New Patient Registration Form

Note: -*indicates mandatory field.

Last Name*: ____________ First Name*: ____________ Middle Initial*: ____

Patient DOB*: ________ (mm/dd/yyyy) Social Security No.*: ___-__-____ Sex*: ☐Male ☐Female ☐Unknown

Address*: ______________________________ Start Date*: ________(mm/dd/yyyy)

Zip*: ____________ City*: ____________ State*: ____________

Work: ____________ Home Phone Number*: ____________ Cell: ____________

Employer: ____________ Email Address: ____________________

Who Should We Thank For Referring You: ____________________

Marital Status*: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employment*: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Military Duty

Preferred method of communication*: ☐ Email ☐ Home Phone ☐ Mail ☐ Mobile Phone ☐ Patient declined to specify ☐ Work Phone

Insurance Information

Insurance(s)*: ____________ Plan*: ____________ ID*: ____________ Effective Date*: ________ (mm/dd/yyyy)

Guarantor/Insured Person Information

Holder*: ____________ Relationship to the patient*: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

DOB*: ________ (mm/dd/yyyy) Social Security No.*: ___-__-____ Employer*: ____________

Address(If different than patient's)*: ______________________________ Start Date*: ________(mm/dd/yyyy)

Home No.*: ____________ Work Number: ____________ Cell Number: ____________

Emergency Contact Information

Name*: ____________ Phone Number*: ____________ Relationship*: ____________

Address*: ______________________________ Start Date*: ________(mm/dd/yyyy)

Due to Healthcare Reform guidlines,
Florida is requesting the following information to get better sense of the overall diversity of our patient population and have a better understanding of our practice and patient needs. This confidential information will assist us in improving the quality of care you receive in our office.
Please place a check mark to the left of whichever option applies:

1) Primary Language*: ☐ English ☐ German ☐ Italian ☐ Spanish ☐ French ☐ Other ____________

2) Race*: ☐ American Indian or Alaska Native ☐ African American ☐ Native Hawaiian ☐ Asian ☐ Other Pacific Islander ☐ More than one Race ☐ Unreported/Refuse to Report ☐ White

3) Ethnicity*: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unreported/Refuse to Report

Patient/Representative Signature*: ____________ Name*: ____________________

Date*: ________ (mm/dd/yyyy)

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SUNRISE Medical Clinic

NILAMBEN D. SHAH, MD
Weekdays: 8 am to 5 pm

Health History

NAME:Last*: ____________ First*: ____________ Middle*: ______

Sex*: ☐ Male ☐ Female ☐ Unknown Birthdate*: ________ (mm/dd/yyyy) Reason for visit*: ____________

PHARMACY:Name*: ____________ City*: ____________ State*: ____________

Pharmacy Address*: ________________________________

Allergies*: | Medication or Substance | Reaction

☐ No Allergies

____________ ____________
____________ ____________
____________ ____________

Current Medications:	Label - Name	Dose	Frequency
☐ See Attached List***	____________	____________	____________
	____________	____________	____________
	____________	____________	____________
	____________	____________	____________
	____________	____________	____________
	____________	____________	____________

***Please bring your list of medication with you to your appointment.

Social History

Marital Status*: ☐ Single ☐ Married (Name:____________) ☐ Domestic Partner (Name:____________) Number of Kids___ ___

Are you sexually active?*: ☐ Yes ☐ No Partners: ☐ Male ☐ Female Birth Control: ____________

Do you drink alcohol? ☐ Never ☐ Yes ☐ No ☐ Quit Date Quit ________ (mm/dd/yyyy) Drinks/Day: ___ Drinks/Week: ___ Type: ☐ Beer ☐ Wine ☐ Liquor

Are you working?*: ☐ Yes ☐ No ☐ Retired ☐ Disabled What do you do? ____________

Do you use tobacco products?*: ☐ Never ☐ Some Days ☐ Quit ☐ Passive ☐ Daily Packs/Day ___ Years Smoked ____ Date Quit __/__/____ (mm/dd/yyyy) Type(s) of Tobacco: ☐ Cigarettes ☐ Cigars ☐ Chew ☐ E-Cigarettes ☐ Snuff

Do you use recreational drugs?*: ☐ Never ☐ Yes ☐ No ☐ Quit -Use/Week ______ Date Quit ________ (mm/dd/yyyy)

Have you ever used injected/IV drugs*: ☐ Yes ☐ No Types: ☐ Cocaine ☐ Marijuana ☐ Methamphetamines ☐ Stimulants ☐ Heroin ☐ Depressants ☐ Hallucinogens(LSD,mushrooms) ☐ Oploids(vicodin,oxycodone)

Medical History - Please select for those conditions you have now or have ever had *

☐ No Past Medical History ☐ Congestive Heart Failure ☐ Gynecologic Problem ☐ Muscle or Joint Pain ☐ Allergies

☐ COPD/Emphysema ☐ Heart Murmur ☐ Heart Attack ☐ Anemia ☐ Heart Disease

☐ Hepatitis or Liver Problems ☐ Osteoporosis (Thin Bones) ☐ Anxiety ☐ Depression ☐ HIV/AIDS

☐ Diabetes Type 1 ☐ Hypertension/High BP ☐ Seizures or Epilepsy ☐ PPD ☐ Arthritis

☐ Bleeding/Clotting Problems ☐ Diabetes Type 2 ☐ Insomnia/Sleep Problems ☐ Stroke ☐ Asthma

☐ GERD (Acid Reflux, Heart Burn) ☐ Gastric Ulcer/Stomach Ulcer ☐ Kidney Disease ☐ Cancer ☐ Tuberculosis

☐ Substance/Drug Abuse ☐ High Cholesterol ☐ Thyroid Disease ☐ Glaucoma ☐ Migraine

☐ Blood Transfusion ☐ Other(Please list): ____________

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Health Maintenance

Women Period*: ☐ Yes ☐ No Last __/____(mm/yyyy) # of pregnancies ______ # deliveries ______

Menstrual Problems*: ☐ Yes ☐ No When __/____ Vaginal Discharge: ☐ Yes ☐ No When __/____

Irritation or Abnormal Bleeding*: ☐ Yes ☐ No When __/____

Pap Smear*: ☐ Yes ☐ No When __/____ Abnormal? ____________

Mammogram*: ☐ Yes ☐ No When __/____ Abnormal? ____________

General Colonoscopy*: ☐ Yes ☐ No When __/____ Where ______________

Dexa/Bone Density*: ☐ Yes ☐ No When __/____ Where ______________

Eye Exam*: ☐ Yes ☐ No When __/____ Where ______________

Dental Exam*: ☐ Yes ☐ No When __/____ Where ______________

Immunizations

Tetanus or TDAP*: ☐ Yes ☐ No When __/____ Where ______________

Flu*: ☐ Yes ☐ No When __/____ Where ______________

Prevnar*: ☐ Yes ☐ No When __/____ Where ______________

Zostavax(Shingles)*: ☐ Yes ☐ No When __/____ Where ______________

Pneumovax*: ☐ Yes ☐ No When __/____ Where ______________

Review of Systems (current symptoms) - please select only if these are bothering you at this time

Gastroinstestinal:

☐ Poor Appetite ☐ Vomiting ☐ Heartburn/Indigestion ☐ Rectal Bleeding ☐ Stomach Pain ☐ Constipation ☐ Vomiting Blood
☐ Black Tarry Stools ☐ Nausea ☐ Diarrhea ☐ Abnominal Swalling ☐ Trouble Swallowing ☐ Other ____________________

Psychosocial:

☐ Anxiety/Nerves ☐ Abusive Relationship ☐ Sexual Problems ☐ Sleep Problems ☐ Alcohol Use ☐ Depression
☐ Feeling Worthless ☐ Want to Hurt Yourself ☐ Want to Hurt Others ☐ Drug Use

Muscles/Bones

☐ Chronic Pain ☐ Arthritis ☐ Bone Pain
☐ Muscle Weakness ☐ Muscle Cramping ☐ Joint Pain

Genitourinary

☐ Sexual Problems ☐ Burning with Urination
☐ Blood in Urine ☐ Leakage of Urine

Endocrine

☐ Hot Flashes ☐ Bothered by Heat
☐ High Thirst ☐ Bothered by Cold

Ears/Nose/Mouth/Throat

☐ Hearing Loss ☐ Chronic Sinus Congestion
☐ Heavy Snoring ☐ Bad Teeth

Neurological

☐ Headaches ☐ Seizures(Epilepsy)
☐ Confusion ☐ Tremor(shaking)

Heart

☐ ChestPain ☐ Palpitations
☐ Irregular Heart Beat ☐ High Blood Pressure

Respiratory(lungs)

☐ Cough ☐ Asthma
☐ Shortness of Breath ☐ Emphysema(COPD)

Head/Eyes

☐ Cataracts ☐ Dry Eyes ☐ Poor Vision ☐ Color Blindness

Constitutional

☐ Fevers ☐ Fatigue ☐ Weight Gain ☐ Weight Loss

Blood/Lymph

☐ Swollen Lymph Nodes ☐ Easy Bruising ☐ Easy Bleeding

Skin

☐ Rash ☐ Jaundice ☐ Itching ☐ Psoriasis

Vascular

☐ Blood Clots ☐ Varicose Vains

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Surgical History - Please select box for any surgery you have had, indicate year (mm/yyyy) *

☐ No Past Surgical History
☐ Gall Bladder Surgery __/____
☐ Thyroid Surgery __/____
☐ Breast Surgery __/____
☐ Hernia Repair __/____
☐ Valve Replacement/ Repair __/____
☐ Other(Please List) ________________________________

☐ Cancer Surgery __/____
☐ Splenectomy __/____
☐ Blood Transfusion __/____
☐ Abdominal Surgery __/____
☐ Ear Surgery __/____
☐ Cataract Removal/ IOL Implant __/____

☐ Pacemaker/Defibrillator __/____
☐ Back Surgery __/____
☐ Colposcopy __/____
☐ Tubal Ligation __/____
☐ Heart Bypass Surgery __/____
☐ Hysterectomy or Uterus Removal __/____

☐ Appendix Removal __/____
☐ Colonoscopy __/____
☐ Tonsillectomy __/____
☐ C-Section __/____
☐ Joint Replacement __/____
☐ Weight Loss Surgery __/____

Family History-Check all that apply

Relationship	First Name	Status	No Known Problems	Arthritis	Asthma	Birth Defects	**Cancer	Clotting Disorder	Depression	Diabetes	Early Sudden Death	Hearing Loss	Heart Disease	Hypertension	Kidney Problems	Mental Illness	Stroke	Substance/Drug Abuse	Vision Loss	Other
Mother	________	☐ Alive ☐ Deceased	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	________
Father	________	☐ Alive ☐ Deceased	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	________
Brother	________	☐ Alive ☐ Deceased	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	________
Sister	________	☐ Alive ☐ Deceased	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	________
Other	________	☐ Alive ☐ Deceased	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	________
Other	________	☐ Alive ☐ Deceased	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	________

**Type of Cancer or Disease: ____________________________

Screening

In the past two weeks, how often have you been bothered by the following? (Please select one response per statement.)

Little interest or pleasure in doing things*: ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless*: ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Have you fallen in the past year?*: ☐ Yes ☐ No

Are you afraid of falling?*: ☐ Yes ☐ No

Do you have issues with balance or feeling unsteady?*: ☐ Yes ☐ No

Do you feel safe at home?*: ☐ Yes ☐ No

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Patient Self Determination Act Questionnaire

Patient Name*: ________________________ Patient DOB*: _________ (mm/dd/yyyy)

DON'T LOSE YOUR RIGHT TO DECIDE

You cannot remove all uncertainty about your future healthcare needs, but by having an advance directive you can have the peace of mind that comes from making your wishes known in advance.

Declaration to Decline Life-Prolonging Procedures

☐ I have made a Living Will
☐ I do NOT designate a Living Will

Health Care Surrogate

☐ I have designated a Health Care Surrogate
☐ I do NOT designate a Health Care Surrogate

Durable Power of Attorney

☐ I have appointed a Durable Power of Attorney for Health Care decisions
☐ I have NOT appointed a Durable Power of Attorney for Health Care decisions

Patient/Representative Signature*: ____________________ Name*: ________________________

Date*: _________ (mm/dd/yyyy)

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Statement of Patient Financial Responsibility

Patient Name*: ________________________ Patient DOB:* _________ (mm/dd/yyyy)

Sunrise Medical Clinic appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Sunrise Medical Clinic, for providing Internal Medicine related services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Sunrise Medical Clinic, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Some insurers require a coinsurance, a deductible for services rendered as well. For high deductible insurances, we may charge allowable amounts up-front at the time the service is rendered. Thank you for your cooperation in this matter.

Consent for Treatment and Authorization to Release Information

I hereby authorize Sunrise Medical Clinic, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Sunrise Medical Clinic, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Cancellation / No Show Policy

We understand there may be times you miss an appointment due to emergencies or obligations to work or family.
However, we urge you to call 24-hours prior to cancelling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

The practice will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described.

Patient/Guarantor Signature*: _____________ Date*: _________ (mm/dd/yyyy)

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HIPAA Information and Consent

The Health Insurance Portability and Accountability Act(HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 18, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records,PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes of office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or servicies.

7. We agree to provide patients with access to their records in accordance with state and federal laws

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning you PHI. However, we are not obligated to alter internal policies to conform to your request.

I *_______________________________ date *_________ (mm/dd/yyyy) do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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Notice Of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with Nilam D Shah, MD, Sunrise Medical Clinic by sending a letter to 5778 5th Ave N, St Petersburg, FL 33710, or calling 727-388-2625
- We will not retaliate against you for filing a complaint

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

continued...

- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

continued...

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

This notice is effective on or after January 1, 2021.

The name and contact of the person you can contact for further information concerning our privacy practices is:
Deval Shah
Email- info@sunrisemedclinic.com
Phone number- 727-388-2625

Notice of Privacy Practices Receipt Acknowledgement

Sunrise Medical Clinic has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact the front desk staff at your physician's office to obtain a current copy of the Notice of Privacy Practices or to ask questions. It is also posted on our website at http://sunrisemedclinic.com/NoticeOfPrivacyPractices.aspx.

By my signature below, I agree that I have received the Notice of Privacy Practices of Sunrise Medical Clinic.

Date*: ____________(mm/dd/yyyy)

Printed name of the patient*: ____________________

Patient or legally authorized individual signature*: ____________________

Printed name (if signed on behalf of the patient): ____________________

Relationship (parent, legal guardian, personal representative): ____________________

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