

**MAHESH BHAMBORE MD, FACP, SUNSTATE MEDICAL CLINIC**  
**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"/> Mrs.		<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)																							
<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"/> 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													
<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 SUNSTATE MEDICAL CLINIC, MAHESH BHAMBORE MD PA or insurance company to release any information required to process my claims.																							
Patient/Guardian signature										Date													

**Maresh Bhamore, 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.

<b>Name</b> <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
<b>Previous or referring doctor:</b>	<b>Date of last physical exam:</b>	

### PERSONAL HEALTH HISTORY

<b>Childhood illness:</b>	<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	
<b>Immunizations and dates:</b>	<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> <input type="checkbox"/> Others
<b>List any medical problems:</b>		
<b>Surgeries</b>		
Year	Reason	Hospital
<b>Other hospitalizations</b>		
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.

<b>Exercise</b>	<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)				
<b>Diet</b>	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	
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# of cups/cans per day?				
<b>Alcohol</b>	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
<b>Tobacco</b>	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			
<b>Drugs</b>	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

<b>Sex</b>	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
<b>Personal Safety</b>	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		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Sibling</b>	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Paternal</i>		

### 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last Pap Smear :	Date of Colonoscopy :	

## 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 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"/> Weight <input type="checkbox"/> Energy level <input type="checkbox"/> Ability to sleep <input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	
<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.

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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**

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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***

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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: \_\_\_\_\_