Ward Dean, M.D.
6708 Plantation Road, Suite C-1, Pensacola, FL 32504

New Patient Registration Packet
Phone: 850-912-6981

Welcome to Our Practice!
Thank you for choosing Ward Dean, M.D. Please complete the following forms accurately to help us provide you with the best care. All information is confidential. If you have questions, please contact our office.

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1. Patient Information Form

Please fill out all the fields. This information helps us understand your medical needs and contact you as needed.

Personal Information

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Email: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Referral and Primary Care

Referred By: _____ Primary Care Physician: _____

Reason for Visit: _____ Date Symptoms Began: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Phone: _____

Responsible Party (if different from patient)

Name: _____ Relationship to Patient: _____

Phone: _____

Certification
I certify that the information provided is accurate and request services from Ward Dean, M.D., PLC.

Signature: _____ **Date**: _____

2. Medical and Social History

Instructions: Provide details about your medical and social history to assist in your care. Check or fill in all applicable fields. **Surgical History:** List all past surgeries and approximate dates:

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Immunization History
Please indicate the year of your last immunization:

Tetanus/Diphtheria: _____ Hepatitis B: _____ Influenza: _____

MMR: _____ Pneumonia: _____ COVID-19:_____

Social History
Do you smoke? ☐ Yes ☐ No If yes: Years smoked: _____ Packs per day: _____

If no: Year stopped: _____ Does anyone in your household smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes: Amount per day: _____

Occupation: _____ Retired? ☐ Yes ☐ No Disabled? ☐ Yes ☐ No

Family Medical History
Check if any immediate family member has had the following:

Condition	Yes	No	Condition	Yes	No
Cancer	☐	☐	Diabetes	☐	☐
High Blood Pressure	☐	☐	Heart Disease	☐	☐
Tuberculosis	☐	☐	Anemia	☐	☐
Mental Illness	☐	☐	Bleeding Problems	☐	☐
Bone Problems	☐	☐	Allergies	☐	☐

Additional Concerns
List any specific questions or concerns for the doctor: _____

_____

I agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Signature: _____ **Date**: _____

3. Medications and Allergies

Instructions: List all current medications, including prescriptions, over-the-counter drugs, and supplements.

Current Medications

Medication Name	Strength/Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Attach additional sheet if needed)

Current Supplements

Supplement Name	Strength/Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Attach additional sheet if needed)

Allergies: Report any known allergies.

Medication	Reaction
_____	_____
_____	_____
_____	_____

4. Hypothyroidism Symptom Checklist

Instructions: Hypothyroidism can cause a variety of symptoms. Check all symptoms you are currently experiencing to help us assess your thyroid health.

Symptom	✓ if Applicable	Symptom	✓ if Applicable
Sensitivity to cold (hands/feet)	☐	Low or high blood pressure	☐
Fatigue or reduced energy	☐	High cholesterol	☐
Weight gain	☐	Diabetes	☐
Inability to lose weight	☐	Hypoglycemia	☐
Frequent infections (e.g., colds)	☐	Low libido	☐
Asthma or allergies	☐	Anxiety or panic attacks	☐
Decreased perspiration	☐	Depression	☐
Dry, coarse, or pale skin	☐	Behavioral/emotional disorders	☐
Poor circulation	☐	Slow-healing wounds	☐
Hair loss	☐	Menstrual problems or infertility	☐
Dry eyes or blurred vision	☐	Enlarged thyroid or goiter	☐
Swelling or puffy eyelids	☐	Thinning of outer eyebrows	☐
Digestive issues (e.g., IBS, constipation)	☐	Poor memory or concentration	☐
Headaches	☐	Arthritis or joint pains	☐
Lateral halves eyebrows missing	☐	Infertility	☐
High blood pressure	☐	Low blood pressure	☐

5. Ward Dean, M.D. PLC - HIPAA Consent Form

Instructions: Please review and sign to authorize the use of your protected health information (PHI) under HIPAA regulations.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____ 2026

Print Name: _____

Signature: _____

6. Medicare Opt-Out Contract (Pursuant to #405.415 of Medicare Regulations)

Instructions: Please review and sign to acknowledge that Ward Dean, M.D., has opted out of Medicare, and you accept responsibility for payment.

By signing this contract I understand that I will not submit (or request that my physician submit) a claim to Medicare or its agents for services, even if such services would be otherwise covered by Medicare.

I agree that I (or my legal representative) accept full responsibility for payment of services rendered to me by Ward Dean, M.D. and I understand that no Medicare reimbursement will be provided for such services.

I (or my legal representative) understand that Medicare limits do not apply to what Dr. Dean may charge for items or services.

I (or my legal representative) agree not to submit a claim to Medicare or ask Dr. Dean to submit a claim to Medicare.

I (or my legal representative) understand that Medicare payment will not be made for any items or services furnished by Dr. Dean that would otherwise have been covered by Medicare if there were no private contract and a proper Medicare claim had been made.

I (or my legal representative) understand that I am entering into this contract with the knowledge that I have the right to obtain Medicare covered items or services from physicians or practitioners who have not opted-out of Medicare, and that I am not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians who have not opted-out.

I (or my legal representative) understand that Medigap plans do not, and that other supplemental plans may not elect to make payments for items and services not paid for by Medicare. Therefore, I understand that Dr. Dean's services will likely not be covered by these plans.

I (or my legal representative) understand that Ward Dean, M.D. is thus excluded from Medicare under Sections 1128, 1156, 1892 or any other section of the Social Security Act.

Signed this _____ day of _____ 2026

Print Name: _____ Physician: _____

Ward Dean, M.D.

Signature: _____

7. Patient Medical History Questionnaire

✓ if Applicaple

General

- ☐ Arthritis
- ☐ Lupus
- ☐ Fatigue
- ☐ Low Energy Level
- ☐ Fever
- ☐ Chills
- ☐ Pain
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Loss of Appetite

Eyes

- ☐ Double Vision
- ☐ Excessive Tearing
- ☐ Impaired Vision
- ☐ Redness
- ☐ Light Sensitivity

Skin

- ☐ Nodules
- ☐ Rash
- ☐ Dry Skin
- ☐ Radiation Therapy Effect
- ☐ Nail Changes

Breast

- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Nipple Discharge

Neurologic

- ☐ Abnormal Gait
- ☐ Confusion
- ☐ Dizziness
- ☐ Headache
- ☐ Memory Loss
- ☐ Numbness & Tingling
- ☐ Paralysis
- ☐ Seizures

Cardiovascular

- ☐ Difficulty Breathing While Lying Down
- ☐ Fainting or Lightheadedness
- ☐ Chest Pain
- ☐ Heart Racing
- ☐ Swelling (Legs or Feet)

Respiratory

- ☐ Cough
- ☐ Coughing up Blood
- ☐ Shortness of Breath
- ☐ Cough with Sputum
- ☐ Wheezing
- ☐ Pain with Breathing

Ear/Nose/Throat

- ☐ Earache
- ☐ Nose Bleeds
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Mouth Sores
- ☐ Dry Mouth
- ☐ Altered Taste
- ☐ Balance Issues
- ☐ Loss of Hearing
- ☐ Ringing in Ears
- ☐ Congestion
- ☐ Bleeding Gums

Gastroenterology

- ☐ Abdominal Cramping
- ☐ Changes in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Dark/Black Stools
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Jaundice