**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 INFORMATION ON SPOUSE/PARENT**

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

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 text/email 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)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hermann Wellness Patient Evaluation Form**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in treatment for the following?

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

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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 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 |

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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, Michelle Roman PA-C, 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

Name of Card Holder

### PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_

**PATIENTS SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_**

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, PA3040 W CYPRESS STREET 6387 CENTRAL AVENUESUITE 103 ST. PETERSBURG, FL 33710TAMPA, FL 33609 PHONE: (727) 278-3992PHONE: (813) 902-9559 FAX: (813) 315-6611FAX: (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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Please initial below to indicate that you understand:

\_\_\_ 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