Charles Ahner, M.D.
25 NE Dixie Hwy.
Stuart, FL 34994
P (772) 692-9200 F (772) 692-9888

REGISTRATION SLIP

PLEASE PRINT Date _____

Name _____

Address _____

City _____ Zip _____

Telephone _____ Birth Date _____ Gender _____

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced

Social Security #: _____ Medicare #: _____

Occupation _____ Phone #: _____

Employed by _____

Employers Address _____

Name of Spouse _____

or Parent _____

Occupation _____ Phone #: _____

Employed by _____

Employers Address _____

Who is responsible for payment of the bill? _____

Method of Payment: ◯ Cash ◯ Check ◯ Credit Card

How did you hear about the Ahner Health and Medical Center? ◯ Patient (Please Name)

_____ ◯ TV ◯ Radio ◯ Newspaper ◯ Seminar ◯ Other _____

Email Address _____

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WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I _____, understand that as part of my healthcare, Ahner Medical Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care of treatment. I understand that this information serves as :

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that serviced billed were actually provided

I understand and can be provided with a Notice of Privacy Policies that provides a more complete description of information, uses and disclosures upon request.

I further understand that Ahner Medical Center reserves the right to change the practices privacy policies and that I may request a copy of such revised notice.

_____ _____

Patient Signature Date

I would also like for _____ to be able to discuss my health with the Ahner Medical Center and their staff.

_____ _____

Patient Signature Date

FOR OFFICE USE ONLY

Written Acknowledgement not signed due to:

_____ Patient refusal

_____ Emergency situation

_____ Other _____

_____ _____

Office Staff Signature Date

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Health History Form

Symptoms and problems:

List your symptoms/problems. Score them 1-5 (1=least bothersome, 5=most bothersome)

Medications:

List all your medications, dosages, and frequency. Include over the counter and supplements.

Pharmacy:

Which pharmacy do you use? Location and phone number if available:

List any hospitalizations/operations within the last year:

Health Maintenance:

Date of your last exam and result (Negative or Positive)

Mammogram _____
Colonoscopy _____
Bone Density _____
Prostate Exam _____
PSA _____
Pelvic Exam _____
EKG _____
Echogram _____
Stress Test _____
Angiogram _____
Eye Exam _____

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Health History Form

Do you have any of the following? Check those which apply:

	YES	NO		YES	NO
Weight loss/Gain			Fatigue		
Headache			Dizziness		
Fainting			Visual Changes		
Ringing in ears			Nose bleeds		
Nasal Discharge			Sinus pain		
Trouble swallowing			Sore throat		
Cough (Dry or phlegm)			Night Sweats		
Shortness of breath			TB exposure		
Chest pains			Palpitations		
Sleep flat			Bowel changes		
Blood/black stools			Abdominal pain		
Diarrhea/constipation			Nausea/vomiting		
Urinary flow problem			Urinary infections		
Muscle aches/pains			Joint pains		
Joint swelling/redness			Weakness		
Pain in legs with walking			Excessive thirst		
Excessive urination			Thyroid disorder		
Anemia (Low blood count)			Blood transfusion		
Any skin changes			Decreased sex drive		
Any change in behavior			Depression		
Hormone replacement			Age of menopause		

List any medicine allergies and what happens when you take that medication:

Other information you wish to share with the Doctor:

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Dear patients,

Due to an increasing problem with the insurance companies not paying for medications we may prescribe, we are willing to fill out the initial prior authorization forms required by your insurance company. If medication is denied there is nothing further we can do. It is your decision at that time whether you would like to pay for the medication out of pocket or not take it.

Sincerely,
Charles E. Ahner, M.D.

_____

Patient Signature

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Dear patients,

Ahner Medical Center will not be held responsible for any lab tests that are not covered by your health insurance. Any tests not covered by your insurance company, are your responsibility, not ours. We code according to your diagnosis or screening test seen necessary by Dr. Ahner.

Also, please understand that we cannot take responsibility for mistakes, or slow "turn around time" with outside labs. We will try to get your lab results for your return office visit, or we will reschedule your office visit until the labs are back. For this reason, it is important that we know where you are having your labs drawn. **LAB RESULTS OR ADVICE ARE NOT GIVEN OVER THE PHONE.** We will, however, be happy to schedule an appointment with Dr. Ahner to discuss them with you.

Thank you,

Ahner Medical Staff

_____ _____

Patient Signature Date

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INFORMED CONSENT FOR HORMONE REPLACEMENT THERAPY

I _____ have been informed that any hormone replacement therapy may have side effects.

Hormone replacement therapy using estrogen may be associated with an increased risk of breast cancer, blood clots, high blood pressure and possibly gall bladder disease (if taken by mouth). Estrogen replacement without the use of natural progesterone may increase the risk of endometrial cancer. I am aware that even though the estrogen replacement contains natural hormones and has been shown to reduce heart attacks, strokes and prevent bone loss, there is still some risk of cancer and blood clots. I agree that I will be tested frequently on the advice of Dr. Ahner. I will have yearly gynecological examinations which will include a Pap Smear if applicable and endometrial biopsy or ultrasound at the discretion of Dr. Ahner or your gynecologist. I also agree to have a yearly breast examination and will do monthly self-examinations on my breasts. If recommended, I will have a Mammogram on a yearly basis. Testosterone replacement in females carries little risk; however, since testosterone is a male hormone, it can produce changes in libido, body hair and may cause an imbalance in estrogen therapy.

Testosterone replacement in males carries some risk of increased prostate cancer and may cause an increase in estrogen levels. If an estrogen blocker is prescribed, I will take it or discontinue testosterone therapy. I am aware of these risks and I agree to have periodic and timely checks of my PSA, TESTOSTERONE AND ESTROGEN levels.

DHEA (dehydroepiandrosterone) replacement in both men and women carries small risks; however, there is no uniform consensus. It is believed possible that in some cases DHEA may increase cancer growth if cancer is present. DHEA is sold over the counter and therefore the federal government feels there is limited risk. I am aware of the potential risks and I agree to have my DHEA levels checked periodically at Dr. Ahner's request.

I further agree that I will keep all of my HRT appointments for office visits and lab work as requested by Dr. Ahner. I also agree to let Dr. Ahner know of any changes I make to my hormone replacement program. To inform Dr. Ahner of any and all potential side effects that might be possibly due to HRT and any changes to my medications and supplements. I realize that HRT is still controversial and has not yet reached total consensus in the medical community.

_____ _____

Patient Signature Date