PATIENT REGISTRATION FORM

*required field

PATIENT INFORMATION

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

*required field

PERSON RESPONSIBLE FOR ACCOUNT *(Guarantor)*

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. If I choose to submit a claim to my insurance company for possible reimbursement, Symphony Healthcare may provide a receipt for that purpose. However, submission of claims and communication with my insurance carrier will be my responsibility, and any reimbursement is not guaranteed.

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*

MEDICAL HISTORY

SURGICAL/HOSPITALIZATION HISTORY

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

Reason	Date	Doctor

MEDICATION LIST

Medication name and dose	Instructions (how often do you take?)	Prescribed by

ALLERGIES TO MEDICATIONS

Name of medications	Type of reaction

OTHER MEDICAL PROVIDERS

Name of provider	Speciality	What condition is being managed?

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 ☐ **Excercise:** Yes ☐ No ☐

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

Pneumonia _____ Shingles _____ Varicela _____ 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 ☐ Join 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 ☐ Erectyle/Sexual Dysfunction ☐

Decreased Muscle Strength ☐ Trouble Sleeping ☐ Anxiety ☐ Irritability ☐

Hair Loss ☐ Join Pain ☐ Shrinking Testicule ☐

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 Trasmitted 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

SYMPHONY HEALTHCARE INC.
(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: _____