

NEW PATIENT REGISTRATION & HEALTH HISTORY

REGISTRATION CHECKLIST

Please bring / provide	☐ Photo ID ☐ Primary insurance card ☐ Secondary/Tertiary card(s), if applicable ☐ MDVIP member information
Patient Portal	☐ Already enrolled ☐ Please send invitation ☐ Need help enrolling

Complete applicable fields; write None, Never or Unknown as needed. Type or print and sign. Ask our office for a secure return method.

PATIENT INFORMATION

Legal Last Name		Legal First Name	
Middle Name / Initial		Preferred Name	
Date of Birth		Sex	☐ Female ☒ Male ☐ Intersex/Other ☐ Decline
Gender Identity	☐ Woman ☐ Man ☐ Nonbinary ☐ Transgender Woman ☐ Transgender Man ☐ Other ☐ Decline		
Pronouns	☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: _____		
Social Security #*		Marital Status	☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed
Home Address (street)			Apt/Unit: _____
City		State / ZIP	
Cell Phone		Home / Alternate Phone	
Email		Preferred Contact	☐ Call ☐ Text ☐ Email ☐ Portal
Occupation		Employment Status	☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Not employed
Employer / Former Occupation		Work Phone	

* Social Security number is required when the practice is billing insurance. Self-pay patients may ask staff whether it is needed.

DEMOGRAPHICS & MDVIP MEMBERSHIP

Race	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Decline
Ethnicity	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline
MDVIP Membership	☐ New to MDVIP ☐ Current MDVIP member transferring care ☐ Established with Dr. Rizzo ☐ Not sure
MDVIP Member #	_____
If transferring	Previous MDVIP physician: _____ City/State: _____
How did you hear about us?	☐ Physician ☐ Patient/Word of Mouth ☐ Hospital ☐ Insurance ☐ MDVIP ☐ Online ☐ Other: _____

EMERGENCY CONTACT — REQUIRED

Emergency Contact Name		Relationship	
Cell Phone		Alternate Phone	
Responsible Party / Guarantor (if different)		Relationship to Patient	
Guarantor DOB		Guarantor Phone	

Patient Name		DOB	
--------------	--	-----	--

INSURANCE & ASSIGNMENT OF BENEFITS

Provide current insurance cards and photo ID. Complete each applicable coverage below.

PRIMARY INSURANCE

Insurance Carrier		Member / Policy ID	
Group #		Plan Type	
Policyholder Name		Relationship to Patient	
Policyholder DOB / Sex		Customer Service / Provider Phone	

SECONDARY INSURANCE

Insurance Carrier		Member / Policy ID	
Group #		Plan Type	
Policyholder Name		Relationship to Patient	
Policyholder DOB / Sex		Customer Service / Provider Phone	

TERTIARY INSURANCE

Insurance Carrier		Member / Policy ID	
Group #		Plan Type	
Policyholder Name		Relationship to Patient	
Policyholder DOB / Sex		Customer Service / Provider Phone	

ASSIGNMENT OF BENEFITS & INSURANCE AUTHORIZATION

I authorize Rizzo Family Medicine to submit claims and supporting information to my health plan(s) and, to the extent permitted by my plan and applicable law, assign payment of covered benefits directly to the practice for services furnished to me. I authorize the practice to use and disclose health information as permitted by law for treatment, payment, health care operations, eligibility and benefit verification, prior authorization, claims submission, claim correction, appeals, and coordination of benefits. I understand that insurance verification or authorization is not a guarantee of payment. I remain responsible for deductibles, copayments, coinsurance, non-covered services, and other patient-responsibility amounts permitted by law and by the practice's contracts. If the practice accepts Medicare assignment for a covered service, the Medicare-approved amount is accepted as payment in full for that covered service, subject to applicable deductible and coinsurance and any non-covered items or services.

☐ I have read and agree to the Assignment of Benefits and Insurance Authorization above.

Patient/Representative Signature		Date	
Printed Name		Relationship (if representative)	

Patient Name	DOB
---------------------	------------

CURRENT CONCERNS & PERSONAL MEDICAL HISTORY

Reason for establishing care / main concerns	
Date of last routine physical	
Self-reported height / weight	

PAST MEDICAL HISTORY — CHECK DIAGNOSED / TREATED CONDITIONS

CARDIOVASCULAR / VASCULAR ☐ High blood pressure ☐ High cholesterol ☐ Coronary artery disease / angina ☐ Heart attack ☐ Atrial fibrillation / arrhythmia ☐ Heart failure ☐ Valve disease / murmur ☐ Peripheral vascular disease ☐ Aneurysm ☐ DVT / PE / blood clot ☐ Varicose veins	RESPIRATORY / SLEEP ☐ Asthma ☐ COPD / emphysema ☐ Chronic bronchitis ☐ Sleep apnea ☐ Home oxygen ☐ Pulmonary fibrosis ☐ Pulmonary hypertension ☐ Recurrent pneumonia ☐ Tuberculosis / positive TB test	ENDOCRINE / METABOLIC ☐ Prediabetes ☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Obesity ☐ Osteopenia ☐ Osteoporosis ☐ Gout ☐ Adrenal / pituitary disorder
GI / LIVER / PANCREAS ☐ GERD / reflux ☐ Peptic ulcer ☐ IBS ☐ Crohn's ☐ Ulcerative colitis ☐ Diverticulosis / diverticulitis ☐ Celiac ☐ Colon polyps ☐ GI bleeding ☐ Gallstones / gallbladder disease ☐ Pancreatitis ☐ Fatty liver ☐ Hepatitis ☐ Cirrhosis / chronic liver disease	KIDNEY / URINARY ☐ Chronic kidney disease (stage: _____) ☐ Kidney stones ☐ Recurrent UTI ☐ Urinary incontinence ☐ Overactive bladder ☐ Prostate / BPH disorder ☐ Urinary retention	NEUROLOGIC ☐ Stroke / TIA ☐ Seizure / epilepsy ☐ Migraine / chronic headaches ☐ Neuropathy ☐ Parkinson's ☐ Multiple sclerosis ☐ Dementia / memory disorder ☐ Tremor ☐ Balance / gait disorder
MUSCULOSKELETAL / PAIN ☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Chronic back pain ☐ Chronic neck pain ☐ Fibromyalgia ☐ Chronic pain disorder ☐ Joint replacement history ☐ Other arthritis	MENTAL / BEHAVIORAL HEALTH ☐ Depression ☐ Anxiety / panic disorder ☐ Bipolar disorder ☐ PTSD ☐ ADHD / attention disorder ☐ Schizophrenia / psychotic disorder ☐ Eating disorder ☐ Substance use disorder	BLOOD / IMMUNE / INFECTIOUS ☐ Anemia ☐ Bleeding disorder ☐ Clotting disorder ☐ Immunodeficiency ☐ HIV ☐ Hepatitis B / C ☐ Lupus / autoimmune disease ☐ Recurrent serious infections
EYE / ENT / SKIN ☐ Glaucoma ☐ Cataracts ☐ Macular degeneration / retinal disease ☐ Hearing loss / hearing aids ☐ Chronic sinus disease ☐ Psoriasis / eczema ☐ Non-melanoma skin cancer history — detail below if cancer	REPRODUCTIVE / HORMONAL ☐ PCOS ☐ Endometriosis ☐ Fibroids ☐ Infertility history ☐ Menopause symptoms ☐ Erectile dysfunction ☐ Low testosterone ☐ Hormone replacement therapy	OTHER IMPORTANT HISTORY ☐ Recurrent falls ☐ Syncope / fainting ☐ Chronic wounds ☐ Amputation ☐ Organ transplant ☐ Dialysis ☐ Other major diagnosis: _____

PERSONAL CANCER HISTORY - SPECIFY TYPE / PRIMARY SITE

Ever diagnosed with cancer? ☐ No ☐ Yes — complete the details below for EACH cancer diagnosis.

Cancer Type / Primary Site	Year Diagnosed	Stage (if known)	Metastatic?	Sites of Spread / Notes
			☐ No ☐ Yes ☐ Unknown	
			☐ No ☐ Yes ☐ Unknown	
			☐ No ☐ Yes ☐ Unknown	

Treatment(s): ☐ Surgery ☐ Radiation ☐ Chemotherapy ☐ Immunotherapy ☐ Hormonal therapy ☐ Targeted therapy ☐ Other |
 Current status: ☐ Active treatment ☐ Remission / NED ☐ Surveillance ☐ Other: _____

Patient Name		DOB	
CARE TEAM & REPRODUCTIVE / HORMONAL HISTORY			
Specialty	Clinician / Practice	Specialty	Clinician / Practice
Primary Care (previous/current)		OB/GYN	
Cardiology		Oncology	
Dermatology		Ophthalmology	
Endocrinology		Orthopedics	
ENT		Pain Management	
Gastroenterology		Pulmonology/Sleep Medicine	
Nephrology		Rheumatology	
Neurology		Urology	
Mental Health		Other	
REPRODUCTIVE / HORMONAL HISTORY — COMPLETE AS APPLICABLE			
Age at first period		Last menstrual period	
Current status	☐ Pregnant ☐ Breastfeeding ☐ Post-menopause ☐ Not applicable	Age at menopause	
Pregnancy history	Total ____ Full term ____ Preterm ____ Miscarriages/abortions ____	Contraception	☐ None ☐ Pill ☐ IUD ☐ Implant ☐ Injection ☐ Other
Hormone therapy	☐ No ☐ Yes — type:	Gynecologic concerns/history	

Patient Name		DOB	
---------------------	--	------------	--

MEDICATIONS, ALLERGIES & PREFERRED PHARMACY

List ALL prescription medications, over-the-counter products, vitamins/supplements, injections, creams, patches, and as-needed medications. Include dose and frequency.

Medication / Supplement	Strength / Dose	How Taken / Frequency	Reason / Diagnosis	Prescriber

ALLERGIES & ADVERSE REACTIONS

☐ No known medication, food or environmental allergies

Allergen	Type	Reaction	Severity / Notes

PREFERRED PHARMACY

Primary Pharmacy Name		Phone	
Address / City		Fax	
Mail-order Pharmacy		Phone / Website	

Patient Name		DOB	
---------------------	--	------------	--

SURGICAL, PROCEDURE, HOSPITALIZATION & INJURY HISTORY

Include major surgeries, outpatient procedures, hospital admissions, emergency admissions, and significant injuries. Approximate dates are acceptable.

SURGERIES / PROCEDURES			HOSPITALIZATIONS		
Date/Year	Surgery or Procedure	Facility / Surgeon	Date/Year	Reason / Diagnosis	Hospital / Facility

SIGNIFICANT INJURIES / ACCIDENTS

Date/Year	Injury / Accident	Treatment / Facility	Ongoing Effects

PROCEDURE / ANESTHESIA / TRANSFUSION NOTES

Problems with anesthesia?	☐ No ☐ Yes — explain: _____	History of blood transfusion?	☐ No ☐ Yes — date/reason: _____
History of surgical complications?	☐ No ☐ Yes — explain: _____		

IMPLANTED DEVICES, PROSTHESES & HARDWARE

Check all that apply: ☐ None ☐ Pacemaker ☐ ICD/defibrillator ☐ Loop recorder ☐ Coronary stent(s) ☐ Artificial heart valve ☐ Vascular graft/filter
☐ Hip replacement ☐ Knee replacement ☐ Shoulder replacement ☐ Spinal hardware/fusion ☐ Neurostimulator ☐ Prosthetic limb ☐ Surgical mesh
☐ Insulin pump ☐ Continuous glucose monitor ☐ Port/PICC ☐ Cochlear implant ☐ IUD/contraceptive implant ☐ Lens implant ☐ Other: _____
Device / location / year placed / manufacturer-model if known: _____

Patient Name			DOB	
SOCIAL HISTORY & LIFESTYLE				
Living Situation	☐ Alone ☐ Spouse/Partner ☐ Family ☐ Roommate ☐ Assisted Living ☐ Skilled Nursing ☐ Other			
Florida Residence	☐ Year-round ☐ Part-year — other residence: _____			
Children	☐ None Sons: ____ Daughters: ____ Other: ____ (Names/ages are collected in Family History)			
Education	☐ High school ☐ Some college ☐ Associate ☐ Bachelor ☐ Graduate/Professional ☐ Other			
Hand Dominance	☐ Right ☐ Left ☐ Ambidextrous			
TOBACCO / NICOTINE HISTORY				
Smoking status	☐ Never ☐ Current ☐ Former	Products	☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Vape/e-cigarette ☐ Chew/snuff ☐ Nicotine pouches ☐ Other	
Started (month/year or age)		Quit (month/year or age)		
Average amount when smoking	_____ packs/day OR _____ cigarettes/day	Current amount/frequency		
Total years used		Secondhand smoke exposure	☐ No ☐ Yes	
If current: interested in quitting?	☐ Yes ☐ No ☐ Not now	Prior quit methods / notes		
ALCOHOL, CANNABIS, RECREATIONAL DRUGS & CAFFEINE				
Alcohol	☐ None ☐ Monthly or less ☐ 2–4x/month ☐ 2–3x/week ☐ 4+ times/week	Typical drinks/day when drinking		
6+ drinks on one occasion	☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily/almost daily	History of alcohol dependence	☐ No ☐ Yes — sober since:	
Cannabis	☐ Never ☐ Current ☐ Former ☐ Medically prescribed — type/frequency:	Other recreational drugs	☐ Never ☐ Current ☐ Former — drug/frequency:	
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Soda ☐ Energy drinks — servings/day:	History of drug dependence	☐ No ☐ Yes — details/sobriety date:	
EXERCISE, SLEEP, DIET & DAILY FUNCTION				
Exercise	☐ None ☐ 1–2 days/wk ☐ 3–4 days/wk ☐ 5+ days/wk	Typical duration/intensity		
Sleep	_____ hours/night ☐ Restful ☐ Poor ☐ Snoring ☐ Daytime sleepiness	Diet	☐ General ☐ Diabetic ☐ Low-salt ☐ Vegetarian/Vegan ☐ Keto/Paleo ☐ Other	
Independent self-care	☐ Yes ☐ No — needs help with:	Mobility / stairs	☐ No difficulty ☐ Some difficulty ☐ Significant difficulty	
Assistive Devices	☐ Glasses ☐ Contacts ☐ Hearing aids ☐ Cane ☐ Walker ☐ Wheelchair ☐ Prosthesis ☐ Other	Transportation difficulty	☐ No ☐ Yes	

Patient Name	DOB
---------------------	------------

SAFETY, ADVANCE CARE & PREVENTIVE HISTORY

SAFETY, SOCIAL NEEDS & ADVANCE CARE PLANNING

Seat belt use	☐ Always ☐ Usually ☐ Rarely/Never	Sunscreen use	☐ Usually ☐ Sometimes ☐ Rarely/Never
Food insecurity in past 12 months	☐ No ☐ Yes ☐ Prefer not to answer	Housing concerns/instability	☐ No ☐ Yes ☐ Prefer not to answer
Do you feel safe at home?	☐ Yes ☐ No ☐ Prefer not to answer	Transportation barriers to care	☐ No ☐ Yes
Living will / advance directive	☐ No ☐ Yes — copy on file? ☐ Yes ☐ No	DNR order	☐ No ☐ Yes — copy on file? ☐ Yes ☐ No
Health care surrogate / POA name		Relationship / Phone	

HEALTH MAINTENANCE & PREVENTIVE CARE

Enter the most recent date completed. If never done, write "Never." If unknown, write "Unknown." Abnormal results or follow-up needs can be noted below.

Preventive Service	Last Date	Preventive Service	Last Date	Preventive Service	Last Date
Routine physical / PCP visit	_____ ☐ Abn	Routine laboratory work	_____ ☐ Abn	Diabetes screening / A1c	_____ ☐ Abn
Colonoscopy	_____ ☐ Abn	Stool FIT / Cologuard	_____ ☐ Abn	Upper endoscopy (EGD)	_____ ☐ Abn
Mammogram	_____ ☐ Abn	Pap / cervical screening	_____ ☐ Abn	HPV testing	_____ ☐ Abn
DEXA / bone density	_____ ☐ Abn	Eye exam	_____ ☐ Abn	Dental exam	_____ ☐ Abn
PSA / prostate screening	_____ ☐ Abn	Low-dose chest CT / lung screening	_____ ☐ Abn	Total body skin exam	_____ ☐ Abn
EKG	_____ ☐ Abn	Diabetic retinal exam	_____ ☐ Abn	Other: _____	_____ ☐ Abn

IMMUNIZATION HISTORY

Vaccine	Most Recent Date	Vaccine	Most Recent Date
Influenza		RSV	
COVID-19		Hepatitis A	
Td/Tdap		Hepatitis B	
Shingles (Shingrix)		HPV	
Pneumococcal		Other	

If any test above was abnormal, briefly note the result / follow-up recommendation:

Patient Name		DOB	
--------------	--	-----	--

DETAILED FAMILY HISTORY

☐ Adopted ☐ Family history unknown / limited. Use full names and blood relationships unless otherwise noted. Living? Y = living; N = deceased. Include adoption status beside the name when relevant.

PARENTS & GRANDPARENTS

Relative	Name	Living? Y / N	Age / Age at Death	Major Conditions / Cause of Death
Mother		☐ Y ☐ N		
Father		☐ Y ☐ N		
Maternal Grandmother		☐ Y ☐ N		
Maternal Grandfather		☐ Y ☐ N		
Paternal Grandmother		☐ Y ☐ N		
Paternal Grandfather		☐ Y ☐ N		

SIBLINGS

Relative	Name	Living? Y / N	Age / Age at Death	Major Conditions / Cause of Death
Sibling 1 ☐ M ☐ F		☐ Y ☐ N		
Sibling 2 ☐ M ☐ F		☐ Y ☐ N		
Sibling 3 ☐ M ☐ F		☐ Y ☐ N		
Sibling 4 ☐ M ☐ F		☐ Y ☐ N		
Sibling 5 ☐ M ☐ F		☐ Y ☐ N		
Sibling 6 ☐ M ☐ F		☐ Y ☐ N		
Sibling 7 ☐ M ☐ F		☐ Y ☐ N		
Sibling 8 ☐ M ☐ F		☐ Y ☐ N		

CHILDREN

Relative	Name	Living? Y / N	Age / Age at Death	Major Conditions / Cause of Death
Child 1 ☐ M ☐ F		☐ Y ☐ N		
Child 2 ☐ M ☐ F		☐ Y ☐ N		
Child 3 ☐ M ☐ F		☐ Y ☐ N		
Child 4 ☐ M ☐ F		☐ Y ☐ N		
Child 5 ☐ M ☐ F		☐ Y ☐ N		
Child 6 ☐ M ☐ F		☐ Y ☐ N		
Child 7 ☐ M ☐ F		☐ Y ☐ N		
Child 8 ☐ M ☐ F		☐ Y ☐ N		

Patient Name		DOB	
---------------------	--	------------	--

DETAILED FAMILY HISTORY - CONDITIONS & CANCER

Write the family member name and full relationship, for example Mary Smith, mother. Use additional rows below if needed. No family member codes are needed.

ADDITIONAL FAMILY MEMBERS / CONTINUED ENTRIES

Relative	Name	Living? Y / N	Age / Age at Death	Major Conditions / Cause of Death
		☐ Y ☐ N		
		☐ Y ☐ N		

COMMON CONDITIONS IN BLOOD RELATIVES

Condition	Affected Family Member Name and Relationship
☐ Heart attack / coronary artery disease	
☐ Stroke / TIA	
☐ High blood pressure	
☐ High cholesterol	
☐ Aneurysm / sudden cardiac death	
☐ Diabetes	
☐ Blood clot / clotting disorder	
☐ Kidney disease	
☐ Liver disease	
☐ Thyroid disease	
☐ Osteoporosis / hip fracture	
☐ Asthma / COPD	
☐ Autoimmune disease	
☐ Seizure disorder	
☐ Dementia / Alzheimer's	
☐ Depression / bipolar / serious mental illness	
☐ Substance use disorder	
☐ Hereditary / genetic disorder	

FAMILY CANCER HISTORY - TYPE / PRIMARY SITE REQUIRED

Family Member Name / Relationship	Cancer Type / Primary Site	Age Diagnosed	Metastatic?	Sites of Spread / Notes
			☐ No ☐ Yes ☐ Unknown	
			☐ No ☐ Yes ☐ Unknown	
			☐ No ☐ Yes ☐ Unknown	

Patient Name	DOB	
---------------------	------------	--

CURRENT SYMPTOMS & SCREENING

PAIN / FALLS / URINARY SYMPTOMS

Pain today	☐ No ☐ Yes - location: _____		
Pain quality	☐ Aching ☐ Burning ☐ Stabbing ☐ Sharp ☐ Dull ☐ Other: _____		
Pain score (0-10)		Falls in past 12 months	☐ None ☐ 1 ☐ 2 or more
Fear of falling / unsteady	☐ No ☐ Yes	Urinary leakage	☐ No ☐ Yes - ☐ with cough/sneeze ☐ urgency ☐ without awareness

PHQ-2 DEPRESSION SCREEN

Over the last 2 weeks, how often have you been bothered by the following? Select one answer for each question.

Question	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐

REVIEW OF SYSTEMS - CURRENT SYMPTOMS

Check current symptoms only. Leave blank if not present.

GENERAL ☐ Fever ☐ Chills ☐ Fatigue ☐ Night sweats ☐ Weakness ☐ Unexplained weight gain / loss ☐ Appetite change ☐ Sleep disturbance	EYES / ENT / MOUTH ☐ Blurred / changed vision ☐ Double vision ☐ Eye pain / redness ☐ Dry eyes ☐ Flashes / floaters / vision loss ☐ Hearing loss ☐ Ringing in ears ☐ Ear pain / drainage ☐ Nasal congestion / sinus pressure ☐ Nosebleeds ☐ Sore throat / hoarseness ☐ Mouth sores / dental problems	URINARY / REPRODUCTIVE ☐ Pain / burning with urination ☐ Blood in urine ☐ Urgency / frequency ☐ Nighttime urination ☐ Leakage / incontinence ☐ Weak stream / difficulty starting ☐ Incomplete bladder emptying ☐ Genital discharge / sores ☐ Erectile / sexual concerns ☐ Vaginal dryness ☐ Abnormal bleeding / discharge
--	--	--

Patient Name	DOB
---------------------	------------

REVIEW OF SYSTEMS - CONTINUED

Check current symptoms only. Leave blank if not present. Describe checked symptoms or additional concerns below.

SKIN / ALLERGY ☐ Rash / itching ☐ Hives ☐ Changing mole / skin lesion ☐ Non-healing sore ☐ Hair / nail changes ☐ Seasonal / environmental allergy symptoms	HEART / CIRCULATION ☐ Chest pain / pressure ☐ Palpitations / racing heartbeat ☐ Leg / ankle swelling ☐ Shortness of breath lying flat ☐ Waking short of breath at night ☐ Fainting / near-fainting ☐ Lightheadedness	LUNGS / SLEEP ☐ Shortness of breath ☐ Cough ☐ Sputum / mucus ☐ Wheezing ☐ Coughing blood ☐ Loud snoring / witnessed apnea ☐ Excessive daytime sleepiness
NEURO / MEMORY ☐ Headache / migraine ☐ Dizziness / vertigo ☐ Numbness / tingling ☐ Focal weakness ☐ Tremor ☐ Seizure ☐ Loss of consciousness ☐ Balance / walking difficulty ☐ Memory / concentration change	GI / ENDOCRINE ☐ Heartburn / reflux ☐ Trouble swallowing ☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Bloating ☐ Diarrhea ☐ Constipation ☐ Black stool / blood in stool / rectal bleeding ☐ Change in bowel habits ☐ Excessive thirst / urination ☐ Heat / cold intolerance	MUSCLE / JOINT ☐ Back pain ☐ Neck pain ☐ Joint pain ☐ Joint swelling / stiffness ☐ Muscle aches ☐ Muscle weakness
MOOD / BLOOD ☐ Depression ☐ Anxiety / panic ☐ Mood swings / irritability ☐ Thoughts of self-harm ☐ Easy bruising / bleeding ☐ Swollen glands / lymph nodes	Additional symptom details 	

OTHER CURRENT SYMPTOMS / DETAILS

Symptoms and details including when symptoms began

Patient Name		DOB	
---------------------	--	------------	--

COMMUNICATION PREFERENCES, PHI DISCLOSURE & PRIVACY

HOW WE MAY CONTACT YOU

Patient Portal	☐ Yes ☐ No / Not enrolled	Text messages	☐ Yes ☐ No
Email for health care communications	☐ Yes ☐ No	Mail to home address	☐ Yes ☐ No
Home/Cell voicemail — appointments	☐ Yes ☐ No	Home/Cell voicemail — billing	☐ Yes ☐ No
Home/Cell voicemail — medical information	☐ Yes ☐ No	Home/Cell voicemail — prescriptions	☐ Yes ☐ No
Work voicemail — appointments	☐ Yes ☐ No	Work voicemail — billing	☐ Yes ☐ No
Work voicemail — medical information	☐ Yes ☐ No	Work voicemail — prescriptions	☐ Yes ☐ No
Preferred phone/email		Do not use / restrictions	

Email and standard text messaging may not be fully secure. By selecting these methods, you acknowledge the privacy risks and standard message/data rates. You may change communication preferences in writing or through the practice's approved process.

OPTIONAL MARKETING / AESTHETICS & WELLNESS INFORMATION

I would like to receive optional promotional or educational messages about aesthetic/wellness services	☐ Yes ☐ No
Preferred method for optional marketing	☐ Email ☐ Text ☐ Both ☐ None

This choice is voluntary and is not a condition of receiving medical care. You may opt out of marketing communications at any time.

PEOPLE AUTHORIZED TO RECEIVE INFORMATION

Name	Relationship	Phone	All	Appointments	Billing	Medical	Prescriptions
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have been offered or provided access to Rizzo Family Medicine's current Notice of Privacy Practices, which explains how my health information may be used or disclosed and describes my privacy rights. I understand that the practice may revise the notice as permitted by law and that the current notice is available from the practice upon request and through any location or website where the practice is required to make it available.

☐ I received/accessed the Notice ☐ I was offered a copy and declined a paper copy ☐ Patient declined/unable to acknowledge (staff document reason)

Patient/Representative Signature		Date	
Printed Name		Relationship (if representative)	

Patient Name		DOB	
CONSENT FOR TREATMENT & OFFICE POLICIES			
Consent for Treatment			
I voluntarily consent to evaluation and medically appropriate treatment by Rizzo Family Medicine and its clinicians and staff. I understand that medicine is not an exact science, that reasonable alternatives and material risks will be discussed when appropriate, and that no guarantee has been made regarding the outcome of care. I agree to provide accurate information and to notify the practice of significant changes in my health, medications, insurance, or contact information.			
Treatment, Payment & Health Care Operations			
I understand that the practice may use and disclose protected health information as permitted by federal and state law for treatment, payment, and health care operations, including care coordination, laboratory and imaging services, referrals, prescriptions, eligibility and benefits, billing, quality activities, and services performed by business associates under appropriate agreements. A separate authorization will be obtained when required by law.			
Prescription History / Medication Safety			
I authorize the practice, as permitted by law, to obtain medication history, pharmacy benefit information, controlled-substance monitoring information, and other medication-related data reasonably needed for treatment, prescribing safety, medication reconciliation, or insurance authorization.			
Audio-Assisted Documentation			
Some visits may use an audio-assisted documentation tool to help create accurate clinical notes. I understand that I may decline or withdraw permission without affecting my care. If used, audio will be handled under the practice's privacy/security procedures and applicable business-associate safeguards. ☐ I CONSENT ☐ I DO NOT CONSENT			
Appointments, Cancellations & Late Arrival			
Please provide at least 24 hours' notice when cancelling or rescheduling. Appointments not cancelled at least 24 hours in advance may be subject to a \$50 missed-appointment/late-cancellation fee that is not billed to insurance. If you arrive 15 minutes or more after your scheduled time, the visit may need to be rescheduled depending on clinical needs and the day's schedule.			
ACKNOWLEDGMENT			
By signing below, I acknowledge that I have reviewed the sections above, had an opportunity to ask questions, and agree to the applicable policies and consents. I understand that separate procedure-specific, medication-specific, or legally required consents may be necessary.			
Patient/Representative Signature		Date	
Printed Name		Relationship (if representative)	

Patient Name		DOB	
---------------------	--	------------	--

FINANCIAL RESPONSIBILITY & PAYMENT AUTHORIZATION

Financial Responsibility

Insurance coverage and benefit verification do not guarantee payment. I am responsible for applicable deductibles, copayments, coinsurance, non-covered services, services denied because required information or authorization was not provided, and other patient-responsibility amounts permitted by law and payer contracts. Payment is expected according to practice policy. Delinquent balances may be referred for collection, and legally permitted collection costs may be added where applicable.

Uninsured / Self-Pay Good Faith Estimates

If I do not have insurance or I choose not to use insurance for scheduled care, I understand that federal law generally gives me the right to receive a written Good Faith Estimate of expected charges when required. I may ask the practice for an estimate before scheduling or receiving non-emergency services. If an eligible bill is substantially higher than the estimate, federal dispute-resolution rights may apply.

CREDIT CARD ON FILE & PAYMENT AUTHORIZATION

Name on Card		Billing ZIP	
Card Type	☐ Visa ☐ MC ☐ AmEx ☐ Discover ☐ Other	Expiration	____ / ____
Card Last 4 Digits			
Card Storage	☐ Authorize secure card-on-file storage ☐ Do not keep a card on file		

Provide full payment card details through the office secure payment process.

I authorize Rizzo Family Medicine to securely maintain the payment card identified above through its payment processor and to charge it for amounts I am responsible for, including copays, deductibles, coinsurance, outstanding balances after insurance processing, the practice missed-appointment/late-cancellation fee, disclosed fees for requested forms or letters, and balances or installments for aesthetic/wellness packages or other services/products that I previously authorized or purchase. I understand I may revoke this card-on-file authorization for future charges by notifying the practice, but revocation does not affect charges already authorized or amounts already owed.

☐ I authorize the charges described above. ☐ I do not authorize card-on-file charges.

Cardholder / Patient Signature		Date	
Printed Name		Relationship (if representative)	

Patient Name		DOB	
---------------------	--	------------	--

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Patient Address		Phone	
City / State / ZIP		Email	

DIRECTION OF AUTHORIZATION - SELECT BELOW

☐ RIZZO FAMILY MEDICINE MAY RELEASE INFORMATION TO the organization/person below
☐ RIZZO FAMILY MEDICINE MAY OBTAIN INFORMATION FROM the organization/person below
 Rizzo Family Medicine: 2325 S. Tamiami Trail, Suite B, Sarasota, FL 34239 | Phone: 941-217-6864 | Fax: _____

Other Physician / Facility / Person		Phone	
Address		Fax	
City / State / ZIP		Secure Email (if applicable)	

PURPOSE, DATE RANGE & INFORMATION AUTHORIZED

Purpose	☐ Continuing care ☐ Changing physicians ☐ Personal use ☐ Insurance/payment ☐ Legal ☐ Other: _____	
Records Date Range	From: _____ To: _____ ☐ All dates	
☐ Entire designated record	☐ Office / progress notes	☐ Medical history & physical exams
☐ Laboratory reports	☐ Imaging reports	☐ Imaging images (if available)
☐ Pathology reports	☐ Operative / procedure reports	☐ Hospital records / discharge summaries
☐ Medication / prescription history	☐ Immunization records	☐ Billing / claim records
☐ Other: _____		

SENSITIVE INFORMATION — SPECIFIC AUTHORIZATION WHEN APPLICABLE

Check/initial any category you specifically authorize to be included, to the extent the records exist and disclosure is permitted by applicable law:

☐ Mental/behavioral health records ☐ Substance use disorder information ☐ HIV/AIDS or sexually transmitted infection information ☐ Genetic testing/information ☐ Other specially protected information: _____

Psychotherapy notes, when applicable, are not included by this authorization and require a separate authorization unless an exception under law applies.

AUTHORIZATION TERMS

I understand that this authorization is voluntary. I may revoke it in writing at any time, except to the extent action has already been taken in reliance on it. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization except when permitted by law. Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA, although other laws may continue to protect it. A copy, facsimile, or electronic copy of this signed authorization may be used as if it were the original. This authorization expires on the date or event stated below unless I revoke it earlier.

Expiration: ☐ One year from date signed ☐ On this date: _____ ☐ Upon this event related to the purpose of the authorization: _____

Patient/Representative Signature		Date	
Printed Name		Relationship (if representative)	

If signed by a legal representative, the representative may be asked to provide documentation of authority. The practice may use a narrower authorization if another law requires additional elements for a particular category of records.

Patient Name		DOB	
---------------------	--	------------	--

TELEHEALTH INFORMED CONSENT

What Telehealth Is

Telehealth uses secure telecommunications technology to provide health care when the patient and clinician are in different locations. Telehealth may be used for assessment, diagnosis, treatment, follow-up, education, medication management, and care coordination when clinically appropriate.

Potential Benefits

Potential benefits include improved access to care, reduced travel, faster follow-up, and continuity of care when an in-person visit is not necessary.

Potential Risks and Limitations

Telehealth may be limited by technology failure, poor audio/video quality, lack of hands-on examination, incomplete information, privacy/security events, or the need for urgent or in-person evaluation. The clinician may stop or convert a telehealth encounter to an in-person visit when necessary for safe care.

Privacy and Records

Telehealth services are documented in the medical record according to the same clinical standards used for in-person care. Medical records created through telehealth are handled under applicable privacy and confidentiality requirements. The visit will not be recorded, photographed, or otherwise captured by the practice unless separate permission is obtained when required.

Patient Responsibilities

At the start of a telehealth visit, I may be asked to confirm my identity, current physical location, a call-back number, and an emergency contact. I agree to participate from a reasonably private setting and to provide complete and accurate information. Telehealth is not a substitute for emergency care; I should call 911 or seek emergency services for an emergency.

Choice and Withdrawal

I may decline telehealth and request an in-person visit when reasonably available. I may withdraw consent to future telehealth care at any time without losing my right to other available care. My usual copay, deductible, coinsurance, or self-pay responsibility may apply to telehealth services.

TELEHEALTH CONSENT

☐ I CONSENT to the use of telehealth when clinically appropriate. ☐ I DO NOT CONSENT to telehealth at this time.

Patient/Representative Signature		Date	
Printed Name		Relationship (if representative)	

