



WESLEY CHAPEL

INTERNAL MEDICINE AND PEDIATRICS

REGISTRATION FORM

(Please Print)

Today's date:		PCP:	
PATIENT INFORMATION			
Patient's last name:		First:	Middle:
		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss
		<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.
Marital status (circle one)			
Single / Mar / Div / Sep / Wid			
Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:
<input type="checkbox"/> Yes	<input type="checkbox"/> No		/ /
			Age:
			Sex:
			<input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Social Security no.:	Home phone no.:
			()
P.O. box:	City:	State:	ZIP Code:
Cell Phone no:	Employer:	Employer phone no.:	
()		()	
Chose clinic because/Referred to clinic by (please check one box):		<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other
Other family members seen here:			
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"/> BC/BS	<input type="checkbox"/> Cigna	<input type="checkbox"/> United Health <input type="checkbox"/> Aetna <input type="checkbox"/> Medicaid
<input type="checkbox"/> Citrus Health	<input type="checkbox"/> Humana	<input type="checkbox"/> Tri Care	<input type="checkbox"/> Medicare <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 (not living at same address):	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 Wesley Chapel Internal Medicine & pediatrics or insurance company to release any information required to process my claims.			
Signature: X		Date:	



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	DOB:
Occupation:			
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Previous or referring doctor:		Date of last physical exam:	

PERSONAL HEALTH HISTORY

Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio	
Immunizations and dates:	<input type="checkbox"/> Tetanus <input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza <input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

Review of systems: If you answer yes to any of the questions below, please explain.

GENERAL

- | | |
|---|--|
| 1. Unexplained weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No | What was the magnitude of this weight loss? 0-5 lbs. <input type="checkbox"/> 5-15 lbs. <input type="checkbox"/> 15-25 lbs. <input type="checkbox"/> >25 lbs. <input type="checkbox"/> |
| 2. Unexplained weight gain <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Night Sweats <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Chronic Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Fever or chills <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Change in appetite <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Any type of cancer <input type="checkbox"/> Yes <input type="checkbox"/> No |

HEART/VASCULAR

- | | |
|---|---|
| 8. Chest pain or pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Calf pain with exercise <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Chest pain with exertion <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Varicose veins <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Phlebitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Rapid/Irregular heartbeats <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Fainting/Lightheadedness <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. High blood cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. High blood triglycerides <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No | |

EYES

- | | |
|---|--|
| 21. Decrease in vision <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. Color blindness <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Double vision <input type="checkbox"/> Yes <input type="checkbox"/> No | 25. Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. Serious injury to eye <input type="checkbox"/> Yes <input type="checkbox"/> No |

EAR-NOSE-THROAT

- | | |
|---|---|
| 27. Hearing loss <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Ruptured eardrum <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28. Prolonged exposure to loud noise <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. Snoring <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 29. Ringing in ears <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. Sinus infection <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 30. Chronic ear infections <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. Allergy related nasal congestion <input type="checkbox"/> Yes <input type="checkbox"/> No |

BONE & JOINT

- | | |
|--|--|
| 35. Chronic joint & muscle pain <input type="checkbox"/> Yes <input type="checkbox"/> No | 38. Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 36. Low back pain <input type="checkbox"/> Yes <input type="checkbox"/> No | 39. Gout <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 37. Swollen/stiff joints <input type="checkbox"/> Yes <input type="checkbox"/> No | |

ENDOCRINE

- | | | |
|--|---|---|
| 40. Thyroid disease <input type="checkbox"/> Yes <input type="checkbox"/> No | 41. High blood sugar <input type="checkbox"/> Yes <input type="checkbox"/> No | 42. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|---|---|



WESLEY CHAPEL

INTERNAL MEDICINE AND PEDIATRICS

PULMONARY

- | | | | |
|-----------------------------|--|-------------------------|--|
| 43. Chronic cough or phlegm | <input type="checkbox"/> Yes <input type="checkbox"/> No | 48. Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 44. Wheezing | <input type="checkbox"/> Yes <input type="checkbox"/> No | 49. Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 45. Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | 50. Coughed up blood | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 46. Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | 51. Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 47. Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

GASTROINTESTINAL

- | | | | |
|---------------------------------------|--|---|--|
| 52. Ulcer disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | 59. Diarrhea caused by milk/lactose intolerance | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 53. Frequent heartburn | <input type="checkbox"/> Yes <input type="checkbox"/> No | 60. Blood in stools | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 54. Vomited blood | <input type="checkbox"/> Yes <input type="checkbox"/> No | 61. Black stool | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 55. Gallbladder trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | 62. Hemorrhoids | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 56. Abdominal Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | 63. Colon Polyps | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 57. Jaundice, hepatitis, or cirrhosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | 64. Chronic constipation | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 58. Frequent diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

NEUROPSYCHIATRY

- | | | | |
|---|--|--|--|
| 65. Loss of consciousness | <input type="checkbox"/> Yes <input type="checkbox"/> No | 71. Difficulty sleeping | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 66. Vertigo | <input type="checkbox"/> Yes <input type="checkbox"/> No | 72. Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 67. Memory problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | 73. Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 68. Seizures or epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | 74. Nervous breakdown | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 69. Frequent headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | 75. Psychiatric or psycho-logical counseling | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 70. Numbness or tingling of arms, legs, or face | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

HEMATOLOGY

- | | | | |
|-----------------------|--|-------------------------------------|--|
| 77. Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | 79. Previous blood transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 78. Bleeding disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | 80. Enlarged or swollen lymph nodes | <input type="checkbox"/> Yes <input type="checkbox"/> No |

DERMATOLOGY

- | | | | |
|--------------------------------|--|---------------------------------|--|
| 81. Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No | 86. Mouth sores that won't heal | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 82. Skin cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | 87. Psoriasis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 83. Shingles/herpes zoster | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 84. Skin sores that won't heal | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

WOMEN ONLY

Age at onset of menstruation:

Date of last menstruation:

Period every days

Heavy periods, irregularity, spotting, pain, or discharge? Yes No

Number of pregnancies Number of live births

Are you pregnant or breastfeeding? Yes No

Have you had a D&C, hysterectomy, or Cesarean? Yes No

Any urinary tract, bladder, or kidney infections within the last year? Yes No

Any blood in your urine? Yes No

Any problems with control of urination? Yes No

Any hot flashes or sweating at night? Yes No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? Yes No

Experienced any recent breast tenderness, lumps, or nipple discharge? Yes No

Date of last pap and rectal exam?



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INTERNAL MEDICINE AND PEDIATRICS

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?		

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had



WESLEY CHAPEL

INTERNAL MEDICINE AND PEDIATRICS

HEALTH HABITS AND PERSONAL SAFETY

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

Exercise	<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)		
Diet	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?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea <input type="checkbox"/> Cola
	# of cups/cans per day?		
Alcohol	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
Tobacco	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	
Drugs	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
Sex	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
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	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
Personal Safety	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



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INTERNAL MEDICINE AND PEDIATRICS

FAMILY HEALTH HISTORY					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> F		Grandmother <i>Paternal</i>		
<input type="checkbox"/> M		Grandfather <i>Paternal</i>			
<input type="checkbox"/> F					

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

NUTRITIONAL SUPPLEMENT INFORMATION

Are you presently taking any type of nutritional supplements (vitamins, minerals, herbs, amino acids, fish oils, etc)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name the supplements that you are presently taking:		
Who recommended you take these supplements?		
Where did you purchase these supplements?		
If this practice offered an advanced, high quality line of supplements, would you consider purchasing them?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If this practice offered a simple genetic test to determine what supplemental regimen is best for you, based on your genetic variations,		
Would you consider doing it?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If this Practice offered a comprehensive weight management program, would you consider it?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If this practice offered a nutrition education program to improve your dietary habits, would you consider it?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
By appointment with one of our staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
By a class exclusively for our patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



Acknowledgement of Receipt of

NOTICE OF PRIVACY PRACTICES

**By signing this document, I acknowledge that I have received a copy of Dr. Shah's
Notice of Privacy Practices.**

Name (Please Print) **Signature** **Date**

If signing as a parent or guardian, please write the name of the patient below.

(minor or unable to sign)

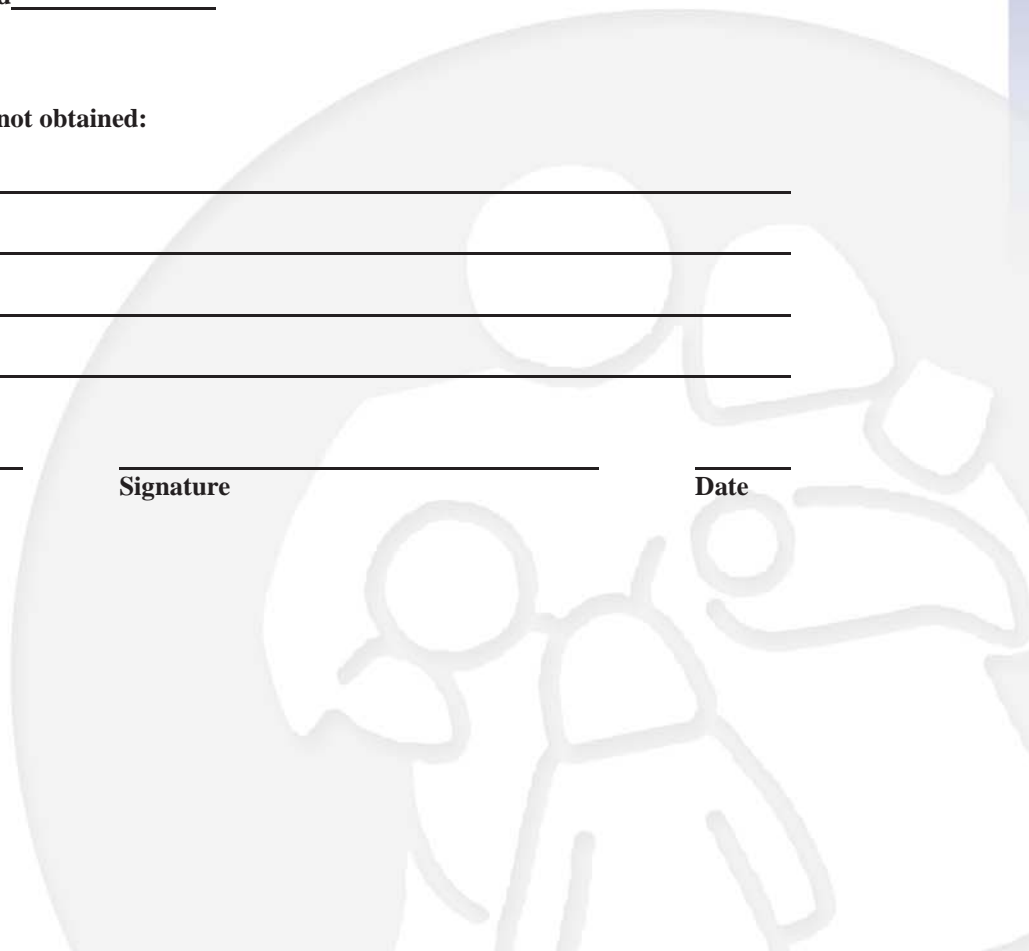
FOR INTERNAL OFFICE USE ONLY

Date Acknowledgement received _____

Or

Reason Acknowledgement was not obtained:

Name (Please print) **Signature** **Date**





Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our practice, we will always keep your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In case an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for these copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier document, but will add new information.

You have a right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of health and Human service 200 Independence Avenue, S.W. , Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy officer, Dr Shah, phone number 813-929-3622.

This notice goes into effect as of the date on file.

Signature _____ Date _____



WESLEY CHAPEL

INTERNAL MEDICINE AND PEDIATRICS

2038 Ashley Oaks Circle Wesley Chapel, FL 33543
Phone: 813-929-3622 Fax: 813-929-3620

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize

(Name of Doctor or Facility): _____

(Previous Doctors Phone #) _____

To release healthcare information of the patient named above to:

Name: Wesley Chapel Internal Medicine & Pediatrics

Address: 2038 Ashley Oaks Circle Suite #102

City: Wesley Chapel State: FL Zip Code: 33543

This request and authorization applies to:

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: _____



Wesley Chapel Internal Medicine and Pediatrics Office Policies

Dear Patient,

As a part of ongoing effort to make being at our office a pleasurable experience, we have adopted some standard policies to ensure your continued satisfaction with our services.

1. We are here to take care of you. **The office is open Monday – Friday from 9am to 5pm.** On Tuesday afternoons we take administrative time to catch up on referrals and other administrative tasks.
2. We will make every attempt to see you when you are ill on the same day or the next day. Dr. Shah will occasionally overbook appointments for this purpose.
3. We attempt sincerely to see you on time. If the wait to be seen is expected to exceed 30 minutes, you should and will be notified. Please be patient as we do try to make room for everyone in the schedule when they are ill.
4. If you are unable to keep an appointment, we ask that you just re-schedule prior to your appointment time. If you no show for an appointment **more than once** in any calendar year, there will be a **no show fee of \$35** charged to your account. Excessive no shows for appointments may result in dismissal from the office at the discretion of Dr. Shah.
5. Please give us at least **1 week notice for medication refills.** (Most prescription refill requests are done within 24-72 hours of your phone call.)
6. You should always receive a call regarding results of labs and other tests that Dr. Shah orders for you. If you do not receive a result, it is imperative that you call the office for the result. Every test is reviewed by Dr. Shah. Most labs and tests are reviewed within 24-72 hours of receiving the result. If it has been more than 10 days, please advise us immediately.
7. We do ask that non health related paperwork i.e. FMLA, Disability, and Medicare required paperwork be filled out during an office visit. Please understand that these forms take time to fill out accurately, and your presence is necessary.
8. School Physicals & Gold and Blue forms will be filled out without requiring an additional office visit if the child has been seen here for a well child exam in the last 6 months. Please give us at least 48 hours notice to have these forms completed.
9. We ask that all children brought to the office act and behave appropriately for their age(s).
10. **Our After Hours Phone Number to speak with Dr. Shah is (813) 681-0093,** to be used only for urgent medical care needs.
11. **All balances are due at the time of service. We ask that you make arrangements for all balances with us prior to your visit. Services will not be rendered, and you may be rescheduled if payment arrangements are not made. Any balances billed to insurance and not paid by or not covered by insurance, do become patient responsibility, and will be due at the time of service.**

For Parents of Newborns, Dr. Shah will provide his direct cell phone number. Please ask during your visit.

We take pride in our work and our office, and are always looking for suggestions for improvement. Please feel free to drop off any suggestions to our Office Manager, Sobey Collazo. Any confidential requests can be discussed with Dr. Shah directly. Thank you, and Welcome to Wesley Chapel Internal Medicine and Pediatrics.

Print Patient Name _____ and Parent/Guardian Name _____
 (if applicable)
 Patient/Guardian Signature _____ Date: _____



WESLEY CHAPEL

INTERNAL MEDICINE AND PEDIATRICS

2038 Ashley Oaks Circle, Suite 102 Wesley Chapel, Fl 33544
Phone: 813-929-3622 Fax: 813-929-3620

Patient Name _____

Please tell us how you heard about our office:

_____ Patient Referral: (please tell us who and we will send them a thank you gift)

_____ Insurance Company (Website):

_____ Newspaper Ad:

_____ Yellow Pages:

_____ Internet Search: (please indicate yahoo, google, etc)

Other:

