WOODLANDS
MEDICAL SPECIALISTS

Welcome to Woodlands Medical Specialists.

We are honored that you have chosen us as your healthcare provider.

ABOUT WOODLANDS

We are a passionate, multi-disciplinary, physician-owned practice.

We work across specialties to provide highly coordinated and individualized treatment that is driven by one focus – our patients. Our physicians and providers believe in our unique and patient-centered approach to healthcare – an approach born of innovative thinking, fueled by passionate caregiving, and deeply rooted in the community.

Current physician specialties and services include **Hematology-Oncology, Urology, Pulmonology, Radiation Oncology, Primary Care, Fully Accredited Diagnostic Imaging Services, and a Women's Center for Breast Health.** We offer in-house laboratory services for our patients, ensuring that our physicians and providers have convenient and quicker access to your healthcare results.

APPOINTMENT DETAILS

Enclosed please find your appointment card, indicating the details of your upcoming, scheduled appointment including the service office location.

New patients are asked to arrive 30 minutes early to complete new patient forms. A late arrival may result in the rescheduling of your appointment.

We understand that sometimes appointments need to be changed. We ask that you call in advance if you cannot make your appointment. We require a 24-hour notice (1 full business day) of any appointment cancellations, so that we may accommodate the needs of another patient. Please be sure to review our cancellation policy in the forms enclosed.

YOUR FIRST VISIT

We understand that your time is valuable, so we have a few suggestions to help you get the most out of your first visit.

- Complete the New Patient Paperwork forms that are included with this packet and bring them to your upcoming, scheduled appointment. These forms are also available on our website at Woodlandsmed.com/patient-forms.
- Be sure to bring the following to your appointment:
  - Most recent insurance card(s)
  - Current driver's license or photo ID
  - A list of all your current medications

Welcome to our practice and thank you for choosing Woodlands Medical Specialists for your healthcare needs!

CORPORATE OFFICE
4724 N. DAVIS HWY, PENSACOLA, FL 32503
850-696-4000
WOODLANDSMED.COM

Revised 02/05/25

WOODLANDS
MEDICAL SPECIALISTS

Woodlands Medical Specialists is committed to providing our patients and their families with the highest quality healthcare. We are equally committed to ensuring our facilities and locations are safe, caring, and respectful environments for all who enter. We ask that patients and visitors follow the example of Woodlands' providers and staff by adhering to our Patient and Visitor Code of Conduct as follows:

- Everyone will be treated with kindness, dignity, and respect. Offensive comments about race, religion, gender, sexual orientation, or personal traits are not acceptable, and neither is the refusal to see a provider or associate based on these traits.
- All patients and visitors will use respectful, appropriate language and behavior. Physical or verbal threats or assaults, suggestive or explicit words, phrases, gestures, or actions will not be tolerated.
- All patients and visitors will respect patient privacy and avoid disrupting other patients' care or experiences.
- All patients and visitors must obtain the consent of everyone involved for any photographing or video/audio recording within all Woodlands locations.

If these guidelines are not followed:

- If patients choose to violate this code of conduct, they may be asked to leave and make other plans for their future healthcare.
- If visitors choose to violate this code of conduct, they may be asked to leave and could be restricted from any future visitation.

Every day, our providers and staff are committed to providing our patients with the highest levels of care. Please show them the respect they deserve and that you expect as a patient or visitor.

Thank you for choosing Woodlands Medical Specialists and joining us in our commitment to ensuring a safe, caring, and respectful environment for us all.

CORPORATE OFFICE **850-696-4000**
4724 N. DAVIS HWY, PENSACOLA, FL 32503 **WOODLANDSMED.COM**
Revised 02/05/25

WOODLANDS
MEDICAL SPECIALISTS

New Patient Paperwork

Date:	**Name (Last, First, M.I.):**		
Date of Birth:	**Social Security #:**		
Primary Phone:	**Cell Phone:**		
Address:	**City:**	**State:**	**Zip Code:**
Email Address:			
Patient's Previous/Maiden Name(s):			

Sex: _____

Gender: _____

Race: _____

Ethnicity: _____

Emergency Contact Information:

Name: _____

Phone: _____

Relationship: _____

Previous/Current Primary Care Physician:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Please list any other physicians that contribute to your health care:

NAME & CONTACT NUMBER	SPECIALITY	DATE OF LAST VISIT

CURRENT MEDICAL PROBLEMS

Please list any concerns or problems you would like to address with your physician

☐ Hypertension	☐ Kidney stones	☐ HIV / AIDS	☐ Insomnia	☐ Hypogonadism (low testosterone)
☐ Diabetes	☐ Enlarged prostate	☐ Hepatitis C	☐ Depression	☐ Bladder Cancer
☐ High cholesterol	☐ Urinary incontinence	☐ Cirrhosis	☐ Osteoporosis	☐ Kidney Cancer
☐ Heart disease	☐ Chronic pain	☐ Stomach ulcer	☐ Osteopenia	☐ Prostate Cancer
☐ Heart attack	☐ Arthritis, degenerative	☐ GERD / reflux	☐ Blood Clots (legs/lung)	☐ Cancer (Specify)
☐ Abnormal heart valve	☐ Arthritis, rheumatoid	☐ Irritable bowel disease	☐ Crohn's Disease	☐ Cancer (Specify)
☐ Heart failure	☐ Arthritis, gout	☐ Seizures	☐ Ulcerative Colitis	☐ Cancer (Specify)
☐ Stroke	☐ COPD	☐ Migraine headaches	☐ UTI	☐ Other (Specify)
☐ Kidney Disease	☐ Asthma	☐ Sleep apnea	☐ Erectile Dysfunction	☐ Other (Specify)
☐ Thyroid Problems	☐ Glaucoma	☐ Anxiety	☐ Pregnant #_____times	☐ Congestive Heart Failure

Exposure to: ☐ Asbestos ☐ Chemicals ☐ Ionizing Radiation

WOODLANDS
MEDICAL SPECIALISTS

New Patient Paperwork

IMMUNIZATIONS & DATES - If checked, please provide date(s)		
☐ Influenza	☐ Hepatitis B	☐ MMR *Measles, Mumps, Rubella*
☐ Pneumonia	☐ Shingles / Zoster	☐ Tdap *Tetanus, diphtheria, pertussis*
COVID Vaccine: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson 1st Dose Date: _____, 2nd Dose Date: _____, 1st Booster Date: _____, 2nd Booster Date: _____		

HEALTH SCREENING TESTS				
Mammogram	☐ Normal	☐ Abnormal	Date:	Provider:
Colonoscopy	☐ Normal	☐ Abnormal	Date:	Provider:
Fecal occult blood	☐ Normal	☐ Abnormal	Date:	Provider:
Pap smear	☐ Normal	☐ Abnormal	Date:	Provider:
Bone density (DEXA)	☐ Normal	☐ Abnormal	Date:	Provider:
Prostate specific antigen (PSA)	☐ Normal	☐ Abnormal	Date:	Provider:
Lipid profile (cholesterol)	☐ Normal	☐ Abnormal	Date:	Provider:
Electrocardiogram (EKG)	☐ Normal	☐ Abnormal	Date:	Provider:
Cardiac stress test	☐ Normal	☐ Abnormal	Date:	Provider:

PAST HOSPITALIZATIONS		
Reason	**Year**	**Hospital**

SURGICAL HISTORY		
Operation	**Year**	**Surgeon**

ALLERGIES TO MEDICATIONS	
Name the Drug	Reaction You Had

MEDICATIONS
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers
***Provide Your Local Pharmacy Name & Phone:**

Name the Drug	Strength	Frequency Taken

MEDICATIONS CONTINUED **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** ***Provide Your Local Pharmacy Name & Phone:**		

SOCIAL HISTORY
Place of Birth:
Occupation:
Travel outside of USA: ☐ No ☐ Yes
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
Tobacco	Do you use or have you ever used tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks. /day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Vaping	Do you use or have you ever vaped?			☐ Yes	☐ No
	☐ # of years	☐ Or year quit			
Sex	How many sexual partners have you had in the past six months?				
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness or other sexual transmitted diseases?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
Depression	In the past two weeks have you felt down, depressed or hopeless?			☐ Yes	☐ No
	In the past two weeks have you felt little interest or pleasure in doing things?			☐ Yes	☐ No
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Domestic Violence	Over the last 12 months, has anyone close to you hurt, hit or threatened you?			☐ Yes	☐ No
Drugs	Do you currently use recreational or illicit drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

WOODLANDS
MEDICAL SPECIALISTS

New Patient Paperwork

FAMILY HISTORY				
RELATIVE	**AGE (CURRENT OR AT DATE OF DEATH)**	**HEART ATTACK OR STROKE**	**CANCER**	**OTHER HEALTH PROBLEMS**
Mother	☐ Deceased	Heart Attack ☐ No ☐ Yes, Age: ______ Stroke ☐ No ☐ Yes, Age: ______	☐ No ☐ Yes (type) ______________	
Father	☐ Deceased	Heart Attack ☐ No ☐ Yes, Age: ______ Stroke ☐ No ☐ Yes, Age: _______	☐ No ☐ Yes (type) ______________	
Sibling ☐ Brother ☐ Sister	☐ Deceased	Heart Attack ☐ No ☐ Yes, Age: ______ Stroke ☐ No ☐ Yes, Age: ______	☐ No ☐ Yes (type) ______________	
Sibling ☐ Brother ☐ Sister	☐ Deceased	Heart Attack ☐ No ☐ Yes, Age: ______ Stroke ☐ No ☐ Yes, Age: ______	☐ No ☐ Yes (type) ______________	
Sibling ☐ Brother ☐ Sister	☐ Deceased	Heart Attack ☐ No ☐ Yes, Age: ______ Stroke ☐ No ☐ Yes, Age: ______	☐ No ☐ Yes (type) ______________	
Sibling ☐ Brother ☐ Sister	☐ Deceased	Heart Attack ☐ No ☐ Yes, Age: ______ Stroke ☐ No ☐ Yes, Age: ______	☐ No ☐ Yes (type) ______________	
Sibling ☐ Brother ☐ Sister	☐ Deceased	Heart Attack ☐ No ☐ Yes, Age: ______ Stroke ☐ No ☐ Yes, Age: ______	☐ No ☐ Yes (type) ______________	
Grandmother *Maternal*	☐ Deceased	Heart Attack ☐ No ☐ Yes, Age: ______ Stroke ☐ No ☐ Yes, Age: ______	☐ No ☐ Yes (type) ______________	
Grandfather *Maternal*	☐ Deceased	Heart Attack ☐ No ☐ Yes, Age: ______ Stroke ☐ No ☐ Yes, Age: ______	☐ No ☐ Yes (type) ______________	
Grandmother *Paternal*	☐ Deceased	Heart Attack ☐ No ☐ Yes, Age: ______ Stroke ☐ No ☐ Yes, Age: ______	☐ No ☐ Yes (type) ______________	
Grandfather *Paternal*	☐ Deceased	Heart Attack ☐ No ☐ Yes, Age: ______ Stroke ☐ No ☐ Yes, Age: _____	☐ No ☐ Yes (type) ______________	

WOODLANDS
MEDICAL SPECIALISTS

New Patient Paperwork

Patient Name: Patient Date of Birth:

APPOINTMENT REMINDERS AND $25 CANCELLATION FEE POLICY

Woodlands Medical Specialists uses various types of electronic communication to remind patients of appointments. If you do not wish to receive these reminders you do have the ability to opt out. Please know, if you are unable to keep your scheduled doctor's appointment, we require a 24-hour notice. In the event notification is not received 24 hours in advance of the doctor's appointment, the patient is charged a $25 fee. This fee also applies to any work-in appointment that is missed or cancelled.

Patient Initials_____

PRESCRIPTION REFILL POLICY

I understand my doctor's refill policy:

1. Prescription refills MUST be requested through your pharmacy.
2. Refills ARE NOT given at night or on weekends.
3. Refills are provided by my doctor only. I will not ask other physicians for refills.
4. Refills ARE NOT given for lost, stolen, spilled, misplaced or "used up early" medications. NO EMERGENCY REFILLS.
5. Some insurances may take 7-10 days for prior authorization to be complete.

Patient Initials_____

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION (HIPAA CONSENT)

I authorize Woodlands Medical Specialists to disclose my health care, billing, and medication/prescription information to those that I designate. I further provide authorization for these individuals to pick up prescriptions and/or medications on my behalf.

Name_____ Relationship _____ Phone _____

Name_____ Relationship _____ Phone _____

Name_____ Relationship _____ Phone _____

Patient Initials_____

NOTICE OF PRIVACY PRACTICES

I have the right to review the "Notice of Practices", prior to signing this consent and agree with these privacy policies.

Patient Initials_____

FINANCIAL POLICY

I hereby authorize Woodlands Medical Specialists to release any medical information required during the course of my examination and treatment to my insurance company, and I permit payment to Woodlands Medical Specialists from my insurance for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible, and non-covered services. I understand that I am responsible for all charges incurred regardless of insurance status. I agree to pay for services incurred after the patient has been charged for the office visit, such as labs, radiology, medical supplies, etc. I agree to pay my bill in full for services rendered by Woodlands Medical Specialists.

Patient Initials_____

Signature of Patient or Legal Representative: _____ Date: _____

EMPLOYEE DEMOGRAPHICS VERIFICATION STATEMENT

By signing this document, I acknowledge that I have followed the Woodlands Medical Specialists process to accurately verify and update this patient's demographics, including full name, date of birth, full address, phone number(s), email address, and insurance information, in the practice management system.

Signature of Employee: _____ Date: _____

WOODLANDS
MEDICAL SPECIALISTS

New Patient Paperwork

4724 N. Davis Hwy
Pensacola, FL 32503
850-696-4000

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Name: _____ Patient Date of Birth: _____

INFORMATION MAY BE DISCLOSED BY: (Please list the name of the provider or facility)

Person/Facility: _____ Phone #: _____

Street Address: _____

City, State, and Zip Code: _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: Woodlands Medical Specialists Provider/Department Name: _____

METHOD OF DISCLOSURE:

_____ Patient pick up at Clinic/Facility (The patient will pick up their records and hand carry them to Woodlands Medical Specialists.)
_____ Mail to Address: _____
_____ Fax #: _____

INFORMATION TO BE DISCLOSED:

- I authorize the above name person/facility to disclose my health care and billing information to Woodlands Medical Specialists.
- I provide authorization to Woodlands Medical Specialists to request any and all medical records my provider deems necessary for adequate and thorough care.

I specifically authorize release of information relating to: (initial selection)

_____Psychiatric, Psychological or Psychotherapeutic notes (or other information regarding my treatment and/or hospitalizations for psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia).
_____ Specific Laboratory Tests of HIV Infection (Human Immunodeficiency Virus, the causative agent of AIDS).
_____ The diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions.

PURPOSE OF DISCLOSURE:

_____ Continuity of Care _____ Personal Use _____ Other (specify)_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: 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 form 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 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 revocation 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, Medicaid, and Medicare.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Printed Name Legal Representative's Relationship to Patient

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to the request this information (for example, power of attorney, healthcare surrogate form, order, appointment of a guardianship, order appointing personal representative, letters of administration).