PATIENT REGISTRATION FORM

Last Name: ______________________ First Name: __________________ Middle Initial: _____

Marital Status: ☐ Single ☐ Married ☐ Cohabitating (living together) ☐ Divorced/Separated

Occupation: ____

Street Address (not PO Box): ____

City: ______________________________ State: _________ Zip Code: __________________

Date of Birth: __________________ E-Mail Address: __________________________________

Must have email address to be seen by Dr. Thomas

Daytime Phone: _________________________ Evening Phone: _________________________

Primary Care Physician's Name & Phone Number: _____________________________________

Must have primary care physician to be seen by Dr. Thomas

Emergency Contact Name & Phone Number: ____

Preferred Lab: ☐ LabCorp ☐ Quest ☐ Self-Pay ☐ Other: __________________________

Preferred Pharmacy's Name & Phone Number: ____

How did you hear about us? ____

Please review, initial, and sign below:

_______ I acknowledge receiving a copy of the Notice of Privacy Practices.

_______ By supplying my email address above, I understand that I am grating permission for the office of Dr. Daniel Thomas to communicate with me by email for such things as laboratory results, appointment reminders, health updates, and responding to medical questions.

_______ Dr. Thomas is "opted-out" of Medicare and is NOT a Medicare provider. Therefore, I understand that this office will NOT bill Medicare and I am NOT eligible for Medicare reimbursement or reimbursement from a Medicare supplement, nor a Medicare HMO plan for services rendered by Dr. Thomas.

_______ I understand that Dr. Thomas does NOT accept any form of insurance or bill directly to my insurance company. However, if you have health insurance coverage or an HSA (Health Savings Account), we will help you get reimbursed for some of your expenses by referring you to our outside medical billing service who can file a medical claim on your behalf after each office visit.

______________________________________ ______________________

Patient Signature Date

MEDICAL HISTORY FORM

Name: ____ Today's Date: ____________

Date of Birth: ____________ Age: _____ Height: ________ Weight: ________ Gender: ☐ M ☐ F

SIGNS AND SYMPTOMS: Please check if you are experiencing any of the following:

Men and Women:
- ☐ Decreased Energy/Stamina
- ☐ Decreased Sex Drive
- ☐ Difficulty Concentrating
- ☐ Lack of Mental Clarity
- ☐ Decreased Short-Term Memory
- ☐ Difficulty Sleeping
- ☐ Irritability or Grumpiness
- ☐ Sadness or Depression

Men and Women:
- ☐ Anxiety
- ☐ Decreased Motivation
- ☐ Weight Gain or Excess Fat
- ☐ Loss of Muscle Mass or Strength
- ☐ Decreased Response to Exercise
- ☐ Joint Pain or Muscle Aches
- ☐ Migraine/Severe Headaches
- ☐ High Cholesterol

Men Only:
- ☐ Weak Erections

Women Only:
- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Vaginal Dryness
- ☐ Sagging Breasts
- ☐ Fibrocystic Breasts

MEDICAL HISTORY: Please check if you have OR have ever had any of the following:

Men & Women:
- ☐ Diabetes or Pre-Diabetes
- ☐ High Blood Pressure
- ☐ Heart Attack or Stroke
- ☐ Head trauma of any kind
- ☐ Parkinson's disease
- ☐ Bipolar Disorder
- ☐ Depression or Anxiety
- ☐ Attention Deficit Disorder
- ☐ Sleep Apnea

Men & Women:
- ☐ Alcoholism
- ☐ Family History of Dementia
- ☐ Family History of Cancer
- ☐ Kidney Disease
- ☐ Low Thyroid
- ☐ Hepatitis or Liver Disease
- ☐ HIV Positive
- ☐ Osteopenia or Osteoporosis
- ☐ Phlebitis or Blood Clots

Men Only:
- ☐ Prostate Enlargement
- ☐ Prostate Cancer
- ☐ Breast Cancer

Women Only:
- ☐ Uterine Fibroids
- ☐ Uterine Cancer
- ☐ Breast Cancer

Men Only: Date of Last Prostate Exam: ____________ Results: ________________________

Women Only: Do you still have periods? ☐ Yes ☐ No First Day of Last Period: ____________

Date of Last Mammogram: ___________ Results: ________________________

Date of Last Pelvic Exam: ___________ Results: ________________________

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE FOR ANY ILLNESSES OR CONDITIONS?

☐ Yes ☐ No *If yes, please explain*: ____

____

____

____

____

PREVIOUS HOSPITALIZATIONS OR SURGERIES: ________________________________

____

____

____

____

Continued on Next Page

MEDICAL HISTORY FORM cont'd

CURRENT MEDICATIONS (prescription and over-the-counter) AND VITAMIN SUPPLEMENTS:

Name	Dosage	Frequency

MEDICATION ALLERGIES: ____

LIFESTYLE:

What is your overall stress level? ☐ Mild ☐ Moderate ☐ Severe
Do you engage in strength-training exercise at least 3 days per week? ☐ No ☐ Yes
How many hours do you sit each day? ______
Do you smoke, chew tobacco, or vape? ☐ No ☐ Yes
Do you drink alcoholic beverages? ☐ No ☐ Yes *Times per week?* ______
Hours of sleep per night: ______
Number of glasses of pure water per day: ______
Number of cups of coffee, tea, or caffeinated soda per day: ______
Number of servings of fruit and vegetables per day: ______
Who does your grocery shopping? ___________________________
Who cooks your meals? ___________________________
Highest educational level achieved: ☐ Grade School ☐ High School ☐ College ☐ Graduate School
Number of hours per week spent with friends face-to-face: ______
Do you engage in lifelong learning activities? ☐ No ☐ Yes
Women: Do you get your hair and/or nails done on a regular basis? ☐ No ☐ Yes

Continued on Next Page

MEDICAL HISTORY FORM cont'd

FAMILY HISTORY: Did your mother or father have a heart attack before age 60? ☐ No ☐ Yes

HEALTH RATING: With 1 being "poor" and 10 being "excellent," on a scale of 1-10, please circle below how you would rate your overall health right now:

1 2 3 4 5 6 7 8 9 10

WHEN WAS THE LAST TIME YOU FELT REALLY GOOD? ___________________________________

GOALS OF TREATMENT: Please check any of the following that you would like to achieve:

☐ Have more energy
☐ Sleep well
☐ Have better digestion
☐ Be able to eat a greater variety of foods
☐ Get rid of my allergies
☐ Have a stronger immune system (e.g., less colds and flus)
☐ No longer use laxatives or stool softeners
☐ Be able to exercise again
☐ Have better muscle tone
☐ Have less pain
☐ No longer use pain medication
☐ No longer use allergy medication
☐ No longer use sleep medication
☐ Feel less sleepy in the afternoon
☐ Lose weight
☐ Increase my sex drive
☐ Have less hot flashes and/or night sweats
☐ Increase my metabolism to burn more fat
☐ Increase my flexibility
☐ Reduce my stress
☐ Improve my memory
☐ Be more mentally focused
☐ Have more stable moods
☐ Have stronger erections
☐ Have fewer headaches

COMMITMENT: To be effective, preventing or reversing disease often requires profound changes in diet and lifestyle. This means getting rid of bad habits and replacing them with good ones. On a scale of 1-10, our commitment to your health and well-being is a 10. So as not to waste our time or yours, on a scale of 1-10, how strong is your commitment to do what it takes to improve and/or maintain your health?

1 2 3 4 5 6 7 8 9 10

QUESTIONS AND CONCERNS: Please write down the items you would like to discuss with Dr. Thomas:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

BIOLOGICAL AGE CALCULATOR

Name: ______________________________________ Age: ______ Today's Date:_______________

How old are you really and which is more accurate: Chronological age or biological age? Biological age is the measure of your inner health, which is influenced by genetics and lifestyle choices. Biological age is an indicator of your TRUE age because it measures how well you are taking care of yourself. For example, a well-maintained car will run for a long time. Conversely, a poorly-maintained car will break down within a few years. Your body is no different. It requires proper maintenance to support a long and healthy life.

The Biological Age Calculator is divided into five sections with a total of 26 questions. Choose and write the number that best answers each question. To achieve an accurate measure of your biological age, it is crucial to answer the questions as accurately and honestly as possible.

SECTION A: Dietary Choices

1. How often do you eat fried, broiled, or barbequed foods?

   More than once a day (4)
   Once a day (3) Number: ______
   Few times per week (2)
   Once a week (1)
   Almost never (-2)

2. How often do you eat healthy fats, such as olive oil, flax seed oil, coconut oil, or avocados?

   Almost never (2)
   Once a week (1) Number: ______
   Once a day (0)
   2+ times per day (-1)

3. How many servings of fruits or vegetables do you eat? (1 serving = 1 cup)

   Almost never (3)
   Few times per week (2) Number: ______
   One per day (1)
   3 per day (-1)
   5+ per day (-2)

4. How often do you eat whole grains and/or take a natural fiber supplement?

   Almost never (3)
   Once a week (2) Number: ______
   Few times per week (1)
   Often (-2)

6. How many glasses of plain water do you drink?

   Almost never (3)
   One per day (2) Number: ______
   4 per day (1)
   6 per day (0)
   8+ per day (-2)

7. Do you consume sugar, soda, white flour, or other refined/processed foods?

   3+ times per week (3)
   Once a day (2) Number: ______
   Few times per week (1)
   Almost never (-1)

8. How many alcoholic drinks do you consume per week?

   12+ per week (3)
   8 per week (2) Number: ______
   4 per week (1)
   1-2 per week (0)
   None (-1)

9. How often do you add salt to your food?

   All food (3)
   Daily (2) Number: ______
   Few times per week (1)
   Once a month (0)
   Almost Never (-1)

TOTAL SCORE FOR SECTION A: ______

SECTION B: Dietary Supplementation

10. Do you take a multivitamin?

    Almost never (2) Number: ______
    Once a week (1)
    Few times per week (0)
    Daily (-1)

11. Do you take a separate antioxidant supplement, such as vitamin C or E?

    Almost never (3) Number: ______
    Once a week (2)
    Few times per week (1)
    Daily (-2)

TOTAL SCORE FOR SECTION B: ______

SECTION C: Daily Activities

12. How often do you exercise (30 or more minutes of continuous activity)?

    Almost never (3)
    Once a week (2) Number: ______
    3 times per week (-2)
    5+ times per week (-3)

13. When you exercise, do you do so for more than 2 hours straight?
    (If you do not exercise, please put “0” as your answer.)

    Most times (4)
    50% of the time (2) Number: ______
    Almost Never (0)

14. Do you sleep well and awaken feeling fully rested?

    Almost never (3)
    Sometimes (2) Number: ______
    Usually (0)
    Always (-1)

15. How often do you have normal bowel movements?

    Once a week (4)
    Every 4 days (3) Number: ______
    Every second day (2)
    Daily (0)
    2+ times per day (-2)

TOTAL SCORE FOR SECTION C: ______

SECTION D: MEDICAL HISTORY

16. Do you have a family history of any of the following conditions: Cancer, diabetes, heart disease, depression, obesity, liver disease, high cholesterol, or high blood pressure?

    2 or more (1)
    One (0) Number: ______
    None (-1)

17. Have you personally had any of the following conditions: Cancer, diabetes, heart disease, depression, obesity, liver disease, high cholesterol, or high blood pressure?

    2 or more (4)
    One (3) Number: ______
    None (-2)

18. How often do you experience any of the following: Headaches, fever, sore throats, muscle aches (not exercise induced), colds or flu, rash, or swelling?

    Once a day (3)
    Once a week (2) Number: ______
    Once a month (0)
    Almost never (-1)

19. How often are you exposed to heavy metals or toxic substances? (Examples: Mechanics, hair dressers, nail salons, etc.)

    Daily (4)
    Weekly (3) Number: ______
    Monthly (2)
    Almost never (0)

20. How many mercury dental fillings do you have?

    3+ fillings (4)
    2 fillings (3) Number: ______
    1 filling (2)
    None (0)

TOTAL SCORE FOR SECTION D: ______

SECTION E: STRESS

21. How many full meals do you eat per day? (A snack is not a full meal.)

    Never (3)
    4+ per day (2) Number: ______
    3 per day (0)
    2 per day (1)
    One per day (2)

22. At work or at home, how often are you in front of electronic equipment? (Examples: Computers, television, live cameras, electrical wires.)

    8+ hours per day (3)
    6+ hours per day (2) Number: ______
    Few hours per day (1)
    Almost never (0)

23. How often are you exposed to cigarette or other smoke (direct or second-hand)?

    All day (4)
    Few times a day (3) Number: ______
    Few times per week (1)
    Almost never (-1)

24. Do you use recreational or street drugs?

    2+ times per day (4)
    Once a day (3) Number: ______
    Once a week (2)
    Once a month (1)
    Never (0)

25. Do you drive in heavy traffic?

    For a living (3)
    Daily (3+ hours) (2) Number: ______
    Daily (1-2 hours) (1)
    Almost never (-1)

26. At work and/or home, how much stress do you experience?

    Very high (4)
    High (3) Number: ______
    Moderate (2)
    Slight (1)
    Almost none (-2)

TOTAL SCORE FOR SECTION E: ______

TO CALCULATE YOUR BIOLOGICAL AGE, ADD YOUR AGE AND SCORES FROM SECTIONS A-E:

AGE: ______
SECTION A: ______
SECTION B: ______
SECTION C: ______
SECTION D: ______
SECTION E: ______
BIOLOGICAL AGE: **TOTAL:** ______

INFORMED CONSENT

Patient Name: ________________________________ Date of Birth: __________________

Florida's freedom of medicine law allows physicians to choose therapies they feel will most benefit their patients, and allows patients to choose the kind of medical care they feel is best for them. Under the law, you are permitted to make informed choices for any type of medical care you deem to be an effective option for treating disease, pain, injury, deformity, or other physical or mental condition. You are permitted to choose from all healthcare options, including the prevailing or conventional treatment methods, as well as other treatments designed to complement or substitute for the prevailing or conventional treatment methods. As such. healthcare practitioners are permitted to offer complementary or alternative health care treatments with the same requirements, provisions, and liabilities as those associated with the prevailing or conventional treatment methods.

Dr. Daniel Thomas, DO, MS provides complementary and alternative treatment. Under Florida law, this is defined as: "Any treatment that is designed to provide patients with an effective option to the prevailing or conventional treatment methods associated with the services provided by a health care practitioner. Such a treatment may be provided in addition to or in place of other treatment options." Dr. Thomas may, in his discretion and without restriction, recommend any mode of treatment that is, in his judgment, in your best interest, including complementary or alternative health care treatments. Dr. Thomas is not a substitute for your primary-care physician and the medical care that he or she provides.

Dr. Thomas has been in practice since 1987. He has a Bachelor of Science degree in biochemistry from Andrews University and a medical doctorate from Des Moines University. Dr. Thomas served his hospital internship at Northwest General Hospital in Milwaukee, Wisconsin. He also has a Master of Science degree in Metabolic and Nutritional Medicine from the University of South Florida College of Medicine, as well as a Graduate Certificate in Metabolic Endocrinology and a Graduate Certificate in Brain Fitness & Memory Management, also from the University of South Florida College of Medicine. Dr. Thomas has Certificate in Plant-Based Nutrition from Cornell University, and he completed a Fellowship in Integrative Cancer Therapies with The Metabolic Medical Institute.

If Dr. Thomas offers to provide a you with complementary or alternative health care treatment, he will inform you of the nature of the treatment, and will explain the benefits and risks associated with the treatment to the extent necessary for you to make an informed and prudent decision regarding such treatment options.

By signing this form, you acknowledge that you understand the above information, and that you are consenting to a medical consultation and/or treatment with Dr. Thomas. Furthermore, you declare that you are seeing Dr. Thomas for your own purposes and not on behalf of a third-party.

________________________________ ____________________

Patient Signature Date

NOTICE OF PRIVACY PRACTICES

YOUR PRIVACY RIGHTS:

"Protected Health Information" ("PHI") is individually identifiable information about your past, present or future health or condition, the provision of health care to you, or payment for the health care. We are required to extend certain protections to you PHI, and to give you this Notice about our privacy practices that explains how, when and why we may use or disclose your PHI.

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a paper copy of the notice information practices upon request, inspect, and obtain a copy of your health record, obtain an accounting of disclosures of your health information, request communications of your health information, and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITY:

We are required to maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices in regards to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice in our waiting room. We will not use or disclose your health information without your authorization, except as described in this notice.

FOR ADDITIONAL INFORMATION OR TO REPORT A PROBLEM:

If you believe there is a mistake or missing information in our records of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is (i) correct and complete; (ii) not created by us and/or not part of our records, or; (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request denial, along with any statement in response that you provide, amended to you PHI. If we approve the request for amendment, we ill change the PHI and so inform you, and tell others what they need to know about the change in the PHI.

If you have questions and would like additional information, you may contact Dr. Sylvia Torres-Thomas, PhD, RN who is the Privacy Officer at 352-729-0923. If you believe your rights have been violated, you may file a complaint with the Dr. Torres-Thomas. There will be no retaliation for filing a complaint.

DISCLOSURES FOR TREATMENT AND PAYMENT:

We will use your information for treatment. Information obtained by any healthcare team member will be recorded in your record and used to determine the course of treatment that should work best for you.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedure and medications provided.

Business Associates: There are some services provided in our organization through contacts with business associates. When these services are contracted, we may disclose you health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Communication with Family: Health professional, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to you care.

Research: We may disclose information to researchers when and institutional review board that has reviewed the research proposal, and established protocols to ensure the privacy of your health information has approved their research.

Marketing: We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the agents thereof health information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by federal, state or local law or in response to a valid subpoena.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION:

We will not use or disclose your health information for any purposes other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization* in writing at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.