

MAHESH BHAMBORE MD, FACP, SUNSTATE MEDICAL CLINIC
REGISTRATION FORM

(Please Print)

Today's date:

PCP:

PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	<input type="checkbox"/> Miss <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:	Age:	Sex:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No					/	/	<input type="checkbox"/> M	<input type="checkbox"/> F
Street address:				Social Security no.:		Home phone no.:			
						()			
P.O. box:		City:			State:		ZIP Code:		
Occupation:		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:		Email:							
RACE: (Optional)									

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"/> MEDICARE	<input type="checkbox"/> UNITED	<input type="checkbox"/> AETNA	<input type="checkbox"/> CIGNA			
<input type="checkbox"/> TRICARE	<input type="checkbox"/> HUMANA		<input type="checkbox"/> MEDICAID	<input type="checkbox"/> Welfare (Please provide coupon)			<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 SUNSTATE MEDICAL CLINIC, MAHESH BHAMBORE MD PA or insurance company to release any information required to process my claims.

	Patient/Guardian signature				Date		

Mahesh Bhambore, MD, FACP.
Sunstate Medical Clinic
21762 State Road 54,
Lutz, FL, 33549
Tel: (813) 949 2999
Fax: (813) 949 4999

Original Date:

Dates Revised:

10/25/2025

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:
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"/> Hepatitis		
	<input type="checkbox"/> Influenza		
		<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>	<input type="checkbox"/> Others

List any medical problems:

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?

Yes No

Please turn to next page

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

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?			
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?			
	Have you considered stopping?			
	Have you ever experienced blackouts?			
	Are you prone to "binge" drinking?			
	Do you drive after drinking?			
Tobacco	Do you use tobacco?			
	<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?			
	Have you ever given yourself street drugs with a needle?			

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 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

FAMILY HEALTH HISTORY

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		Grandmother <i>Maternal</i>	<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
<input type="checkbox"/> M		Grandfather <i>Maternal</i>	<input type="checkbox"/> M		
<input type="checkbox"/> F			<input type="checkbox"/> F		
<input type="checkbox"/> M		Grandmother <i>Paternal</i>	<input type="checkbox"/> M		
<input type="checkbox"/> F			<input type="checkbox"/> F		
<input type="checkbox"/> M		Grandfather <i>Paternal</i>	<input type="checkbox"/> M		
<input type="checkbox"/> F			<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

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 NoHave you had a D&C, hysterectomy, or Cesarean? Yes NoAny urinary tract, bladder, or kidney infections within the last year? Yes NoAny blood in your urine? Yes NoAny problems with control of urination? Yes NoAny hot flashes or sweating at night? Yes NoDo you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? Yes NoExperienced any recent breast tenderness, lumps, or nipple discharge? Yes No

Date of last Pap Smear : Date of Colonoscopy :

MEN ONLYDo you usually get up to urinate during the night? Yes No

If yes, # of times _____

Do you feel pain or burning with urination? Yes NoAny blood in your urine? Yes NoDo you feel burning discharge from penis? Yes NoHas the force of your urination decreased? Yes NoHave you had any kidney, bladder, or prostate infections within the last 12 months? Yes NoDo you have any problems emptying your bladder completely? Yes NoAny difficulty with erection or ejaculation? Yes NoAny testicle pain or swelling? Yes NoDate of last prostate exam : Date of Colonoscopy : **OTHER PROBLEMS**

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Patient Authorization for Release of Health Information

**Mahesh Bhambore MD PA
Sunstate Medical Clinic
21762 State Road 54,
Lutz, FL, 33549**

**Tel: (813) 949 2999
Fax: (813) 949 4999**

Welcome to Sunstate Medical Clinic!

I, _____, hereby authorize Mahesh Bhambore MD PA DBA Sunstate Medical Clinic to release my health information to the following family members.

1.

2.

Signed: _____

Patient Name: _____

Dated: _____

Sunstate Medical Clinic
Mahesh Bhambore MD PA

Acknowledgement of Receipt of
NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received or have been offered a copy of Dr. Bhambore'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

Mahesh Bhambore MD, FACP
Sunstate Medical Clinic
21762 State Road 54,
Lutz, FL, 33549

Tel: (813) 949 2999
Fax: (813) 949 4999

Welcome to Sunstate Medical Clinic!
Office Policy and Authorizations Form

The following policies help us to ensure that we give the best care to each of our patients. We have only your best interests, therefore, if you have questions regarding a certain policy, please do not hesitate to ask.

- All new patients are required to bring a driver's license (picture ID) and insurance card (if applicable) with them at time of visit. Policy numbers and policy information *will not* be accepted as a substitute for the card.
- Co-payment is due at time of visit.
- Past due balances are due at time of visit.
- 24 hour notice is required for cancellation of appointments. There is a **\$40.00** fee for all missed appointments not cancelled 24 hours in advance.
- Please allow 48 hours for all refill requests to be processed. Refills requested on a Friday will not be processed until the following Monday. Refill of prescriptions is at the discretion of the physician.
- We are not able to call in prescriptions for narcotics or antibiotics. If you are in need of these medications you must have a visit with a doctor.
- Any change of prescription will require an office visit.
- There will be a **\$40.00** charge on all returned checks
- There will be a **\$35.00** charge for completing FMLA/School Physical forms/other forms.
- For Self-Pay patients, the initial office visit charge would be **\$150.00**
- For Self-Pay patients, the follow-up office visit charge would be **\$125.00** per visit

1. I authorize this office to release or receive any information necessary to expedite insurance claims.
2. I hereby authorize this office to bill my insurance company directly for their services.
3. I authorize payment directly to this provider of my insurance benefits otherwise payable to me.
4. In the event I receive payment from my insurance carrier, I agree to endorse any payment over to the provider for which these fees are payable.

I, _____, have read the above office policies as well as the authorizations and my questions regarding these policies and authorizations have been answered to my satisfaction. By signing below I accept that these policies and authorizations have been put into place for my own best interest and understand that the staff of Mahesh Bhambore MD PA dBA Sunstate Medical Clinic reserves the right to enforce these policies at their discretion.

Signature of Patient (or Guardian): _____ Date: _____

Mahesh Bhambore MD, FACP

Sunstate Medical Clinic

***21762 State Road 54,
Lutz, FL, 33549***

Tel: (813) 949 2999

Fax: (813) 949 4999

Patient Self-Determination Act Questionnaire

Don't lose the right to decide your future. Having an advanced directive assures you peace of mind that comes from making your wishes known in advance.

Declaration to Decline Life-Prolonging Procedures (Living Will):

- I have made a Living Will.
- I do NOT have a Living Will.

Health Care Surrogate:

- I have designated a Health Care Surrogate.
- I have NOT designated 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.

Print Patient Name: _____

Date: _____

Signature of Patient: _____

If you have any questions regarding the Patient Self Determination Act you can contact your family attorney, local hospital, or your local medical association for additional information

(PLEASE MAIL RECORDS TO ADDRESS BELOW)

Mahesh Bhambore MD, FACP

**Sunstate Medical Clinic
21762 State Road 54,
Lutz, FL, 33549**

**Tel: (813) 949-2999
Fax: (813) 949-4999**

I authorize the named healthcare provider to release the information or records specified to upon requested in person or by mail to the address specified at the time of the request.

Provider:

Records to: **Mahesh Bhambore MD, FACP.
Sunstate Medical Clinic
21762 State Road 54,
Lutz, FL, 33549**

Records from:

Phone:

Fax:

Patient Information

Name:

SSN:

Date of Birth:

- Admission history and physical
- Consults
- Office notes
- Hospital Notes
- Lab reports
- Medication
- Radiology X-rays
- All the above

This information to be released for the purpose of:

- Continuation of care
- Other: _____

This authorization will expire one year from the date of signature below. I understand that I can revoke this authorization at any time by writing to the healthcare provider, but that revoking this authorization will not affect disclosure made or actions taken before the revocation is received. Federal privacy regulations will no longer apply to the information disclosed, and that may redisclose the information. A copy of this authorization may be utilized with the same effectiveness as original.

Patient's signature: _____

Date: _____