Advance Preventive Medicine
1400 E Robinson St Orlando, FL 32801

Welcome to our Office

Patients Name: _____

Date of Birth: _____

Medical Record #: _____

Primary Care Provider: _____ Patient Phone #: _____

Parent or Guardian Information (if patient is minor):

First and Last name of Parent or Guardian: _____ Relationship: _____

Emergency Phone #: _____ Contact Relationship: _____

Consent to call in the case we are not able to reach you?
☐ Y ☐ N

Patient Email: _____

Primary Insurance: _____ ID #: _____

Secondary Insurance: _____ ID #: _____

Drug Allergies/Sensitivities(Y/N): _____ If yes, please list below:

- _____
- _____
- _____
- _____

Preferred Lab (Please check one):

☐ Quest ☐ LabCorp

Medical Problem List	Past Surgical History/Dates	Hospitalizations/Reasons/Dates	Vaccine Record/Date
•	•	•	•
•	•	•	•
•	•	•	•
•	•	•	•

Family History of			Family Member	Initial Risk Assessment	Date
Y	N				
☐	☐	Alzheimer's	_____		
☐	☐	Breast CA	_____	☐ Alcohol/Drug Use	_____
☐	☐	Heart	_____		
☐	☐	Stroke	_____	☐ STD's	_____
☐	☐	Cancer History	_____		
☐	☐	Colon CA	_____	☐ Domestic Violence	_____
☐	☐	Depression	_____		
☐	☐	DM	_____	☐ Osteoporosis	_____
☐	☐	Vision	_____		
☐	☐	Glaucoma	_____	☐ Geriatric Assessment	_____
☐	☐	Cholesterol	_____		
☐	☐	HTN	_____	☐ MMSE	_____
☐	☐	Mental Issue	_____		
☐	☐	Prostate CA	_____	☐ Screenings	_____
☐	☐	Skin CA	_____		
☐	☐	Thyroid	_____		

Social History

☐ Married ☐ Single ☐ Civil Union

☐ Divorced ☐ Widowed

☐ Lives Alone ☐ Separated

Occupation: _____

Religious Preference: _____

Education:
☐ JHS ☐ HS ☐ College

☐ Other_____

By signing below, you acknowledge that the above information including insurance are correct and any future accommodations including billing, you are liable for. Also, by signing below you give APMUC consent to call in the event we are unable to reach you.

Signature: _____ **Date:** _____

Advance Preventive Medicine & Urgent Care
1400 E Robinson Street Orlando, FL 32801
Tel: (407)845-8623 Fax: (407)845-8667

Consent for Procedure/Treatment

Patient Name: _____

Patient ID: _____

Patient DOB: _____

Address: _____

Date: _____

I hereby authorize and direct Dr. Shemiranei and assistants, as necessary to perform quality care, to perform the following procedure/treatment(s) on me:

Covid-19 Rapid Test Results are not guaranteed, you may receive a false positive or negative result. In general, antibodies can be detected 1-3 weeks after infection, as there is a window period. If any symptoms i.e. fever or cold appears, whether you received a positive or negative result, be sure to get further diagnosis combined with clinical indications and other diagnostic methods to prevent delay of treatment. Dr. Shemiranei is not and can not be held reliable for **ANY** test results you receive.

- _____

- _____

The nature and purpose of the procedure/treatment, alternative methods of treatment, and potential risks and complications have been fully explained to me, including but not limited to:

- _____

- _____

- _____

I acknowledge that no guarantees have been made to me as to the outcome of the procedure(s) and/or treatment(s).

I grant this consent without duress, confusion, or pressure from my physician and/or staff, associate, or colleagues.

FOR MM PATIENTS**: Dr. Shemiranei does not recommend Inhalation Route(Vaping) nor Smoking Route for Medical Cannabis unless you do not want to try any other routes. If you are a MM patient, by signing below you consent to use the smokable or vaping version which is not recommended by the provider.

_____
Patient Printed Name

_____ _____
Patient/Representative Signature Date

_____ _____
Witness Signature Date

Advance Preventive Medicine & Urgent Care
1400 E Robinson Street Orlando, FL 32801
Tel: (407)845-8623 Fax: (407)845-8667

HIPAA Privacy and Release of Information Authorization

Patient Name: _____

Patient ID: _____

Patient DOB: _____

I, _____ hereby authorize ADVANCE PREVENTIVE MEDICINE & URGENT CARE and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have aright to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____

Patient Printed Name Date

_____

Patient Signature

PATIENT RESPONSIBILITY FORM

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**
   - I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
   - Co-payments are due at time of service.
   - If my plan requires a referral, I must obtain it prior to my visit.
   - In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
   - If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**
   I hereby authorize and direct payment of my medical benefits to (PROVIDER OR GROUP NAME) on my behalf for any services furnished to me by the providers.

3. **AUTHORIZATION TO RELEASE RECORDS**
   I hereby authorize (PROVIDER OR GROUP NAME) to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. **MEDICARE REQUEST FOR PAYMENT**
   I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (PROVIDER OR GROUP NAME). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party — Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party — Relationship to Patient

Medical Release Form

Advance Preventive Medicine & Urgent Care
1400 E. Robinson St Orlando, FL 32801
Phone: 407-845-8623 **Fax:** 407-845-8667

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ Care Plan
- ☐ Pathology Reports
- ☐ Hospital Reports
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Treatment Record
- ☐ Medication Record
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Other (Please specify below)

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care;

To: Advance Preventive Medicine

From: _____

Phone: _____ Fax: _____

The purpose/reason for this release of information is as follows:

_____

_____.

_____
Printed Name of Patient or Personal Rep.

_____
Signature of Patient or Personal Rep

_____
Date

Please release medical records to the fax number listed below our address. If you have any questions or concerns, please feel free to call the office. Thank you in advance. - APMUC Staff

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		+	+

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

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 _____

A2663B 10-04-2005

ADVANCE PREVENTIVE
MEDICINE & URGENT CARE

Name: _____
Date of Birth: _____
Phone: _____
Insurance Name: _____

Cognitive Assessment

Have you ever experienced:

If Yes, please select how often below symptoms are occurring either daily, weekly, or monthly

- Sensation of not feeling right, being a little confused or unsteady? ☐ Yes ☐ No | ☐ Daily ☐ Weekly ☐ Monthly
- Spells you would describe as feeling faint or as if you might pass out? ☐ Yes ☐ No | ☐ Daily ☐ Weekly ☐ Monthly
- Events where you've experienced altered awareness? ☐ Yes ☐ No | ☐ Daily ☐ Weekly ☐ Monthly

Have you ever experienced:

If Yes, please select how often below symptoms are occuring either daily, weekly, or monthly

- Episodes of temporary confusion or brain fog? ☐ Yes ☐ No | ☐ Daily ☐ Weekly ☐ Monthly
- Dizziness accompanied by loss of awareness or confusion? ☐ Yes ☐ No | ☐ Daily ☐ Weekly ☐ Monthly
- Difficulty finding the right words or expressing yourself? ☐ Yes ☐ No | ☐ Daily ☐ Weekly ☐ Monthly
- Lapse of time or zoning out? ☐ Yes ☐ No | ☐ Daily ☐ Weekly ☐ Monthly
- Difficulty recalling the details of conversations you just had or TV shows you just watched? ☐ Yes ☐ No | ☐ Daily ☐ Weekly ☐ Monthly

Do you have history of:

- TBI (Traumatic Brain Injury) ☐ Yes ☐ No
- TIA (Transient Ischemic Attack/ Mini-Stroke) ☐ Yes ☐ No
- Brain concussion or Post-concussion Syndrome ☐ Yes ☐ No
- Dementia ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- Brain injury, surgery, or tumors ☐ Yes ☐ No
- Migraines with Nausea, light sensitivity, or other aura ☐ Yes ☐ No

Physician/ Office Use Only:

Notes: _____

_____

_____

Onset: _____

_____

Patient Signature: _____ **Date:** _____