision
- Headaches
- Jaw Pain
- Difficulty swallowing
- Mass or lump in neck
- Chest Pain
- Heart Palpitations
- Difficulty Breathing
- Wheezing
- Cough
- Abdominal Pain
- Nausea or vomiting
- Diarrhea or constipation
- Skin rash
- Atypical mole or other skin lesion
- Weakness in legs, arms, hands, or feet
- Shooting pain in back, legs, arms or neck
- Muscle soreness
- Gum bleeding?
- Difficultly urinating?
- Difficulty sleeping?
- Depression, anxiety or memory loss
- Decreased libido?
- Women only: Please list date of last Pap smear and mammogram
 - Vaginal dryness Hot Flashes
 - Irregular periods Breast lumps or tenderness
 - Painful periods

Please describe any other complaints not covered in the list:



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CONSENT FOR TREATMENT

Patient Name: _____

CONSENT TO TREAT: I request and give consent to the providers of Hermann Wellness (Anne Hermann, MD, Robin McClain ARNP, Jeanna Hepler ARNP, Mandy Brown LE to provide and perform medical/surgical/acupuncture treatments, tests, procedures, medications and other services and supplies as are considered necessary or beneficial for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INITIAL: _____

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. I agree that I the responsible party will make payments to Anne Hermann, MD. PA. In the case of default payment, I promise to pay any legal interest on the balance due, together with collection costs and reasonable attorney fees incurred to effect collection of this account and future outstanding accounts. If I fail to notify the office of a cancellation of an appointment within 24 hours of that appointment, I understand that I will be responsible for the full payment of that appointment

INITIAL: _____

CANCELLATION POLICY

We ask that you leave a credit card number to hold your appointment. In the event that you do not show or cancel an appointment in less than 24 hours from the time of the appointment, we reserve the right to charge a \$50 cancellation fee for each missed appointment.

I understand the above text and agree to comply.

Credit Card Type	Credit Card Number	Exp. Date	Security Code
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Name of Card Holder

PRINT NAME: _____ **DATE:** _____

PATIENTS SIGNATURE: _____ **DATE:** _____



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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____ Phone #: _____
Address: _____ City, State, Zip: _____

DR'S NAME PH# FAX#

I request and authorize release healthcare information of the patient named above to:

ANNE HERMANN, MD, PA

3040 W CYPRESS STREET 6387 CENTRAL AVENUE
SUITE 103 ST. PETERSBURG, FL 33710
TAMPA, FL 33609 PHONE: (727) 278-3992
PHONE: (813) 902-9559 FAX: (813) 315-6611
FAX: (813) 315-6611

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates: _____
- All healthcare information
- Other: _____

Yes No I authorize the release of my medical records to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Patient Signature _____ Date _____



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Please initial below to indicate that you understand:

___ Hermann Wellness is not taking new primary care patients.

___ Hermann Wellness does not accept insurance, for problem focused visits with Anne Hermann, MD and Robin McClain, ARNP for treatment of allergies, nutrition, hormones, cosmetic services, and well women exams including pap smears.

___ Nutrition and bio-identical hormone services are performed as separate appointments from standard medical visits.

___ Please note that we call all patients when we receive new test results such as blood work or reports. If you do not receive a call from us within 7 to 10 days after a test is performed, please contact the office.

___ All providers prescribe enough refills to last until you are supposed to be seen again in clinic. Please schedule your follow up visit prior to your prescriptions running out.

Print name of patient

Signature of patient