



Dear New Client:

We are pleased to welcome you to our practice! Thank you for allowing us to serve your health care needs. We are enclosing with this letter our new patient information forms. Please complete the forms and bring them to your first appointment. **Please plan to arrive 15 minutes prior to your appointment time.**

**LOCATION AND HOURS:**

Please visit our website for door-to-door directions: [www.thewoodruffinstitute.com](http://www.thewoodruffinstitute.com)

Our **NORTH NAPLES** office is located at 2235 Venetian Court, Suite 1, in the Venetian Plaza located at the south west corner of the intersection at Vanderbilt Beach Road and Airport-Pulling Road.

Our **DOWNTOWN NAPLES** office is located at 1333 3<sup>rd</sup> Avenue South, Suite 201, in the Bayfront Professional Center, just off of Goodlette Frank Road.

Our **BONITA SPRINGS / ESTERO** office is located at 23471 Walden Center Drive, Suite 300, on the third floor of the US Trust building, located on the west side of US 41, just south of Coconut Road, across from the Bonita Community Health Center.

Our **FORT MYERS** office is located at 14440 Metropolis Avenue, Suite 102, just north of the intersection of Six Mile Cypress Parkway and Metro Parkway.

We have office hours **Monday through Friday from 8:00am until 5:00pm**. We do not close for lunch. We request that you give us at least 24-hour notice if you are unable to keep a scheduled appointment. This will give us time to schedule someone else who may have an urgent need for care.

**FINANCIAL:** If you have medical insurance, please bring all of your current insurance identification cards with you to the appointment. **Please contact your insurance company prior to your appointment to verify that our office is contracted with your plan. You may do this by calling the 800 telephone number on the back of your card and giving them our Tax ID# 200113558. If your insurance plan requires a referral / authorization from a Primary Care Physician, please obtain prior to your appointment.** Please check to make sure that your cards are not expired. You will also need to bring a valid photo identification card.

All co-payments, coinsurance, and/or deductible monies will be collected at time of check-in. For self-pay patients, payment in full at the time of service is required. We accept cash, checks, and Mastercard, VISA or America Express. There is a \$25.00 insufficient (bounced check) fee if your check does not clear the bank, in addition to the amount of your check.

***We look forward to meeting you soon!***



Today's Date \_\_\_\_\_

## PATIENT INFORMATION (Please print)

Name \_\_\_\_\_ Nickname \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security \_\_\_\_\_ Gender M or F

Local Mailing Address \_\_\_\_\_

Alternative/Seasonal Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Preferred Contact Number: ☐ Home ☐ Cell ☐ Work *Ok to leave detailed message?* ☐ Yes ☐ No

Preferred Language ☐ English ☐ Spanish Other: \_\_\_\_\_

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Caucasian/White  
☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Decline to specify

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to specify

Email address: \_\_\_\_\_

☐ Yes ☐ No *Please add my e-mail address to your mailing list to receive e-mail updates/ specials*

How did you hear about the Woodruff Institute?

- ☐ Physician referral, please specify: \_\_\_\_\_  
☐ Newspaper / magazine, please specify: \_\_\_\_\_  
☐ Family / friend, please specify: \_\_\_\_\_  
☐ Website / social media, please specify: \_\_\_\_\_  
☐ Other: \_\_\_\_\_

Have you verified In-Network Coverage? ☐ Yes ☐ No

If not, I understand that I am responsible for all payments, copayments, and deductibles specified by the insurance company if these services are deemed Out-of-Network by my insurance company.

## INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Name of Insured \_\_\_\_\_ Name of Insured \_\_\_\_\_

Insured's SSN # \_\_\_\_\_ Insured's SSN # \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

*I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.*

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PREFERRED PHARMACY:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**City & Intersection:** \_\_\_\_\_

**Seasonal Pharmacy & Phone:** \_\_\_\_\_

**PAST MEDICAL HISTORY: (please check all that apply)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> NONE                              | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Inflammatory liver disease     |
| <input type="checkbox"/> Anxiety disorder                  | <input type="checkbox"/> Elevated blood pressure | <input type="checkbox"/> Leukemia                       |
| <input type="checkbox"/> Arthritis                         | <input type="checkbox"/> End stage renal disease | <input type="checkbox"/> Malignant lymphoma             |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Malignant tumor of lung        |
| <input type="checkbox"/> Atrial fibrillation               | <input type="checkbox"/> GERD (reflux)           | <input type="checkbox"/> Malignant tumor of breast      |
| <input type="checkbox"/> BPH (enlarged prostate)           | <input type="checkbox"/> Hearing loss            | <input type="checkbox"/> Malignant tumor of colon       |
| <input type="checkbox"/> Cerebrovascular accident (stroke) | <input type="checkbox"/> HIV/ AIDS               | <input type="checkbox"/> Malignant tumor of prostate    |
| <input type="checkbox"/> COPD                              | <input type="checkbox"/> Hypercholesterolemia    | <input type="checkbox"/> Radiation treatment            |
| <input type="checkbox"/> Coronary artery disease           | <input type="checkbox"/> Hyperthyroidism         | <input type="checkbox"/> Transplantation of bone marrow |
| <input type="checkbox"/> Depressive disorder               | <input type="checkbox"/> Hypothyroidism          |   |

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

**PAST SURGICAL HISTORY: (please check all that apply)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> NONE                                | <input type="checkbox"/> History of cholecystectomy (gallbladder)                                    | <input type="checkbox"/> Oophorectomy (ovaries removed)   |
| <input type="checkbox"/> Abdominoperineal resection          | <input type="checkbox"/> History of colectomy  | <input type="checkbox"/> Pancreatectomy   |
| <input type="checkbox"/> Bilateral replacement knee joints   | <input type="checkbox"/> History of liver excision   | <input type="checkbox"/> Procedure: Kidney stones   |
| <input type="checkbox"/> Biopsy of breast                    | <input type="checkbox"/> History of PTCA (coronary angioplasty)                                      | <input type="checkbox"/> Portosystemic shunt operation  |
| <input type="checkbox"/> Biopsy of prostate                  | <input type="checkbox"/> History of heart valve replacement  | <input type="checkbox"/> Prostate removed: Prostate cancer  |
| <input type="checkbox"/> Coronary artery bypass graft        | <input type="checkbox"/> History of total cystectomy (urinary bladder)                               | <input type="checkbox"/> Prosthetic arthroplasty of hips  |
| <input type="checkbox"/> Entire transplanted kidney          | <input type="checkbox"/> History of prostatectomy  | <input type="checkbox"/> Spleen removed   |
| <input type="checkbox"/> Excision of basal cell carcinoma    | <input type="checkbox"/> Hysterectomy  | <input type="checkbox"/> Surgical biopsy of skin  |
| <input type="checkbox"/> Excision of melanoma                | <input type="checkbox"/> Kidney biopsy   | <input type="checkbox"/> Total nephrectomy (kidneys)  |
| <input type="checkbox"/> Excision of squamous cell carcinoma | <input type="checkbox"/> Low anterior resection of rectum  | <input type="checkbox"/> Total orchidectomy (testicles)   |
| <input type="checkbox"/> History of colostomy                | <input type="checkbox"/> Lumpectomy of breasts <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Total replace of hips <input type="checkbox"/> R <input type="checkbox"/> L  |
| <input type="checkbox"/> History of tubal ligation           | <input type="checkbox"/> Mastectomy of breasts <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Total replace of knees <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> History of appendectomy             |  | <input type="checkbox"/> Transplantation of heart   |
| <input type="checkbox"/> History of bilateral mastectomy     |  | <input type="checkbox"/> Transplantation of liver   |

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

**SKIN DISEASE HISTORY: (please check all that apply)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> NONE                   | <input type="checkbox"/> Contact dermatitis from poison ivy | <input type="checkbox"/> Melanoma                  |
| <input type="checkbox"/> Acne                   | <input type="checkbox"/> Dysplastic nevus of skin           | <input type="checkbox"/> Pruritis of scalp         |
| <input type="checkbox"/> Actinic keratosis      | <input type="checkbox"/> Eczema                             | <input type="checkbox"/> Psoriasis                 |
| <input type="checkbox"/> Asteatosis cutis       | <input type="checkbox"/> History of asthma                  | <input type="checkbox"/> Squamous cell skin cancer |
| <input type="checkbox"/> Basal cell skin cancer | <input type="checkbox"/> History of hay fever               | <input type="checkbox"/> Sunburn of second degree  |

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

**Do you wear sunscreen?** Yes No **If yes, what SPF?** \_\_\_\_\_

**Do you tan in a tanning salon?** Yes No

**Do you have a family history of melanoma?** Yes No

**If yes, which relative(s)?** \_\_\_\_\_



**MEDICATIONS:** (Please list all current medications, including name, dosage and how often used, if possible)

☐ I do not take any medications

**ALLERGIES:** (Please list all allergies and reactions)

☐ I do not have any allergies to medications

**REVIEW OF SYSTEMS:** (Are you currently experiencing problems with any of the following?)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Bleeding       | <input type="checkbox"/> Night sweats              | <input type="checkbox"/> Headaches           |
| <input type="checkbox"/> Healing        | <input type="checkbox"/> Unintentional weight loss | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Scarring       | <input type="checkbox"/> Thyroid                   | <input type="checkbox"/> Cough               |
| <input type="checkbox"/> Rashes         | <input type="checkbox"/> Sore throat               | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Immune system  | <input type="checkbox"/> Blurry vision             | <input type="checkbox"/> Wheezing            |
| <input type="checkbox"/> Hay fever      | <input type="checkbox"/> Abdominal pain            | <input type="checkbox"/> Anxiety             |
| <input type="checkbox"/> Chest pain     | <input type="checkbox"/> Joint aches               | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Fever / chills | <input type="checkbox"/> Muscle weakness           |  |

**ALERTS:** (Please check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Allergy to adhesive               | <input type="checkbox"/> Defibrillator                     |
| <input type="checkbox"/> Allergy to lidocaine              | <input type="checkbox"/> MRSA                              |
| <input type="checkbox"/> Allergy to topical antibiotics    | <input type="checkbox"/> Pacemaker                         |
| <input type="checkbox"/> Artificial heart valve            | <input type="checkbox"/> Premedication prior to procedures |
| <input type="checkbox"/> Artificial joints in past 2 years | <input type="checkbox"/> Rapid heartbeat with epinephrine  |
| <input type="checkbox"/> Blood thinners                    | <input type="checkbox"/> Pregnancy or planning a pregnancy |

**COSMETIC INTEREST:**

**Do you have any skin care or anti-aging concerns today?** (i.e. fine lines, brown spots, etc.) ☐ Yes ☐ No

**Have you had any cosmetic treatments in the past?** (i.e. Botox, fillers, laser, facials, etc.) ☐ Yes ☐ No

**Are you interested in hearing about the cosmetic procedures we offer in our office today?** ☐ Yes ☐ No

**WOMEN ONLY:**

**Do you experience any bladder problems such as painful urination, leaking, or frequency?** ☐ Yes ☐ No

**Do you have any pelvic health issues such as loss of libido or laxity due to childbirth?** ☐ Yes ☐ No



## Patient HIPAA Privacy Consent Form

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy Practices is available for your review at the front desk.

By signing this form, you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices available to you at our front desk. You have the right to revoke this consent at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Woodruff Institute provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operation. This request must be done in writing. Whenever possible we will honor your request.

The patient understands that:

- We will not release information to any future doctor, attorney, life insurance company, workman's comp company without your written consent
- Protected health information may be used for treatment through one of your current doctors (such as your primary care physician or a specialist referral), payment with your insurance company, or healthcare operations within our office
- The Woodruff Institute has a Notice of Privacy Practices that is available for review
- The Woodruff Institute reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but The Woodruff Institute does not have to agree to these restrictions if, for example, it interferes with payment, daily operations, or providing quality health care
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- The Woodruff Institute may condition treatment upon the execution of this consent (for example, you may be required to pay for your visit at the time of service)

**Omnibus Final Rule- Final modifications to the HIPAA Privacy, Security and Enforcement Rules mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act, are as follows:**

- You have the right to be notified of a protected health information breach.
- You have the right to ask for a copy of your electronic medical record in an electronic form.
- You have the right to opt out of fundraising communications for The Woodruff Institute.
- The Woodruff Institute cannot sell your health information without your permission.
- Certain uses of your medical data, such as use of patient information in marketing, require prior disclosure and your authorization. Uses and disclosures not described in the Notice of Privacy Practice will only be made with your authorization.
- If you pay in full for services out-of-pocket, you can instruct The Woodruff Institute not to share information about your treatment with your health plan.

I \_\_\_\_\_ grant authorization for The Woodruff Institute and its associates to  
**Patient Name**  
disclose information regarding my diagnosis and or treatment to (via in person or by phone):

_____ <i>Authorized person</i>	_____ <i>Relationship</i>	_____ <i>Telephone Number</i>
_____ <i>Authorized person</i>	_____ <i>Relationship</i>	_____ <i>Telephone Number</i>
_____ <i>Authorized person</i>	_____ <i>Relationship</i>	_____ <i>Telephone Number</i>
_____ <b>Patient or Patient Representative Signature</b>	_____ <b>Date</b>	



## **Financial Policy**

*Thank you for choosing The Woodruff Institute as your healthcare provider. We strive to render excellent medical care to you, your family, and all of our patients. Along with providing you with quality service, The Woodruff Institute would also like to assist you with your billing needs.*

**Any change in home address, phone number, insurance information, or a change of primary doctor must be given to us prior to your appointment. Charges incurred if this information is not given will be patient responsibility.**

**As a courtesy to you, we will file claims with your health insurance plan and assist you in every way we can. Please contact your insurance company prior to your visit to clarify your covered benefits for services. *Our office does not guarantee that your insurance will pay. Please understand that if, for whatever reason, the company does not pay for the services, you will be responsible for the unpaid balance.***

We require all patients to pay their insurance deductible, copay and/or coinsurance payment at the beginning of each visit. We do our best to verify your benefits prior to your appointment to make sure we collect the appropriate amount owed and to make sure your visit will be covered by your insurance plan. However, it remains the policy holder's responsibility to know their insurance policies, as The Woodruff Institute cannot know every detail of your specific plan. It must be fully understood that the contract is between you and your insurance company, and you are fully responsible for any unpaid balances

**(Initial)\_\_\_\_\_ Basic Policy:** Payment for service in full is expected at the time of service, without exception. For your convenience we accept Visa, MasterCard and American Express. Payment plans will be extended to established patients of the practice only. All special arrangements must be made in advance.

**(Initial)\_\_\_\_\_ For Patients with Insurance:** We participate with many PPOs, POS plans, HMOs and other health insurance plans including Medicare. Each plan contains unique rules which must be followed by patients. Please familiarize yourself with the particular benefits and rules of your health care plan since the contract is between you (the patient) and your health insurance carrier.

**(Initial)\_\_\_\_\_ Medicaid Patients:** At this time, we do not participate with Medicaid or any of its advantage plans. This includes Medicare QMB and United Healthcare Dual SNP PPO & HMO plans. If you (the patient) have Medicaid as your secondary insurance please refer to our Medicaid Policy form for additional information on how your claims will be processed.

**(Initial)\_\_\_\_\_ Medicare Patients:** As a participating provider, we will bill Medicare for you. However, you will still be responsible for the 20% that Medicare does not cover. (Please note: Not all services are covered by Medicare). We will also bill secondary insurance carriers for you that we participate and are credentialed with. However, claims denied, rejected or partially paid by your supplemental carrier will be your responsibility in 30 days.

**(Initial)\_\_\_\_\_ Referrals:** Some insurance plans require a referral. It is the patient's responsibility to obtain a referral for all of their visits including any renewal referrals. This may involve calls to your primary care or referring physician. If you do not have a referral for an office visit or procedure, you will be required to pay for your visit on the day of service, or given the option to reschedule your appointment.

**(Initial)\_\_\_\_\_ Electronic Health Record:** Our practice utilizes an Electronic Health Recording system. Occasionally, progress notes may be in a preliminary state and awaiting final review from the

provider when a patient checks out. In the event your billing status changes from time of check out, a refund will be issued and/or you will be responsible for the balance. Only finalized notes that have been reviewed and signed by a provider are submitted to insurance companies.

(Initial)\_\_\_\_\_ **Minor Patient Policy:** The adult accompanying a minor patient or the parents/guardians of the minor patient are responsible for full payment.

(Initial)\_\_\_\_\_ **Surgery Fees:** All copays, deductibles, and payments for noncovered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.

(Initial)\_\_\_\_\_ **Non-covered Services:** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

(Initial)\_\_\_\_\_ **Personal Injury Cases:** This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

(Initial)\_\_\_\_\_ **Worker's Compensation:** This office does not bill for worker's compensation cases. You are responsible for payment at the time of service.

(Initial)\_\_\_\_\_ **Yearly Skin Screenings:** Periodic preventive skin screenings may or may not be covered under your health insurance policy; however, they may be recommended by your provider.

(Initial)\_\_\_\_\_ **Pathology Services:** If you have a tissue biopsy done, you will receive a separate bill from an outside pathology laboratory in addition to your bill from The Woodruff Institute, as pathologists perform the analysis of the tissue biopsy. There may be times where additional diagnostic testing needs to be done at a referenced lab to support the diagnosis; therefore, you will receive an additional bill for these services if applicable.

(Initial)\_\_\_\_\_ **Laboratory Services:** If you receive laboratory services, such as blood tests, you may receive a bill from an outside laboratory, as they perform the analysis of the lab specimen. Services may/ may not be covered by your insurance company.

(Initial)\_\_\_\_\_ **Returned Check Fee:** All returned checks will incur a \$25.00 fee.

(Initial)\_\_\_\_\_ **Statements:** Prompt payment of mailed invoices is required. In the event you receive a statement in the mail from us for payment, it is your responsibility to pay that amount within 10 days. Payments can be mailed to 2235 Venetian Court, Suite 1, Naples, FL 34109; paid for via credit card by calling 239-596-9337 Option 4; or online at [www.thewoodruffinstitute.com](http://www.thewoodruffinstitute.com)

(Initial)\_\_\_\_\_ **Skin Care Products:** Returns are not accepted on any of our skin care products.

(Initial)\_\_\_\_\_ **Patient Satisfaction:** The Woodruff Institute takes pride in the services that are rendered to our patients. Our goal is to provide you with the highest quality of care in a courteous and professional setting. If at any time your experience with us did not meet your expectations, please contact us at any time to report your question, issue or concern. You can reach us by calling 239-596-9337 Option 4 or email at [billing@thewoodruffinstitute.com](mailto:billing@thewoodruffinstitute.com)

**I have read this Financial Policy and understand the billing procedures of The Woodruff Institute. I agree to pay any balances that are my responsibility. Balances unpaid will result in collection actions.**

\_\_\_\_\_  
**Signature of Patient or Responsible Party**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**



### OPTIONAL AUTHORIZATION FOR CREDIT CARD USE FORM

Print and complete this authorization **ONLY** if you wish to keep a credit card on file.  
All information will remain confidential.

Name on Card: \_\_\_\_\_

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

Credit Card Type:    ☐ Visa        ☐ Master Card        ☐ AMEX

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Card Identification Number: \_\_\_\_\_ (last 3 digits on back of VISA/MC or 4 digits on front of AMEX)

Maximum Amount to Charge: \$\_\_\_\_\_

I have read and agree to The Woodruff Institute's financial policy. I hereby authorize The Woodruff Institute to charge the amount listed above to the credit card provided herein to pay any invoices for my account. I will be provided a copy of my receipt by fax, mail or electronically at my discretion.

This form will be kept on file and will remain in effect until the expiration of the credit card account. Applicants may also revoke this form by submitting a written request to the address listed below.

#### **Cardholder- Please Sign and Date**

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

I wish to receive receipts via:

☐ Fax \_\_\_\_\_

☐ Mail \_\_\_\_\_

☐ E-mail \_\_\_\_\_

The Woodruff Institute Billing Department  
2235 Venetian Court, Suite 1  
Naples, FL 34109





## Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

First name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Primary Care Physician \_\_\_\_\_

Email address: \_\_\_\_\_

### **SOCIAL HISTORY:** (Please check all that apply)

**Tobacco/ E-Cigarette Use:** ☐ Never smoked ☐ Quit; former smoker ☐ Current smoker\* (\*please request additional sheet)

#### **Alcohol Use:**

**Men under age 65:** How many times in the past year have you had more than 5 drinks in one day? \_\_\_\_\_

**Women/All adults over 65 years:** How many times in the past year have you had more than 4 drinks in a day? \_\_\_\_\_

#### **Food:**

☐ Yes ☐ No Within the past 12 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?

#### **Housing/Utilities:**

☐ Yes ☐ No Are you homeless or worried that you might be in the future?

☐ Yes ☐ No Do you have trouble paying for your utilities (electricity, phone, etc.)?

#### **Transportation:**

☐ Yes ☐ No Do you have trouble finding or paying for a ride for important events such as medical appointments, getting your medications, work, or other things that you need?

#### **Interpersonal Safety:**

☐ Yes ☐ No In the last 12 months, have you been emotionally or physically harmed or threatened?

#### **Advanced care plan:**

☐ Yes ☐ No Do you have an Advanced Care Plan (Living Will) or surrogate decision maker/healthcare proxy?

**Living Will decision maker (if applicable):** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

### **MEDICATIONS:** (Please list all current medications, including name, dosage and how often used)

☐ I do not take any medications

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### **ALLERGIES:** (Please list all allergies and reactions)

☐ I do not have any allergies to medications

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**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# THE WOODRUFF INSTITUTE

## QUITTING SMOKING- PATIENT FACTS

### Why Should I Quit Smoking?

Smoking can lead to many health problems, including:

- Cancer
- Asthma & chronic obstructive pulmonary disease (COPD)
- Heart Disease
- Gum disease
- Stroke
- Type 2 diabetes
- Vision problems (cataracts)
- Hip fractures
- Pregnancy problems, like miscarriage and birth defects
- Erectile dysfunction
- Death

### It's Never Too Late to Quit Smoking

If you quit smoking, you can reduce your risk of health problems and early death. The earlier you are able to quit smoking, the more you can look forward to better health. However, quitting smoking at any age will help you, especially if you already have health problems from smoking. You are never too old, too healthy, or too sick to quit smoking. You may notice some changes right away after quitting, including:

- Less coughing and wheezing • Clearer skin • Lower blood pressure • Healthier teeth and gums

Your health can continue to improve years after you quit by lowering your risk for major health problems. These include:

- **Stroke:** Your stroke risk is the same as a nonsmoker within 2 to 4 years of quitting.
- **Heart Disease:** Within 2 to 3 years, your risk is similar to a person who has never smoked.
- **Lung Cancer:** Lung cancer risk is cut in half after 10 years of quitting.

### Why is Quitting So Hard?

Quitting smoking can be hard for many reasons. The substance in cigarettes, called nicotine, is very addictive. Smoking and the act of "lighting up" can become a comforting habit. It can become part of things you do every day, like having a cigarette after a meal or when you wake up. Changing your routine can help you break the habit, and medicines can help you with your addiction.

### How Can I Quit?

You are more likely to be successful if you quit with help. Ask your doctor about counseling, support groups, or hotlines that you can call for help. These programs can help you learn more about your habit and how to change your behavior. It can also help to tell your friends and family you're trying to quit, so they can support you.

Medicines may help curb your cravings for nicotine and include:

- **Nicotine Replacement Therapy:** This includes nicotine gum, patch, lozenge, inhaler, or nose spray. These products release nicotine in your body that you would usually get from smoking. They help to reduce your cravings and can lessen symptoms of nicotine withdrawal.
- **Prescription Medicines (Bupropion and Varenicline):** These are medicines that you take by mouth. They always come with a doctor's prescription. These medicines work in your brain to help reduce nicotine cravings.


### Bottom Line

- Smoking cigarettes can cause serious health problems.
- There are benefits to quitting at any age. It's never too late to quit. Quitting smoking reduces your risk of stroke, heart disease, and lung cancer.
- Ask your doctor about counseling or support groups to help you quit smoking. Nicotine replacement therapy, like the patch or gum, can help control cravings. Some prescription medicines can help too.

### For More Information

- **Centers for Disease Control:** [https://www.cdc.gov/tobacco/data\\_statistics/fact\\_sheets/cessation/quitting/](https://www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/quitting/)
- **Medline Plus:** <https://medlineplus.gov/quittingsmoking.html>





# THE WOODRUFF INSTITUTE

## ALCOHOL: IS YOUR HEALTH AT RISK

### What counts as one drink?

One 12-ounce can of beer  
One 5-ounce glass of wine  
One shot of hard liquor (1.5 ounces)

### Are you at risk?

If you use alcohol, taking a look at your drinking pattern and knowing your risks is important for your health, now and in the future. Know the difference between low-risk versus risky or harmful drinking. You owe it to yourself!

### What is low-risk drinking?

- For healthy adults age 65 and under:
  - Men: low-risk limits are no more than 4 drinks on any given day or 14 drinks per week
  - Women: low risk limits are no more than 3 drinks on any given day or 7 drinks per week
- For people over 65: low-risk limits are 3 drinks a day or 7 drinks a week
- Women who are pregnant or may become pregnant should not drink

### What is risky or harmful drinking?

- **Risky alcohol use** is drinking more than the single-day or weekly amounts shown above.
- **Harmful alcohol use** is drinking more than the single-day or weekly amounts shown above, and having negative effects from drinking such as accidents, not being able to stop drinking, or not doing what you normally do (work, school, family) because of drinking.

### What can happen from risky or harmful alcohol use?

- People who use alcohol at risky or harmful levels are at greater risk for health problems- cancer, obesity, high blood pressure, stroke, injury, diabetes, accident/death, suicide, and cirrhosis.
- It makes a difference both how much you drink on any given day and how often you have a heavy drinking day.
- The more drinks in a day and the more heavy drinking days over time, the greater the risk for problems.

### Tips for cutting down on alcohol use

- **Measure and Count.** Measure drinks per standard drink size and count how much you drink on your phone, a card in your wallet, or calendar.
- **Set Goals.** Decide how many days a week you want to drink, and how many drinks you want to have on those days.
- **Pace and Space.** Pace yourself. Sip slowly. Have no more than one drink per hour. Alternate “drink spacer”- non-alcohol drinks (water, soda, or juice).
- **Include Food.** Don’t drink on an empty stomach.
- **Avoid “Triggers.”** What triggers you to drink? Avoid people, places, and activities that trigger the urge to drink.
- **Plan to Handle Urges.** When an urge hits: remind yourself of reasons for changing, talk it through with someone, do a healthy, distracting activity, or “urge surf” and accept the feeling and ride it out, knowing it will pass.
- **Know your “no.”** Have a polite, convincing “no” ready for times when you don’t want to drink.

### Helpful Links

<http://rethinkingdrinking.niaaa.nih.gov/>  
<http://www.niaaa.nih.gov/alcohol-health>  
<http://findtreatment.samhsa.gov>