LOVE THE GOLDEN RULE, INC

3000 1St Ave N, St. Petersburg, FL 33713
PH: 727-826-0700 FAX: 727-954-6994

Date: _____

Personal Information:

Patient Name: _____
(Last) (First) (Middle)

Address: _____

City: _____ State: _____ Zip: _____ Sex (Legal): M/F

Home Phone: _____ Cell: _____ Other: _____

Social Security #: _____ Date of Birth: _____

Employer: _____ Phone: _____

Spouse/Partner: _____ Physician: _____

Emergency Contact: _____ Phone: _____

Reason for Visit: _____ Previous Doctor: _____

Pharmacy: _____ Phone: _____

Pharmacy Address: _____ City: _____ State: _____

How did you hear about us? _____

Demographic:

Which of the following best describes you?

Please select one answer.

- Asian or Pacific Islander
- Black or African American
- Hispanic or Latino
- Native American or Alaskan Native
- White or Caucasian
- Multiracial or Biracial
- A race/ethnicity not listed here

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Love the Golden Rule Consent Form

Authorization to Release Information:

I Hereby authorize Love the Golden Rule, Inc. to release to my insurance carrier(s) any information acquired during my examination or treatment required for payment of any insurance claim.

Signed: _____ Dated: _____

Assignment of Benefits:

I hereby authorize payment directly to Love the Golden Rule, Inc. for medical benefits. I understand that I am financially responsible for the charges not covered by the insurance company.

Signed: _____ Dated: _____

Electronic Privacy Waiver:

I understand that my medical records may be transmitted electronically. Although every effort will be made to assure the records are sent/received by the appropriate third party, I absolve Love the Golden Rule, Inc./ Robert J. Wallace MD from liability should they be received in error by a third party. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.

Signed: _____ Dated: _____

Acknowledgement of Office Policies:

I am aware that I will be charged $50-$175 for missed appointments not cancelled 24 hours in advance. I am also aware that $25 will be charged for preparation of FMLA/private disability forms at the time the forms are dropped off at the office.

Signed: _____ Dated: _____

Permission to Share Medical Information:

You have my authorization to share my medical records and medical information with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signed: _____ Dated: _____

If you would like them released to **no one** then sign here:

Signed: _____ Dated: _____

Please note, this page must be printed and signed.

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Love the Golden Rule Consent Form

Permission to Leave Messages on Answering Machine:

By signing below, you authorize us to leave voice/text/email messages regarding appointment reminders, referral information, etc. on the numbers below. We will use your email address to create a portal account for you so can access your labs/appointment reminders/messages through our secure portal:

Email Address: _____

Mobile Number: (_____) _____-_____Other Number (_____) _____-_____

Signed: _____Dated: _____

Medications:

Request Refills of Medications

Refills on medications should be done during your appointment with your provider. Please check your refills before you come see us and confirm you will have enough medication to last until your NEXT appointment.

Prescriptions that are lost, stolen, or destroyed will not be replaced.

Request a New Medication

Any new medication prescription will require an office visit with a physician. Please call the office to inquire.

Signed: _____Dated: _____

Please note, this page must be printed and signed.

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Patient Treatment Agreement

Dear Patients,

We reserve the right to refuse care to anyone for any reason. The philosophy of Love the Golden Rule is to "Do unto others as you would have done to you. That means to treat everyone the way you want to be treated. Our expectation of you is that we will treat you with respect and we expect the same from you.

Here are the rules of the clinic:

1. The use of swear words, or cursing will no be tolerated. The use of the "F" word will especially not be tolerated.
2. If we feel that you are being aggressive or threatening you will be asked to change your tone. If you do not you will be asked to leave the clinic. If you are on the phone my staff will ask you to change your tone or the call will be terminated.
3. If you make repeated phone calls leaving the same message, we will return your call and let you know that you are not to continue that behavior.
4. If you have just called and we return your call and you do not answer you are to listen to the message we left, you before returning a call to the office.
5. If you appear to be intoxicated or under the influence of drugs you will be asked to leave the clinic.
6. If you fail to make your appointment without calling to cancel at least 24 hours in advance it will be documented and missed appointment charged to your account. After the 3rd missed appointment, you will not be given any further appointments.
7. If you feel that you have been treated unfairly Dr. Wallace will want to speak to you personally so you can share your experience and see if there is something we need to improve upon.
8. If at any time Dr. Wallace has determined that the relationship cannot continue you will be sent a certified letter informing you of that decision and you will need to find another doctor.

The most important thing to remember is that this clinic was developed to help those in need. We all at some point need help and by living the Golden Rule you will find that your life will improve.

Signed: _____ Dated: _____

Please note, this page must be printed and signed.

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PH: 727-826-0700 FAX: 727-954-6994

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Love the Golden Rule, Inc.
3000 1st Ave N
St. Petersburg, FL 33713

Phone: 727-826-0700
Fax: 727-954-6994

INFORMATION MAYBE DISCLOSED TO:

Person/Facility: _____ Phone: _____
Address: _____ Fax: _____

METHOD OF COMMUNICATION: Fax: ☐ US Mail: ☐ Other (Specify): ☐

INFORMATION TO BE DISCLOSED (INTITIAL SECTION):

☐ General Medical Records, including STD and TB ☐ Progress Notes ☐ History and Physical Results
☐ Immunizations ☐ Family Planning ☐ Prenatal Records ☐ Consultations ☐ All Lab Results
☐ Other (Specify)_____

I SPECIFICALLY AUTHORIZE RELEASE OF ALL INFORMATION RELATED TO (INTIAL SECTION):

☐ HIV Test Results for non-treatment purposes ☐ Substance Abuse Service Provider Client Records
☐ Psychiatric, Psychological or Psychotherapeutic ☐ Early Intervention ☐ WIC

PURPOSE OF DISCLOSURE:

☐ Continuity of Care ☐ Personal Use ☐ Other (Specify)_____

EPIRATION DATE: This Authorization will expire on _____. I understand that if I fail to specify an expiration date of event this Authorization will expire twelve (12) months from the date of which it was signed.

REISCLOSURE: I understand that once the above information is disclosed it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this Authorization is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this Authorization at any time. If I revoke this Authorization, I understand that I must do so in writing and that I must present my revocation to the medical records department. I understand that the evocation will not apply to information that has already been released in response to this Authorization. I understand that the revocation will not apply to my insurance company, Medicare and Medicaid.

_____ _____
Client/Representative Signature Date

_____ _____
Print Name Date of Birth

Please note, this page must be printed and signed.

LOVE THE GOLDEN RULE, INC

3000 1St Ave N, St. Petersburg, FL 33713
PH: 727-826-0700 FAX: 727-954-6994

AUTHORIZATION TO RECEIVE CONFIDENTIAL INFORMATION

INFORMATION MAYBE DISCLOSED BY:
Person/Facility: _____ Phone: _____
Address: _____ Fax: _____

INFORMATION MAY BE DISCLOSED TO:
Love the Golden Rule, Inc. Phone: 727-826-0700
3000 1st Ave N Fax: 727-954-6994
St. Petersburg, FL 33713
METHOD OF COMMUNICATION: Fax: ☐ US Mail: ☐ Other (Specify): ☐

INFORMATION TO BE DISCLOSED (INTITIAL SECTION):
☐General Medical Records, including STD and TB ☐Progress Notes ☐History and Physical Results
☐Immunizations ☐ Family Planning ☐Prenatal Records ☐Consultations ☐All Lab Results
☐Other (Specify)_____

I SPECIFICALLY AUTHORIZE RELEASE OF ALL INFORMATION RELATED TO (INTIAL SECTION):
☐HIV Test Results for non-treatment purposes ☐Substance Abuse Service Provider Client Records
☐Psychiatric, Psychological or Psychotherapeutic ☐Early Intervention ☐WIC

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_____ _____
Client/Representative Signature Date

_____ _____
Print Name Date of Birth

Please note, this page must be printed and signed.

Medical History Worksheet

Patient's Name_____

Date_____

Please all questions on these worksheets. If you don't want to answer a question put a line through the question. (These information sheets will be shredded after the information is entered into the electronic medical record.)

Please mark the box ☒ in front of any of the things YOU have had. Select "*NONE*" if this does not apply.

Behavioral/Mental Health Problems ☐ None
☐ Anxiety ☐ Attention-Deficit/Hyperactivity ☐ Bipolar Disorder ☐ Depression ☐ Schizophrenia
☐ Other Behavioral/Mental Health Problems _____

Birth Defects/Genetic Problems ☐ None
☐ Yes _____ ☐ No
What kind? _____

Blood Problems ☐ None
☐ Anemia ☐ Sickle Cell Disease ☐ Sickle Cell Trait ☐ Other Blood Problems _____

Cancer ☐ None
☐ Bladder ☐ Breast ☐ Cervical ☐ Colon ☐ Lung ☐ Prostate ☐ Skin ☐ Uterine
☐ Other Cancer _____

Cardiovascular (Heart) Disease ☐ None
☐ Chest pain ☐ Congestive Heart Failure ☐ Blood Clot in leg ☐ High Cholesterol / High triglycerides
☐ High Blood Pressure ☐ Heart Attack ☐ Hardening or blockage of arteries/veins
☐ Other Cardiovascular (Heart) Problems _____

Ear, Nose, Throat, Mouth Problems ☐ None
☐ Allergic Rhinitis ☐ Deaf/Hearing Impaired ☐ Dental Problems ☐ Chronic Sinusitis ☐ TMJ
☐ Other Ear, Nose, Throat Problems _____

Endocrine (Glands) ☐ None
☐ Diabetes on Insulin ☐ Diabetes Not on Insulin ☐ Ovarian Cysts (Polycystic ovaries) ☐ Thyroid problems
☐ Other Endocrine (Gland) Problems _____

Eye Problems ☐ None
☐ Blind/Visually Impaired ☐ Cataracts ☐ Glaucoma ☐ Problems with your Retina
☐ Other Eye Problems

GI Disease (Stomach/Intestines/Liver) ☐ None
☐ Gall Stones/Inflamed Gall Bladder ☐ Cirrhosis ☐ Colitis ☐ Diverticulitis ☐ GERD (Reflux)
☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Irritable Bowel Syndrome (IBS) ☐ Ulcer
☐ Other GI Problems _____

HIV Information ☐ None
☐ AIDS ☐ HIV ☐ Been Tested and Negative ☐ Never Been Tested ☐ Don't Know

Kidney Disease ☐ None
☐ Kidney Disease ☐ Endometriosis ☐ Blood in Urine ☐ Kidney Stones ☐ Ovarian Cysts ☐ Prostate enlargement
☐ Prostate Infections ☐ Urinary Tract Infections (UTI) ☐ Other Kidney Disease _____

Lung Disease ☐ None
☐ Asthma ☐ Bronchitis ☐ COPD ☐ Emphysema ☐ Pneumonia ☐ Blood Clot in Lung ☐ Tuberculosis
☐ Other Lung Disease _____

Did your mother take DES? (Hormone given from 1938-1971 during pregnancy to prevent miscarriage)
☐ Yes ☐ No ☐ Don't Know ☐ What is this?

Patient's Name: _____ **Date:** _____

Musculoskeletal (Bone) Problems ☐ **None**
☐ Fractures ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Scoliosis
☐ Other Bone Problems _____

Neurological Disease ☐ **None**
☐ Stroke ☐ Migraines ☐ Pain, numbness, tingling of fingers, toes, feet ☐ Seizures ☐ Ever fainted
☐ Other Neurological Problems _____

Skin Problems ☐ **None**
☐ Acne ☐ Eczema ☐ Lupus ☐ MRSA ☐ Psoriasis ☐ Tattoos
☐ Other Skin Problems _____

STD (sexually transmitted disease) ☐ **None**
☐ Chlamydia ☐ Herpes ☐ Gonorrhea ☐ HPV (warts) ☐ Syphilis
☐ Other STDs _____

Have you ever had a blood transfusion or been given blood products? ☐ Yes ☐ No

Please mark the box, ☒ If anyone in your family has had the following: (mother, father, sister, brother, children only)
☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Cholesterol ☐ High Blood Pressure ☐ Stroke
☐ Other disease in family _____

Have you ever been admitted to the hospital? ☐ Yes (Please list date and reason) ☐ No
Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____

Have you had any surgeries? ☐ Yes (Please list date and type of surgery) ☐ No
Date: _____ Surgery type: _____
Date: _____ Surgery type: _____
Date: _____ Surgery type: _____
Date: _____ Surgery type: _____

Please mark the box, ☒ for the immunizations you have had:

Vaccination	**Last Known (approx. date)**
☐ Chicken Pox (Varicella)	_____
☐ Flu (Seasonal/Regular)	_____
☐ Flu (H1N1 / Swine)	_____
☐ Hepatitis A	
☐ Hepatitis A Series Complete	_____
☐ Hepatitis B	
☐ Hepatitis B Series Complete	_____
☐ Human Papillomavirus (HPV)	
☐ HPV Series Complete	_____
☐ Measles	_____
☐ Meningococcal	_____
☐ Pneumonia	_____
☐ Tetanus	_____
☐ Zoster	_____
☐ Other Vaccine	_____
☐ Other Vaccine	_____
☐ Other Vaccine	_____
☐ Other Vaccine	_____

Patient's Name _____ **Date** _____

Allergies Do you have any allergies to any of the following. ☐ Yes ☐ No

	Allergic To:	Reaction
Drugs		
Foods	☐ eggs ☐ milk/dairy ☐ nuts	
	☐ Shellfish ☐ wheat	
Environmental	☐ dust ☐ feathers	
	☐ pollen ☐ insect stings	
	☐ iodine ☐ pet dander	

Please list any medications you are taking.

Medication Name	Dosage	Instructions

Tobacco, Alcohol and other Substance Use

☐ Yes ☐ No Do you smoke?
How many packs per day? _____
☐ Yes ☐ No Do you use smokeless tobacco?
☐ Yes ☐ No Other form of tobacco used: _____
How long have you used tobacco products? _____ ☐ days ☐ weeks ☐ months ☐ years
☐ Yes ☐ No Have you used tobacco products in the past?
How long ago? _____ ☐ less than 1 year ☐ more than 1 year ☐ other _____
☐ Yes ☐ No Do you drink alcohol? (A drink is considered a 12 oz. beer, a 5 oz. glass of wine or 1.5 oz. of liquor)
How may drinks? _____ week _____ occasion

Do you abuse any of the following?

☐ Yes ☐ No over the counter medications
☐ Yes ☐ No prescription drugs
☐ Yes ☐ No street drugs
☐ Yes ☐ No other drugs. Type of drug: _____

Would you like to receive information to get help for tobacco, alcohol and/or drug use?

☐ Alcoholics Anonymous ☐ Drug Free America Hotline ☐ Florida Quitline (Smoking)
☐ Other type of assistance desired: _____

Nutrition and Exercise

☐ Yes ☐ No Do you eat 5 or more fruits and/or vegetables per day?
☐ Yes ☐ No Do you eat less than 2 meals per day?
☐ Yes ☐ No Do you exercise 30 minutes at least 3 times per week?

Safety

Do you wear a seatbelt? ☐ Always ☐ Sometimes ☐ Rarely
Do you wear a helmet when riding a bicycle/motorcycle? ☐ Always ☐ Sometimes ☐ Rarely ☐ I don't ride
Are you exposed to hazards while ☐ Doing a Hobby ☐ At Home ☐ At Work ☐ Other hazard _____

Patient's Name: _____ **Date:** _____

Domestic Violence

☐Yes ☐No Does your relationship make you feel threatened, ashamed or unsafe at home
☐Yes ☐No Have you ever been hit, kicked, punched, slapped, shoved or bitten your spouse, boyfriend or partner?
☐Yes ☐No Would you like to receive information about a shelter or Domestic Violence Hotline?
☐ Domestic Violence Hotline ☐ Rape Crisis Hotline ☐ State Abuse Hotline ☐ CASA ☐ The Haven
☐ Other Abuse Information _____

Sexual History

Age at first sexual encounter: _____ Number of Sex Partners in the last year: _____
☐Yes ☐No Are you currently sexually active?
Do you have any of the following risk factors for transmitted infections?
☐Yes ☐No Do you currently have anal sex?
☐Yes ☐No Are you a hemophiliac blood recipient?
☐Yes ☐No Are you an IV drug user?
☐Yes ☐No Do you have any occupational exposure?
☐Yes ☐No Do you have oral sex?
☐Yes ☐No Have you had sex for drugs or money?
☐Yes ☐No Do you have sex with women?
☐Yes ☐No Have you had sex with an HIV positive person?
☐Yes ☐No Have you had sex with an IV drug user?
☐Yes ☐No Do you have sex with men?
☐Yes ☐No Are you a man that has sex with men?
☐Yes ☐No Do you have sex without a condom?
☐Yes ☐No Are you a victim of sexual assault?
Please list any other risk factors you have: _____
Do you use birth control? ☐Yes ☐No If yes, what type?

☐abstinence	☐male condoms	☐female condom	☐spermicide	☐vaginal film
☐natural	☐combination pills	☐progestin only pills	☐Depo Provera	☐hormonal patch
☐diaphragm	☐vaginal ring	☐Implanon	☐IUD	☐tubal ligation
☐vasectomy	☐rely on female method(s)		☐other type of birth control _____	

Women's Health

When was the first day of your last menstrual period (LMP)? _____
When was your last mammogram? _____
Have you ever had an abnormal mammogram? ☐Yes ☐No When? _____
Do you practice self breast exams? ☐Yes ☐No How often? _____
When was your last pap smear? _____
Have you ever had an abnormal pap smear? ☐Yes ☐No When? _____
Age at first pregnancy: ____ Number of times Pregnant: ____ Number of times given birth: ____
Number of full-term births: ____ Number of pre-term births: ____ Number of abortions: ____
Number of living children: ____ Number of multiple births: ____
Age at first period: _____
Are your periods ☐ regular ☐ irregular?
Is your menstrual flow ☐ light ☐ normal ☐ heavy?
How long does you period last? _____days.
How many days is your cycle (time from the start of one period to the start of the next period? _____
☐ Yes ☐ No Do you have bleeding between periods?
☐ Yes ☐ No Do you have painful periods?
Other problems with your period: _____
☐ Yes ☐ No Are you in menopause?
When did you start menopause? _____
☐ Yes ☐ No Are you taking hormone replacements (for menopause)?