

Deleon Wellness Medical Center

1546 Kingsley Ave. Orange Park, Florida 32073

Phone: (904) 579-4616 Fax: (904) 579-4962

New Patient Registration Form

Name: _____

(Last)

(First)

(Middle Initial)

Address: _____ Apt #: _____

City: _____ State: _____ ZIP: _____

Home Phone: () _____ Cell Phone: () _____

Work Phone: () _____ Birth Date: _____

Email: _____

Sex: Male Female

Emergency Contact

Name: _____ Relationship: _____

Home Phone: () _____ Cell Phone: () _____

Work Phone: () _____

Patient Signature

Print Name

Date

Medical History (Circle and Answer all questions)

Diabetes Yes or No Hypertension Yes or No Heart Disease Yes or No
Stroke Yes or No Cancer Yes or No High Cholesterol Yes or No

Other Medical Problems or Conditions:

Drug Allergies:

List ALL medications and doses (including supplements):

Family History:

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Hospitalization/Surgery/Serious Injuries:

Reason: _____

Reason: _____

Social History:

Marital Status: Single Married Separated Divorced Widowed

Use of Alcohol: Never Rarely Moderate Daily

Use of Tobacco: Never Quit (____ Year) Current Packs/Day _____

Use of Drugs: Never Past Use Current Use _____ (Type/Frequency _____)

Do you have any of the following?

Fatigue	Y or N	Loss of Appetite	Y or N	Dizziness	Y or N
Fever	Y or N	Nausea	Y or N	Seizures	Y or N
Eye Problems	Y or N	Change in Bowels	Y or N	Tingling Sensations	Y or N
Ear Problems	Y or N	Blood in Stool	Y or N	Tremors	Y or N
Sinus Problems	Y or N	Abdominal Pain	Y or N	Memory Loss	Y or N
Sore Throat	Y or N	Heartburn	Y or N	Confusion	Y or N
Voice Change	Y or N	Painful Urination	Y or N	Nervousness	Y or N
Chest Pain	Y or N	Frequent Urination	Y or N	Depression	Y or N
Palpitations	Y or N	Blood in Urine	Y or N	Insomnia	Y or N
Shortness of Breath	Y or N	Loss of Urine	Y or N	Excessive Thirst	Y or N
Swelling	Y or N	Joint Pains	Y or N	Heat or cold intolerance	Y or N
Coughing	Y or N	Joint Stiffness	Y or N	Dry Skin	Y or N
Wheezing	Y or N	Back Pain	Y or N	Easy Bruising	Y or N
Spitting Blood	Y or N	Rash or Itching	Y or N	Bleeding Tendency	Y or N
Weight Loss	Y or N	Headaches	Y or N	Cold Extremities	Y or N

Women

Painful Period Y or N Irregular Periods Y or N Vaginal Discharge Y or N
Breast Pain Y or N Breast Lumps Y or N Breast Discharge Y or N
Last Menstrual _____ Last Pap smear _____ #of Pregnancies _____ # of Miscarriages _____
Uterine fibroids/Cancer/Polyps Y or N Ovarian Cysts/Polyps Y or N Breast Cancer/Lumps/Pain Y or N

Men

Testicular Pain Y or N Straining to Urinate Y or N Impotence Y or N
Male Breast Cancer Y or N Male Prostate Cancer Y or N

I attest that the above Information is true and accurate. If there are any changes to my condition or anything to the medical history, I will promptly inform the Doctor and this office in writing so that they are aware.

Patient Signature

Date

Reviewed by (Physician) Signature

Date

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Botox and Juvederm Treatment Consent Form

Patient Name: _____

Date: _____

To the patient: You have the right to be informed about your skin condition and treatment so that you can make the decision whether or not to undergo the procedure after knowing the risk and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for the treatment program.

I have requested that the ARNP/RN attempts to improve my facial expression lines with Botox. This is the trademark for botulinum toxin. These injections have been used for more than a decade in children and adults to improve problems of facial muscle spasms. This toxin has also been useful to correct double vision due to muscle imbalance and also severe migraines. Injection of minimal amounts weakens the muscle and prevents frowning, crow's feet, and expression lines. *Although the results are usually dramatic, I have been informed that the practice of medicine is not an exact science and that no guarantees can be or have been made concerning expected results in my case.*

Initial if you understand and agree _____

The solution is injected with a small needle into the muscle, improvement in injected area will occur within two weeks. If results are not satisfactory after two weeks please call our office to schedule an appointment to treat area of concern again, and an administrative fee of \$40.00 (*for juvederm patients with remaining juvederm*) will be charged at this time.

Initial if you understand and agree _____

Side effects and complications have been minimal. Occasionally a slight swelling or bruising may last for several days after the injection. Rarely an adjacent muscle may be weakened for several weeks. I have been advised of the risk involved in such treatment, and alternative treatments.

Initial if you understand and agree _____

I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have sufficient opportunity for discussion and to ask any questions that I may have.

Patient Print Name

Patient Signature

Date

Deleon Wellness Medical Center

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After Botox/Juvederm Treatment Care

- ❖ Do not lay flat for 4 hours following your procedure.
- ❖ No bending over or strenuous working out for 24 hours following procedure.
- ❖ There is no need to massage the area.
- ❖ For the next 2-4 hours over exaggerate facial expressions to allow Botox to set in.
- ❖ Results could take up to 7-10 days to be seen. If after 10-14 days you are not seeing results, please contact our office at (904) 579-4616.
- ❖ Please keep in mind NO touchups can be administered without a before photo.
- ❖ It is recommended NO alcohol for up to 4 hours after procedure.
- ❖ NO smoking for up to 48 hours after Juvederm.
- ❖ NO sucking out of a straw for up to 48 hours after Juvederm.
- ❖ NO puckering of the lips after any injections for up to 24 hours.
- ❖ It is not recommended that you massage the injected area of Juvederm unless instructed by the nurse.

Patient Signature

Date

Witness Signature

Date

Deleon Wellness Medical Center

1546 Kingsley Ave. Orange Park, Florida 32073

Photograph Release Form

Attention Deleon Wellness Medical Center Patients. All Botox, Juvederm, Voluma, and Sclereotherapy patients are required to take before and after photos.

These photos are to follow up on all medical visits. Per HIPAA requirements, no photos will be used without consent. If you choose, you may choose to consent to have photos taken for use of illustrations, bulletins, advertisements, portfolios and or any promotion or educational materials.

_____ please initial that you agree and understand photos are required to monitor the treatment stated above.

_____ please initial to give consent to Deleon Wellness Medical Center to use your photos for any promotional or educational purposes.

_____ please initial that you have read and understand this consent and release form.

Patient Signature

Date

Witness Signature

Date

Deleon Wellness Medical Center

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Financial Policy, Consent and Authorization Form

_____ There will be a \$25.00 charge for Medical Follow Up or Consultations not rescheduled within 24 hours, also a \$50.00 charge for all procedures including Botox, Juvederm, Voluma, Etc. not canceled within 24 hours. Please allow at least 48 hours in advance to cancel or reschedule any set appointments.

_____ For Laser Patients, If an appointment was canceled in less than 24 hours of your appointment you will forfeit one laser session.

_____ All patients who purchase a promotion or certificate from Deleon Wellness Medical Center must provide at least 48 hours advance notice before canceling any visit. Any patient that fails to provide this notice will forfeit that specific visit.

_____ There is no guarantee that one treatment will be sufficient to treat a particular area. Each additional treatment, if required, may entail additional charges.

_____ All medical treatments entail risk including, but not limited to: lack of improvement, reaction to medications and worsening of condition. The procedures offered by our office may involve bleeding, bruising, scarring, infection and numbness. As a patient of this practice, you understand that these risks are inherent in the practice of medicine and that you wish to receive treatment.

_____ All patients must be 18 years or older unless accompanied by the parent or legal guardian.

_____ All sales of products, treatments, or services are final.

Patient Signature

Date

Office Staff Member Print Name

Date

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Privacy Practices HIPAA

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At Deleon Wellness Medical Center, we will always keep your health information secure and confidential. The law required for us to continue maintaining your privacy, to give you this notice and to follow the terms of the notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment on service render. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal health care operations. For example, one of our staff personnel may enter your information into our computer.

We may use your information to contact you. In an emergency, we may disclose your health information to a family member authorized by you or another person responsible for your care. We may release some or all of your information when required by law.

If this practice is sold, your information will become property of the new owner. This practice will not use or disclose your health information without prior or written authorization. You may request in writing that we not use or disclose your health information as described above. WE will inform you if we cannot fulfill your request. You may have the right to know of any uses or disclosures we make with your health information beyond and above the normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you provided in your health information questionnaire. You have the right to transfer copies of your health information to another practice with written authorization.

You may cancel or reschedule 24-48 hours prior to your upcoming appointment. If you miss your scheduled appointment without notifying the office a \$25.00 fee will be assessed to your account.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request of the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. The first ten copies are free and any additional copies will have a \$0.25 charge per page.

You have the right to request an amendment or change your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes to your request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services. You will not be retaliated against for filing a complaint; however,

before filing a complaint, please contact our Privacy Officer, Yvette Sims, at 904-579-4616. This notice is effective as since August, 2015.

I have read and understand the Privacy Practices of Deleon Wellness Medical Center

I consent that you discuss my medical information with my spouse/family member

Please Provide Spouse/Family Member name.

I do not consent that you discuss my medical information with anyone

Print Name

Signature

Date