

Suncoast Internal Medicine Consultants Patient Registration

Name _____

Preferred Name _____

Address _____

City _____ State _____ Zip Code _____

Secondary Address _____

Date of Birth _____ Last Four of Social Security Number _____

Marital Status: S M D W Sex: M F Ethnicity: Hispanic or Non Hispanic

Race: American Indian Asian Black Caucasian Pacific Islander Other Prefer Not to Answer

Primary Language _____ Email _____@_____

Employer _____ Phone _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone _____

Referring Physician _____

Pharmacy Name _____ Phone _____

Address _____

Insurance Name _____ Policy Holder Name _____

Account Number _____ Group Number _____

Secondary Insurance Name _____ Policy Holders Name _____

Account Number _____ Group Number _____

Cancellation/No Show Policy

In consideration of other patients and staff, No Shows and Same Day Cancellations are susceptible to a \$50 fee. Cancellations are to be made 24 hours prior to scheduled appointment time.

Assignment of Benefits

I request that payments of any and all authorized insurance benefits be made on my behalf to Suncoast Internal Medicine Consultants for any service or equipment provided to me by the organization.

Responsibility

I understand that it is my responsibility to inform this office immediately of any change in my insurance coverage. I am financially responsible for all fees incurred on my behalf for any service furnished. I am responsible for any balance, Co-Payment, and/or deductible not covered by my insurance. I further agree to pay any fees incurred in the collection of any delinquent charges that I am financially responsible for.

Release of Medical Information

I authorize Suncoast Internal Medicine Consultants to release information concerning my medical care to the Health Care Administration and its agents, and any information needed to determine benefits payable for related services.

Residents and Interns

I understand that Suncoast Internal Medicine Consultants is a teaching facility. Residents, interns and fellows may participate, under the supervision of an attending physician, in my care as part of the Suncoast Internal Medicine education program.

Medicare Recipients Only

I certify the information given by me in applying for payments under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf of Suncoast Internal Medicine Consultants for any services furnished to me by any physician. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for the related services.

Privacy Practices

I have been made aware of Suncoast Internal Medicine Consultants Notice of Privacy Practice and that I have a right to receive a copy upon request. This notice describes the types of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Suncoast Internal Medicine Consultants health care operations. I understand that copies of the Notice of Privacy Practices are available in the lobby of the clinic and on the web site SUNCOASTINTERNALMEDICINE.com.

X _____
Signature of Patient or Personal Representative

DATE _____

Description of Personal Representative's Authority



New Patient Questionnaire

Date Completed _____

Personal Information

Name _____ Date of Birth: _____

Do you have special needs in the following areas?

- Reading Vision Mobility (wheelchair, walker, etc) Hearing Communication

HOME

- Single Married Long-Term Partner Divorced Separated Widowed

Children's Ages _____

Current members of your household _____

EMPLOYMENT

- Full-Time Part-Time At Home/Homemaker Looking Disabled Retired Student

Current occupation _____ Former Occupation _____

ALLERGIES

List medication allergies and the type of reaction you had. I have no drug allergies.

MEDICATIONS

List with doses. Include contraceptives, vitamins, supplements, etc. Attach list if needed NONE

Name: _____

YOUR MEDICAL CONDITIONS (check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Myocardial infarction |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gastroesophageal reflux disease (GERD) | <input type="checkbox"/> Nerve/muscle disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Clotting disorder | <input type="checkbox"/> Hypertension/high blood pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Congestive heart failure | | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | | |

Details/Other: _____

SURGICAL HISTORY (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> C-section | <input type="checkbox"/> Small intestine surgery |
| <input type="checkbox"/> Brain surgery | <input type="checkbox"/> Eye surgery | <input type="checkbox"/> Spine surgery |
| <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Fracture surgery | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> CABG | <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Valve replacement |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Colon surgery | <input type="checkbox"/> Joint surgery | <input type="checkbox"/> Vascular surgery |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Bunionectomy | <input type="checkbox"/> Cardiac stent |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Varicose vein surgery | <input type="checkbox"/> Bladder surgery |
| <input type="checkbox"/> Thyroid surgery | <input type="checkbox"/> Prostate surgery | |
| <input type="checkbox"/> Lung surgery | <input type="checkbox"/> Weight reduction surgery | |

Have you ever had a blood transfusion? No Yes, approximate dates: _____

FAMILY HISTORY (check all that apply)

	Alcohol abuse	Breast cancer	Ovarian cancer	Prostate cancer	Other cancer(s)	Diabetes	Heart disease	High cholesterol	Hypertension	Mental illness
Mother										
Father										
Sister										
Brother										
Daughter										
Son										
Other relative										

Other family history: _____

HABITS AND ACTIVITIES

Do you use tobacco? No Yes, what form? _____ How much? _____ For how long? _____

In the past How many years ago did you quit? _____

Have you tried to quit? No Yes Would you like to quit? No Yes

Do you drink alcohol? No In the past Yes, how many drinks per week? _____

Do you, or have you ever used recreational drugs? No Yes, describe: _____

Do you get regular exercise? No Yes, what kind of exercise?

How often? Daily N Name: _____

List any hobbies or leisure activities:

Name: _____

IMMUNIZATIONS

Vaccination	Approximate Date	Never
Pneumonia (pneumovax)	_____	<input type="checkbox"/>
Tetanus booster (Tdap)	_____	<input type="checkbox"/>
TB skin test (PPD)	_____	<input type="checkbox"/>
Hepatitis B vaccine	_____	<input type="checkbox"/>
Hepatitis A vaccine	_____	<input type="checkbox"/>
Varicella (chicken pox)	_____	<input type="checkbox"/>
Shingles (Zostavax)	_____	<input type="checkbox"/>

PREVENTIVE CARE

Test or Procedure	Date and Result	Never
Colonoscopy	_____	<input type="checkbox"/>
Bone density test (DXA)	_____	<input type="checkbox"/>
Cholesterol test	_____	<input type="checkbox"/>
PSA (prostate cancer test)	_____	<input type="checkbox"/>
Pap smear	_____	<input type="checkbox"/>
Mammogram	_____	<input type="checkbox"/>
HIV test	_____	<input type="checkbox"/>

List any abnormal screening test results (e.g. polyps, breast biopsies, etc.): _____

SEXUAL HISTORY

My sexual partners have been: Male Female Both Never Sexually Active

Have you had more than one sexual partner in the past year? No Yes

Have you ever had a sexually transmitted disease? No Yes, what and when? _____

GYNECOLOGICAL AND OBSTETRIC HISTORY

How many times have you been pregnant? _____ Live births? _____ Miscarriages? _____ Abortions? _____

Do you use contraception? No Yes, what kind? _____

What was your age at first menses? _____ Menstrual periods: Regular Irregular Menopausal

Age at menopause? _____ Do you have hot flashes or other symptoms (specify)? _____

Any gynecological conditions or problems? _____ Name: _____

OTHER HEALTH ISSUES

Do you feel unsafe, or have you been harmed in a physical, emotional or sexual manner, in any relationship or recent encounter? No Yes, describe: _____

Name: _____

In the past year, have you had two weeks or more during which you felt sad, blue, or depressed or when you have lost all interest or pleasure in the things that you usually care about or enjoy? No Yes, Describe _____

In the past year, have you had any major life changes or stresses that you feel have impacted your overall health?

No Yes, describe _____

ADDITIONAL COMMENTS OR CONCERNS
