MAHESH BHAMBORE MD, FACP, SUNSTATE MEDICAL CLINIC

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ 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:	
❑ Yes	❑ No			/ /		❑ M	❑ 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):	❑ Dr.		❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ 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?	❑ Yes	❑ No		

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?	❑ Yes	❑ No	

Please indicate primary insurance	❑ BC/BS	❑ MEDICARE	❑UNITED	❑ AETNA	❑ CIGNA

❑ TRICARE	❑ HUMANA	❑ MEDICAID	❑ Welfare *(Please provide coupon)*	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ 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 SR 54, Lutz, FL, 33549 Tel: (813) 949 2999 Fax: (813) 949 4999
Web: www.sunstatemedicalclinic.com

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:	07/01/2018

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.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella* ☐ 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	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ 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?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ 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?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ 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?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

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

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Patient Authorization for Release of Health Information

Mahesh Bhambore MD PA
Sunstate Medical Clinic
21762 State Road 54, ***Tel: (813) 949 2999***
Lutz, FL, 33549 ***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, ***Tel: (813) 949 2999***
Lutz, FL, 33549 ***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 $25.00 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 $25.00 charge on all returned checks
- There will be a $25.00 charge for completing FMLA/School Physical forms/other forms.
- For Self-Pay patients, the initial office visit charge would be $95.00
- For Self-Pay patients, the follow-up office visit charge would be $75.00 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, *Tel: (813) 949 2999*
Lutz, FL, 33549 *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***

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: _____