2350 Vanderbilt Beach Rd.
Suite 101
Naples, FL 34109

(239) 948-3444
Fax (239) 948-9028

8800 Terrene Court
Suite 102
Bonita Springs, FL 34135

(239) 948-3444
Fax (239) 948-9028

www.shahlamedical.com

Patient Name: ______________________________

Yearly Preventive / Wellness Exams

Most insurance plans will cover the cost for your preventive/wellness visit at 100% with no deductible, co-pay or co-insurance applied and most offer this benefit on a yearly basis. It is your responsibility to check with your carrier to see exactly what they consider as part of this yearly benefit.

Please be aware that if any other procedures or discussions take place during this visit that your insurance carrier considers beyond the scope of your annual preventive/wellness exam, then they may apply these charges to any deductibles, co-pays or co-insurances that you may have according to your own individual policy.

You have the option of scheduling another appointment, separate from your preventive/wellness visit, if you choose to do so.

Patient Signature: ______________________________

Date Signed: ________________

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PATIENT CONSENT FORM (HIPAA COMPLIANT)

With my consent, Shahla Medical Group may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Shahla Medical Group's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Shahla Medical Group reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Shahla Medical Group Privacy Officer at 8800 Terrene Court, Suite 102, Bonita Springs, FL 34135.

With my consent, Shahla Medical Group may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others.

With my consent, Shahla Medical Group may mail or email to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Shahla Medical Group restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Shahla Medical Group's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Shahla Medical Group may decline to provide treatment to me.

Patient Full Name (Printed): ______________________________

Patient Signature: ______________________________

Date Signed: ______________________________

Revised 08/20/2014

ADULT MEDICAL HISTORY

Patient Full Name (Printed): ________________________________ **DOB:** ____/____/______ **Sex:** _____

Current Occupation:____________________________ **Past Occupation:** ______________________________

I am allergic to the following (including all medications, foods, pollens, etc) and the type of reaction: ____

____

I am currently taking the following medications (including over the counter, birth control, etc): __________

____

____

I have had the following surgeries (including the dates procedure occurred): ______________________

____

____

I have the following medical problems: ____

____

____

Immunization History: Please fill in the year in which you received the following:

Tetanus shot: ____________ Pneumonia shot: ____________ Hepatitis B shot: ____________

Habits: Please circle your response and answer additional information if needed:

Do you smoke?: YES NO If yes, how many packs per day?: ______________________

Do you drink alcohol?: YES NO If yes, how much/often?: ____________________________

Do you exercise regularly?: YES NO If yes, how often?: ______________________________

Family Medical History: Please complete the medical history for each family member listed below:

Father: ____

Mother: ____

Siblings: ____

Children: ____

When was your most recent Colonoscopy/Sigmoidoscopy?: __________ Stool Cards Done: ___________

For Women ONLY: Please complete the following information:

Number of Pregnancies: _____ When was your last bone density test?: ____/____/______

Number of Live Births: _____ When was your last pap smear?: ____/____/______

Number of Miscarriages: _____ Have you ever had an abnormal pap smear?: ________________

Number of Abortions: _____ When was your last mammography?: ____/____/______

Have you ever had an abnormal mammography?: ________________

Have you ever had a breast biopsy/surgery?: ________________

Any other information your doctor should know about?: ______________________________________

____

Do you have a living will or other advanced directives? (please circle): **YES** **NO**
If yes, please provide our office with a copy of the documents.
If no, would you like our office to provide you with the appropriate documents?: **YES** **NO**

Patient Signature: ______________________________ **Date**: ____/____/______

Revised 08/20/2014

NEW E PRESCRIPTION INFORMATION

WE ARE NOW USING A NEW PROGRAM WHICH SENDS PRESCRIPTIONS ELECTRONICALLY. PLEASE PROVIDE US WITH THE FOLLOWING UPDATED INFORMATION:

LOCAL PHARMACY:

NAME__________________________

PHONE_________________________
If available

LOCATION ___________________________
Required

MAIL ORDER PHARMACY

NAME_____________________________

PHONE_____________________________
If available

WHEN YOU NEED A REFILL OF A PRESCRIPTION TO LOCAL PHARMACY, DO NOT CALL US. PLEASE CONTACT YOUR PHARMACY AND THEY WILL SEND REQUEST TO US.

IF YOU NEED A WRITTEN PRESCRIPTION FOR MAIL ORDER, PLEASE TELL US WHEN YOU LEAVE A MESSAGE FOR US.

PATIENT NAME______________________________
print

SIGNATURE________________________________DATE____________________

Suggested form of a Health Care Surrogate, Florida Statutes Section 765.203

Designation of Health Care Surrogate

Name____

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate, as my surrogate for health care decisions:

Name ________________________________
Street Address ____________________________
City ________________ State _____ Zip ________
Phone ________________________________

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name ________________________________
Street Address ____________________________
City ________________ State _____ Zip ________
Phone ________________________________

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional Instructions (optional):

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name ____________________________________
Name ____________________________________
Signed: __________________________________

Witnesses 1. __________________________
2. __________________________

At least one witness must not be a husband or wife or a blood relative of the principal.

— This form offered as a courtesy of The Florida Bar and the Florida Medical Association —

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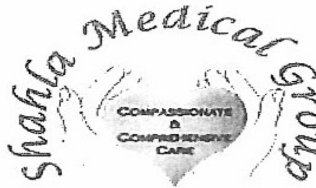

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NEW PATIENT REGISTRATION FORM

Last Name: ____________________ **First Name:** ________________ **Middle Initial:** ___

Address: ____ ________
Street Apt. #

___________________________________, ______ ________________
City State Zip Code

Home Phone: ______________________ Cell Phone: ______________________

Work Phone: ______________________ Northern Phone: ____________________

Northern Address: ____ ________
Street Apt. #

___________________________________, ______ ________________
City State Zip Code

Email Address: __________________________ Marital Status: _______________

Date of Birth: ______________ Sex: _______ Social Security #: _____-____-_____

Employer Name: ________________________ **Phone #:**______________________

Race: __Black __White __Hispanic __Other Ethnicity: __Hispanic __Non-Hispanic

Language: ____________________________

Emergency Contact Name: _______________________ **Relation:** _____________
(Other than Spouse)

Emergency Contact Phone #: ______________________

Primary Insurance Company Name: _____________________________________

Name of Subscriber: _______________________________ **DOB:** _____________

Subscriber Social Security #: _____-____-_____ **Relation to Patient:** _____________

Secondary Insurance Company Name: ___________________________________

Name of Subscriber: _______________________________ **DOB:** _____________

Subscriber Social Security #: _____-____-_____ **Relation to Patient:** _____________

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Shahla Medical Group for all my insurance claims related to services received. I agree to pay any and all charges that are not covered by my insurance. I understand that co-pays, deductibles and non- covered services are due at the time of service. I understand that in the event that any claims are denied due to the patient not providing the Shahla Medical Group with all updated insurance information the patient will be responsible for all charges.

Signature of Responsible Party: ______________________________ Date: ___________