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### AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

to release healthcare information of the patient named above to: **Advanced Wellness Institute**  
2881 NC 108 Hwy E Columbus, NC 28722

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_  
\_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes  No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

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Patients Name \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_\_\_

CONSENT FOR TREATMENT: I consent to the evaluation and medically necessary treatment by staff of Advanced Wellness Institute. No guarantee is being made to me about the results of treatment. I can terminate this consent for treatment at any time.

AGREEMENT TO PAY: I agree to pay Advanced Wellness Institute all charges for professional services and I allow Advanced Wellness Institute to file for insurance benefits to pay for the care I receive.

**I understand that:**

- Advanced Wellness Institute will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.
- I will be personally responsible for charges my medical insurance company does not pay.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize and direct payment of benefits under my medical insurance to Advanced Wellness Institute or its designated professional staff.

FOR MEDICARE RECIPIENTS ONLY: I request that payment of authorized Medicare and Medicaid benefits be made on my behalf to Advanced Wellness Institute for any services furnished me by the professional staff of Advanced Wellness Institute. I authorize any holder of medical information about me to release to the health care financing administration, its agents, and my Medigap (supplemental) insurance company and information needed to determine these benefits or the benefits payable for related services.

PRIVACY PRACTICES: I have reviewed the Notice of Privacy Practices and I have been provided an opportunity to review it.

PHOTOCOPIES: I hereby authorize photocopies and electronic copies of this form to be as valid as the original.

The invalidity of any provision of this agreement will not affect the validity of any other provision.

**I have read this agreement carefully before signing.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

# ADVANCED WELLNESS INSTITUTE REGISTRATION FORM

(Please Print)

Today's date:						
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former/Maiden name):	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:	Home Phone: Cell Phone:		
P.O. Box:	City:		State:	ZIP Code:		
Occupation:	Employer:			Employer phone no.: ( )		
Chose clinic because/Referred to clinic by (please check one box):						
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Other
<input type="checkbox"/> Dr.				<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital
Driver's License Number Expiration date State				Email Address		

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:	Birth date: / /	Address (if different):			Home phone no.: ( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:			Employer phone no.: ( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance						
<input type="checkbox"/> Medicare		<input type="checkbox"/> BCBS		<input type="checkbox"/> MedCost		<input type="checkbox"/> Humana
<input type="checkbox"/> AARP		<input type="checkbox"/> Continental Life		<input type="checkbox"/> Equitable		<input type="checkbox"/> Everence
<input type="checkbox"/> Other						
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						

IN CASE OF EMERGENCY			
Name of local friend or relative		Relationship to patient:	Home phone no.: ( )
			Work phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Advanced Wellness Institute or insurance company to release any information required to process my claims.			
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>

# INITIAL HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.): _____	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: _____
Previous or referring doctor: _____		

## PERSONAL HEALTH HISTORY

**Childhood illness:**    Measles    Mumps    Rubella    Chickenpox    Rheumatic Fever    Polio    None    Other

<b>Immunizations and dates:</b>	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Date	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Date
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Date	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Date
	<input type="checkbox"/> Influenza	<input type="checkbox"/> Date	<input type="checkbox"/> MMR <small>(Mumps, Measles, Rubella)</small>	<input type="checkbox"/> Date

**List any medical conditions that other doctors have diagnosed**

### Surgeries

Year	Reason	Hospital

### Other Hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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### Allergies to medications

Name the Drug	Reaction You Had

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

Name the Drug	Dose	Frequency Taken

**HEALTH HABITS AND PERSONAL SAFETY**

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
<b>Diet</b>	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?	Do you snack during the day?	
	Rank salt intake	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	
<b>Caffeine</b>	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
<b>Alcohol</b>	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
<b>Drugs</b>	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sex</b>	Are you sexually active?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	What contraceptive or barrier method do you use?		
	Do you experience any discomfort with intercourse?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Personal Safety</b>	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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you live alone?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have an Advance Directive and/or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**FAMILY HEALTH HISTORY**

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Sibling</b>	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b>		

**MENTAL HEALTH**

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor or psychologist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**REVIEW OF SYSTEMS**

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

**WOMEN ONLY**

Age at onset of menstruation:		
Date of last menstruation:		
Period every      days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies      Number of live births		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you seen any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you experience any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension/cramps, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times		
Date of last pap and rectal exam?		

**MEN ONLY**

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?		

**ANY OTHER QUESTIONS/CONCERNS**


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