

PATIENT REGISTRATION FORM



PATIENT INFORMATION

*required field

Patient Name*		Birth Date*		Female*	☐	Male*	☐
SS#	(Required if we are billing insurance or to accept checks)						
Address*							
	Street*	City*	State*	ZIP Code*			
Home Phone*		Cell Phone*		Work Phone			
Email*		Marital Status: Single	☐	Married	☐	Divorced	☐
		Widowed	☐				
Employer Name			Occupation				
In Case of Emergency*							
	Name	Phone*	Relationship*				
Mother's Maiden Name							

PERSON RESPONSIBLE FOR ACCOUNT (Guarantor)

*required field

Patient Name		Birth Date		Female	☐	Male	☐
SS#	(Required if we are billing insurance or to accept checks)						
Address							
	Street	City	State	ZIP Code			
Home Phone		Cell Phone		Work Phone			
Primary Insurance							
Secondary Insurance							
Preferred Pharmacy*							
	Name*	Location*	Phone*				
What Lab is Your Insurance Contracted With				(We will default to Quest)			
How Did You Hear About Us*							

I authorize & direct Symphony Healthcare, Inc. to perform medical evaluation and treatment upon me. I acknowledge that the practice of medicine is not an exact science & that no guarantees have been made to me as to the outcomes of the treatments. With my signature below, I grant consent without duress, confusion, or pressure from Symphony Healthcare.

Symphony Healthcare, Inc. is a self-pay medical practice and does not participate with or bill any insurance companies. Payment for services is due at the time care is provided. I understand that I am financially responsible for all charges related to my care, and I agree to pay for services directly to Symphony Healthcare, Inc.

I authorize Symphony Healthcare, Inc. to release medical information as necessary to me or to my insurance company if I request documentation for reimbursement purposes. I understand that payment to Symphony Healthcare is not dependent upon reimbursement from my insurance company. The information I have provided is true and accurate to the best of my knowledge, and I acknowledge my financial responsibility for services received.

Signature*

Date*

Please include reason for surgery/hospitalization, date, and doctor that performed

[illegible][illegible][illegible]

MEDICAL HISTORY

GENERAL INFORMATION

Tobacco Use:

Current Former Never Packs/day Year quit Year started

Alcohol Use:

Current Former Never

How often Daily Weekly Social Rare

Caffeine Use:

Current Former Never

How often Daily Weekly Social Rare

Sexually Active: Yes No

Exercise: Yes No

Vaccine History (date of last): Flu TdAP (Tetanus)

Pneumonia Shingles Varicella Others

WOMEN ONLY

Age menses began Regular menses? : Yes No

Date of last:

Cycle Mammogram Bone Density Colonoscopy

Dental Exam Eye Exam Total # of Pregnancies

Total # of Births Method of Birth Control Age of Menopause

Do you experience any of the following symptoms:

Fatigue Hot Flashes Depressive Mode Memory Loss Weight Gain

Vaginal Dryness Joint Pain Trouble Sleeping Night Sweats

Anxiety Irritability Low Libido Headaches Hair/Skin Issues

MEN ONLY

Date of last:

Prostate Exam Blood PSA Level Colonoscopy

Do you experience any of the following symptoms:

Fatigue Depressive Mode Memory Loss Weight Gain

Headaches Low Libido Erectile/Sexual Dysfunction

Decreased Muscle Strength Trouble Sleeping Anxiety Irritability

Hair Loss Joint Pain Shrinking Testicle

MEDICAL HISTORY



Patient Name: _____ DOB: _____

Medical History Diagnosis ("X" all that apply)	Self	Mother	Father	Sister	Brother	G-Mother	G-Father	Child
• Allergy (Seasonal/Food)								
• Anemia								
• Anxiety								
• Arthritis								
• Asthma								
• Blood Transfusion								
• Breast Cancer								
• Cataracts								
• Colon Cancer								
• Depression								
• Diabetes								
• Drug/Alcohol Abuse								
• Emphysema								
• Endometriosis								
• GI Problems								
• Headaches/Migraines								
• Hearing Problems								
• Heart Attack								
• Heart Disease								
• High Cholesterol								
• High Blood Pressure								
• Irritable Bowel Syndrome								
• Kidney Problems								
• Lung Disease								
• Mental Illness								
• Neurological Disease								
• Prostate Disease								
• Sexually Transmitted Disease								
• Skin Issues/Rashes/Itchiness								
• Sinus Infection, Chronic								
• Stroke								
• Thyroid Problems								
• Others:								

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED)



Symphony Healthcare, Inc 1329 SE 25th Loop,
Suite 102; Ocala, FL 34471

☎ (352) 629-5939 📠 (352) 629-7833

Patient Name Date of Birth

I HEREBY REQUEST SYMPHONY HEALTHCARE, INC TO: OBTAIN FROM RELEASE TO
health care information for the patient named above

This request and authorization applies to:

Doctor / Facility	Phone Number	Fax Number

Healthcare information relating to the following treatment, condition, or dates:

Lab Reports Diagnostic testing Other:

The Purpose of Request:

Concurrent Care ☐ Transferring Care ☐ Moving ☐ Self ☐ Insurance ☐ Legal ☐

I specifically consent to the release of any material in your possession, including, if any, existing results of STD & HIV (AIDS) test and any which might address chemical dependence, depression, or other psycho-emotional issues. I understand that I do have the right to limit the release of this information at any time by putting my request into writing. Yes ☐ No ☐

I request the provider named above promptly honor this request for medical information and/or copies of medical records. A copy of this request is as valid as the original. This authorization and request is valid for a period of one year from the date signed below, unless I request in writing to have this authorization revoked. I do, however, understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I may inspect and obtain a copy of any information disclosed. **I may be charged a fee of \$1.00 per page plus a \$10.00 processing fee for personal copies.**

Patient Signature: Date Signed:

Address:

City/State / Zip Code:

Faxed by: Date Signed:

FUNCTIONAL MEDICINE TREATMENT PROTOCOL INFORMED CONSENT



 (352) 629-5939

 www.shocala.com

You are about to begin an Integrative medicine treatment approach to your healthcare. As you may already realize, many of the recommendations you receive during this treatment are different from those which other traditional physicians may have previously made. As a functional medicine practitioner, I will make recommendations to address imbalances in all areas that I have observed need treatment. Functional medicine addresses the underlying root causes of disease, using an approach that engages both the patient and the practitioner in a therapeutic partnership. Rather than traditional medications or prescriptions, a stimulation of natural healing will be emphasized. In my experience, I feel that these are the most effective ways of dealing with most of the chronic health problems in our culture.

Natural treatments do not typically work quickly, but they work over time in a cumulative fashion. It is important that you follow the plan exactly as prescribed to receive the maximum benefits. All elements of treatment are important and work synergistically together. If at any time you feel that you will have difficulty or are unable to comply with treatment, please let our office know we & we will make the appropriate changes to your care plan that might be a better fit for you.

As part of my treatment philosophy, there are times when diagnostic testing might be necessary, and I will recommend the appropriate testing when needed. You have the right to refuse diagnostic testing at any time; however, I will be unable to properly manage your healthcare without the testing. Alternatively, when utilizing a functional medicine approach, there are times when diagnostic testing is not indicated as it would be with traditional medicine. You have the right to utilize a practitioner that might be a better fit for you or a specialist for certain conditions.

- ☐ I agree to follow the plan of care created for me at my visits.
- ☐ I agree to be an active participant in this plan to achieve optimal outcomes.
- ☐ I agree to follow-up office visits as requested by my provider.
- ☐ I agree to lab testing as requested by my provider.
- ☐ I will notify Symphony Healthcare if I want to opt out of this agreement. Doing so may change which medications and testing will be offered.

I certify that I have read or had read to me the contents of this form. I understand both the benefits and risks of proceeding with the functional medicine approach. I also understand the risks and consequences associated with my refusal to any specific recommendations given to me. I understand that functional medicine is not traditional medicine and should I require any traditional medical intervention, my care may need to be referred to the appropriate practitioner.

Name: Relation to patient: Date: