**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 |
|  |  |
|  |  |
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|  |  |
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|  |  |
| --- | --- |
| List any allergies to medications | Please list any surgical procedures that you have had. |
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|  |  |

|  |
| --- |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutritional Evaluation**

1. Present Weight: \_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_ Desired Weight: \_\_\_\_\_\_\_\_\_\_\_
2. In what time frame would you like to reach your desired weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Birth Weight: \_\_\_\_\_\_\_\_\_\_ Weight at Age 20? \_\_\_\_\_\_\_\_\_\_  Weight one year ago? \_\_\_\_\_\_\_\_

1. When did you begin losing/gaining weight, please explain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

1. How often do you eat?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What restaurants do you frequent?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How often do you eat “fast foods?”\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Who plans meals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cooks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shops? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you use a shopping list? Yes No

1. What time of day and on what day do you shop for groceries? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Food Allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Food dislikes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Foods you crave?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is there a specific time of day or month you crave food? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you drink coffee or tea? Yes No How much daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you drink cola drinks?   Yes No How much daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you drink alcohol? Yes No What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much daily? \_\_\_\_\_\_\_ Weekly/. \_\_\_\_\_

1. Do you use sugar substitute? \_\_\_\_\_\_\_\_\_\_\_\_ Butter Substitute? \_\_\_\_\_\_\_\_\_\_

Margarine Substitute? \_\_\_\_\_\_\_\_\_ 

1. Do you awaken hungry during the night? Yes No What do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What are your worst food habits? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Snack Habits: What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When under a stressful situation at work or family related, do you tend to eat more or less, please explain.

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

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

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

1. Do you think you are currently under going a stressful situation or an emotional upset, explain: \_\_\_\_\_\_\_\_\_\_\_\_

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

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

1. Smoking Habits:

\_\_\_\_\_ You are currently a smoker

\_\_\_\_\_ You have NEVER smoked cigarettes, cigars or a pipe? 

\_\_\_\_\_ You quit smoking \_\_\_\_\_\_ years ago and have not smoked since

\_\_\_\_\_ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling

|  |  |
| --- | --- |
| Smoke. |  |
| \_\_\_\_\_ You smoke 20 cigarettes per day (1 pack) |  |
| \_\_\_\_\_ You smoke 30 cigarettes per day ( 1-1/2 packs) |  |
| \_\_\_\_\_ You smoke 40 cigarettes per day (2 packs) |  |
|  |  |
| 25. Typical Breakfast  Typical Lunch | Typical Dinner |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Time eaten: \_\_\_\_\_\_\_\_\_\_\_  Time eaten: \_\_\_\_\_\_\_\_\_\_\_ | Time eaten: \_\_\_\_\_\_\_\_\_\_\_ |
| Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| With Whom: \_\_\_\_\_\_\_\_\_\_  With Whom: \_\_\_\_\_\_\_\_\_\_ | With Whom: \_\_\_\_\_\_\_\_\_\_ |

1. Describe your energy level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Activity Level (answer only one)

\_\_\_\_\_ **Inactive:** no regular physical activity with a sit down job

\_\_\_\_\_ **Light Activity:** no organized physical activity during leisure time

\_\_\_\_\_ **Moderate Activity:** occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling

\_\_\_\_\_ **Heavy Activity:** consistent lifting, stair climbing, heavy construction, etc., or regular participation in

jogging, swimming, cycling or active sports at least 3 times per week

\_\_\_\_\_ **Vigorous Activity:** participation in extensive physical exercise for at least 60 minutes per session, 4 times per week

1. Behavior Style (answer only one)

\_\_\_\_\_You are always calm and easygoing

\_\_\_\_\_You are usually calm and easygoing

\_\_\_\_\_You are sometimes calm with frequent impatience

\_\_\_\_\_You are seldom calm and persistently driving for advancement

\_\_\_\_\_You are never calm and have overwhelming ambition

\_\_\_\_\_You are hard-driving and can never relax

1. Please describe your general health goals and improvements you wish to make:

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

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

**\*THIS INFORMATION WILL ASSIST US IN ASSESSING YOUR PARTICULAR PROBLEM AREAS IN ESTABLISHING**

**YOUR MEDICAL MANAGEMENT. THANK YOU FOR YOUR TIME AND PATIENCE IN COMPLETING THIS FORM**

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, 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please initial below to indicate that you understand:

\_\_\_ Hermann Wellness does not accept insurance, for problem focused visits with Anne Hermann MD,

Robin McClain ARNP, and Michelle Roman PA-C, 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