



# WESLEY CHAPEL

## INTERNAL MEDICINE AND PEDIATRICS

### REGISTRATION FORM

(Please Print)

Today's date:		PCP:	
<b>PATIENT INFORMATION</b>			
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:			
<b>INSURANCE INFORMATION</b>			
(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
<b>IN CASE OF EMERGENCY</b>			
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:	



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## CHILD HEALTH HISTORY QUESTIONNAIRE

Please complete this to the best of you abilities, this will help us to better care for your child.

Name: (Last, First, MI) \_\_\_\_\_

Childs Previous Pediatrician: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

### A. Birth History

- Who was the Mother's obstetrician? : \_\_\_\_\_ Date begun: \_\_\_\_\_
- Any problems with the pregnancy? YES NO
- Full term? YES NO  
If not full term, how many weeks? \_\_\_\_\_  
What was baby's birth weight? : \_\_\_\_\_ length? \_\_\_\_\_
- Delivered at: (Name of Hospital) \_\_\_\_\_  
Vaginal \_\_\_\_\_ C-section \_\_\_\_\_
- Problems at delivery? Mother? YES NO Baby? YES NO  
Type of problem \_\_\_\_\_
- Do you know if Tobacco, alcohol, or drugs were used during pregnancy? YES NO

### B. Past Medical History

- Where has your child gone for checkups? \_\_\_\_\_
- Date of last visit to Doctor: \_\_\_\_\_  
Dentist: \_\_\_\_\_
- Allergy to: \_\_\_\_\_
- Any reactions to shots? YES NO  
Please explain: \_\_\_\_\_
- Any hospitalizations, accidents, injuries? YES NO
- Is child taking medicines? YES NO  
What kind? \_\_\_\_\_

### C. FEEDING & NUTRITION

- Is your child's appetite usually good? YES NO
- Any colic, spitting, feeding problems? YES NO
- Check: Breast Bottle Type of formula \_\_\_\_\_
- Does your child eat things that are not food? YES NO  
What? \_\_\_\_\_

### D. DEVELOPMENT & BEHAVIOR

- At what age did your child sit alone? \_\_\_\_\_
- At what age did your child walk alone? \_\_\_\_\_
- Did your child say words by 18 months? YES NO
- At what age was your child toilet trained? \_\_\_\_\_
- Does your child wet the bed? YES NO
- Does your child have trouble sleeping? YES NO
- Does your child play well with others? YES NO
- Has your child repeated a grade in school? YES NO





**Nutritional supplement information: (continued)**

- |  |     |    |
|--|-----|----|
| 5. If this Practice offered natural alternatives to prescriptions, when applicable, would you be interested in these alternatives? | YES | NO |
| 6. If this Practice offered a comprehensive weight management program, would you consider it?                                      | YES | NO |
| 7. If this Practice offered a nutrition education program to improve your dietary habits, would you consider it?                   | YES | NO |
| by appointment with one of our staff?  | YES | NO |
| by a class exclusively for our patients?   | YES | NO |

\_\_\_\_\_  
PRINT NAME PLEASE

\_\_\_\_\_  
(Relationship)

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





*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***

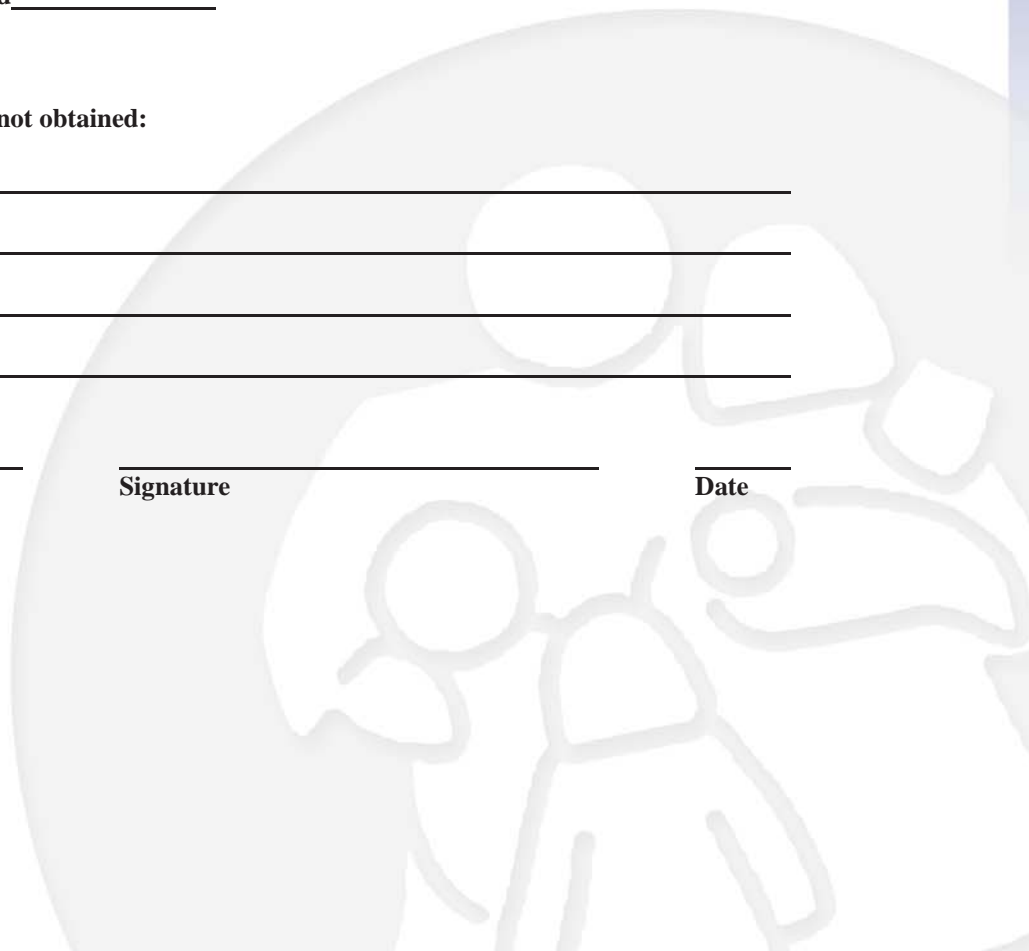
**Date Acknowledgement received** \_\_\_\_\_

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



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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:

