Premier
ADULT MEDICAL CARE

Simrita Sidhu, MD
Ramnik Banwatt, MD
Internal Medicine

Tel (352) 597 1011 4428 Commercial Way, Spring Hill FL 34606 Fax (352) 597 7803

Dear Patient,

Thank you for choosing Dr. Sidhu to provide your health care. Our practice strives to provide the very best in medical care in a friendly environment.

Please fill out the attached forms to give us essential information needed to provide your care. It may be helpful to fill the forms home prior to your visit if you have a complicated medical history.

Please note in our practice Dr. Sidhu will provide the majority of your care in the office and Dr. Banwatt will assume care while hospitalized.

On behalf of myself and the staff at Premier Adult Medical I extend a warm welcome.

Sincerely Yours

Simrita Sidhu, MD

Check List of things to bring on your 1st visit

Completed Forms

- ☐ Registration Form
- ☐ Practice Policy Agreement
- ☐ Hippa Form
- ☐ History Forms

Other items

- ☐ Medication bottles
- ☐ Copies of old records (if possible)
- ☐ Insurance cards
- ☐ Photo Identification
- ☐ Cash / Credit Card
  (no checks on first visit)

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REGISTRATION / INSURANCE INFORMATION

PATIENT INFORMATION

_____ ____ _____ ____/____/____ _____
FIRST MI LAST NAME DATE OF BIRTH SOCIAL SEC. NUMBER

_____ _____ _____ _____
PATIENT STREET ADDRESS CITY STATE ZIP CODE

_____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Separated
EMPLOYER / SCHOOL / RETIRED

☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Native American ☐ Other

_____
EMAIL ADDRESS HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

☐ I have no medical insurance and will pay in full today by Cash or Credit Card
☐ I have Insurance to cover part or all of the charges. Please complete the assignment of benefits below

TELEPHONE PREFERENCE

	Telephone #	Preferred Contact #	May leave appointment reminders
Home		☐	☐ Yes ☐ No
Mobile		☐	☐ Yes ☐ No
Work		☐	☐ Yes ☐ No

☐ I understand a mobile number is not considered a secure or private line.

EMERGENCY CONTACTS / PRIVACY

First Name	Last Name	Relationship	Tel #	Alternative Tel #	Emergency Contact (X)	May Receive Private Medical Information
					☐	☐ Yes ☐ No
					☐	☐ Yes ☐ No

GUARANTOR INFORMATION IF NOT THE PATIENT

_____ ____ _____ ____/____/____ ( ) _____ _____ ( ) _____ _____
FIRST MI LAST NAME DATE OF BIRTH HOME TEL NUMBER WORK TEL NUMBER

_____ _____ _____ _____ _____ ___ _____
PATIENT STREET ADDRESS CITY STATE ZIP CODE SOCIAL SEC. NUMBER

INSURANCE ASSIGMENT OF BENEFITS

I request payment of authorized Medicare/ Health Insurance benefits be made directly to Premier Medical Care for any medical services provided by the practice or any of its physicians. I authorize Premier Medical Care and its employees to release any medical information about me to Medicare / My Health Plans and its agents and any secondary insurance, if required or requested to determine benefits or payment. I further expressly agree and acknowledge that my signature on this document authorizes Premier Medical Care to submit claims for benefits, for services rendered without obtaining my signature on each and every claim to be submitted for myself and that I will be bound by this signature as though I the undersigned had personally signed the particular claim.

Signed _____ Print name (if not patient)_____ Date _____

Premier ADULT MEDICAL CARE

PRACTICE POLICIES

FINANCIAL RESPONSIBILITY

This forms a binding agreement between PRACTICE and the responsible party. The responsible party may be the patient or another individual who is financially responsible for payment of medical bills. We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The responsible party must,

•Inform the office of current address and phone number.
•Present all current insurance cards.
•Pay any required copayment.
•Verify at each visit that your demographic information is correct.
•Pay any additional amount owed within 30 days of receiving a statement from our office (When we receive an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you.)
•We accept Visa, Mastercard and Discover. We do not accept personal checks on the first visit.
•Processing and Bank fees will be charged for all returned checks.

MISSED APPOINTMENTS AGREEMENT

A scheduled appointment means that this time is reserved only for you. We request that if you cannot make your appointment that you give us advanced notice at least 24 hours prior to your appointment. We will remind you of your appointment one business day before it is scheduled. If you miss an appointment the first one is a courtesy, for subsequent missed appointments without notice you will be changed a $25.00 administration fee. This is not a charge that will be billed or paid by your insurance carrier.

PRESCRIPTION REFILL AGREEMENT

Prescriptions for long term/routine medication are usually written to provide adequate supply until your next routine appointment. If you are going to run out before your scheduled visit you agree to telephone the office 7 days prior to running out and additional prescription will be sent to your pharmacy. NO routine refills will be given on weekends or during evening hours. We will not do telephone refills for patients who are not regularly following up with Dr. Sidhu.

Permission is given to obtain history of all past prescriptions from external sources.

By signing below I understand and agree to comply with the above practice policies / statements.

Print _____ _____/_____
Name of Patient Responsible party / relationship if NOT the patient.

Signature (Responsible party) _____ **Date**_____

Premier ADULT MEDICAL CARE

HIPPA FORM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Print Name of Patient _____

I acknowledge that I have received, read and understood the 'Notice of Health Information Privacy Practices' and consent to disclosure of Protected Health Information under the terms outlined above, and that this information is provided to me in compliance with the requirement of federal law under the Health Insurance Portability and Accountability Act (HIPAA).

_____ _____ _____

Signature of Patient Witness Print name and sign Date / Time

_____ _____

Printed Name / Signature of Authorized Representative Relationship to patient

OFFICE USE ONLY - DOCUMENTATION OF GOOD FAITH EFFORTS

The patient was provided with a copy of this notice and a good faith effort was made to obtain a written acknowledgement of receipt of the same but could not be obtained because

☐ *The patient refused*

☐ *The patient was unable to sign or initial because of* _____

☐ *There was a medical emergency and consent will be obtained as soon as possible.*

☐ *Other* _____

Signature of employee _____ *date and time* _____

Simrita Sidhu,MD

Internal Medicine *4428 Commercial Way, Spring Hill FL 34606`*

PatientName_____ Today's Date_____
Last, First Middle

Who was your previous Dr? _____

Reason for change?
☐ Change of address ☐ Change of Insurance ☐ Poor Communication/Care ☐ Other _____

Have you been Hospitalized in Last One Year? ☐ Yes ☐ No Date _____Reason _____

QUESTIONS TO ASK THE DOCTOR

Please list these in order of importance. Symptoms e.g. cough, Concerns e.g. "Do I have lung cancer?". It really helps you to get the most out of your visit. Tip: write "personal" if it is of a sensitive nature and you would prefer not to write it down.

1. _____
2. _____
3. _____

How do you rate your overall health? ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Bad

ALLERGIES

Medication / Reaction	Medication / Reaction
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS

Medication	Dose (mg)	How Often	Date Started	Medication	Dose (mg)	How Often	Date Started

PREFERRED PHARMACY

_____

SELF DETERMINATION PREFERENCES

☐ Yes ☐ No	I have a living will (Advance Directive)
☐ Yes ☐ No	I have a Health Care Surrogate (Health Care Proxy)

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PREVENTIVE HEALTH CARE

HERE IS A LIST OF RECOMMENDED TESTS, VACCINATION AND FREQUENCIES. ADD YOUR PERSONAL INFORMATION BELOW

Flu Shot	Pneumovax	Tetanus / Diphtheria	Mammogram	Pap Smear	PSA	Stool Test for blood	Sigmoidoscopy/ Colonoscopy	Cholesterol Test
Annual	*> 65 or if any serious illness*	*Every ten years*	*Annual Women >40*	*Every 1 to 3 years.*	*Men >50*	*Yearly age > 50*	*Over Age 50*	*Annual*

NAMES OF MOST RECENT DOCTORS	SPECIALTY

HOSPITALIZATION	DATES / REASON

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Reviewed By _____ Date_____

Simrita Sidhu,MD

Internal Medicine *4428 Commercial Way, Spring Hill FL 34606*

Name _____ *Date* _____/_____/_____

Past Medical History	***Yes***	***No***		***Yes***	***No***		***Yes***	***No***
Abdominal Aneurysm	O	O	GERD / Heartburn	O	O	Heart Attack	O	O
Angina	O	O	Gout	O	O	Migraine Headache	O	O
Anxiety Disorder	O	O	Heart Failure	O	O	Osteoporosis	O	O
Arthritis	O	O	Hiatal Hernia	O	O	Panic Attacks	O	O
Asthma	O	O	Hormone Replacement	O	O	Psoriasis	O	O
Atrial Fibrillation	O	O	High Blood Pressure	O	O	Peptic Ulcer Disease	O	O
Blood Clots Legs /Lungs	O	O	High Cholesterol	O	O	Rash	O	O
Blood Transfusion	O	O	Hypothyroidism	O	O	Seasonal Allergies	O	O
Cancer	O	O	Insomnia	O	O	Seizures	O	O
Carotid Stenosis	O	O	Kidney Stones	O	O	Rotator Cuff Tear	O	O
Carpal Tunnel	O	O	Knee Pain	O	O	Sleep Apnea	O	O
Chronic Diarrhea	O	O	Liver Disease	O	O	Stroke	O	O
Depression	O	O	Low Back Pain	O	O	Thyroid Disease	O	O
Diabetes	O	O	Macular Degeneration	O	O	Urinary Incontinence	O	O

Surgical History	***Yes***	***No***
Appendix removal	O	O
Angioplasty or stent	O	O
Heart Bypass	O	O
Gall Bladder removal	O	O
Hernia Repair	O	O
Hystereclomy	O	O
Tonsillectomy	O	O
Tubal ligation	O	O
TURP	O	O
Other_____		

Infectious Diseases	***Yes***	***No***
Hepatitis B	O	O
Hepatitis C	O	O
Pneumonia	O	O
Rheumatic Fever	O	O
Tuberculosis	O	O

Diagnostic Procedures	***Yes***	***No***
Colostomy	O	O
Other_____		

Other Medical Conditions Not Listed

_____

_____

.

_____

_____

_____

Family History

	Mother	Father	Siblings	Children
Unknown	O	O	O	O
Breast Cancer	O	O	O	O
Colon Cancer	O	O	O	O
Diabetes	O	O	O	O
Heart Attack	O	O	O	O
High Blood Pressure	O	O	O	O
High Cholesterol	O	O	O	O
Kidney Failure	O	O	O	O
Lung Cancer	O	O	O	O
Prostate Cancer	O	O	O	O

Social History

Occupation:	O Working	O Disabled	O Homemaker	O Unemployed		
Alcohol:	O Nil	O Occasional	O Weekly	O Daily	O Weekends	O Binge
Smoking:	O Nonsmoker	O Exsmoker				
	O Smoking	O 1/2ppd	O 1ppd	O 2ppd	O 3ppd	
Years of smoking	O 5yrs	O 10yrs	O 15yrs	O 20yrs	O 30yrs	O 40yrs
Marital Status:	O Single	O Married	O Divorced	O Widowed		
Children:	O Nil	O 1	O 2	O 3	O 4 O 5	O 6 O 7

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Name _____ *Date* _____/_____/_____

Review of Current Symptoms

CONSTITUTIONAL		
Chills	O Yes	O No
Fever	O Yes	O No
Loss of Appetite	O Yes	O No
Night Sweats	O Yes	O No
Unintentional Weight Loss	O Yes	O No
Swollen Lymph Nodes	O Yes	O No
Easy Bruising	O Yes	O No
ENDOCRINOLOGY		
Hair Changes	O Yes	O No
Excessive Thirst	O Yes	O No
Skin Changes	O Yes	O No
Heat Intolerance	O Yes	O No
Cold Intolerance	O Yes	O No
ALLERGY		
Facial Pressure	O Yes	O No
Itchy Eyes	O Yes	O No
Post-nasal Drip	O Yes	O No
Sneezing	O Yes	O No
RESPIRATORY		
Cough	O Yes	O No
Chest Congestion	O Yes	O No
Shortness of Breath	O Yes	O No
Wheezing	O Yes	O No
Hemoptysis	O Yes	O No
CARDIOLOGY		
Orthopnea	O Yes	O No
Chest Pain	O Yes	O No
Palpitations	O Yes	O No
Leg Edema	O Yes	O No
GASTROENTEROLOGY		
Nausea	O Yes	O No
Vomiting	O Yes	O No
Dysphagia	O Yes	O No
Heartburn	O Yes	O No
Abdominal Pain	O Yes	O No
Change in Bowel Habits	O Yes	O No
Constipation	O Yes	O No
Diarrhea	O Yes	O No
Hemorrhoids	O Yes	O No
NEUROLOGY		
Dizziness	O Yes	O No
Headache	O Yes	O No
Gait Abnormality	O Yes	O No
Memory Loss	O Yes	O No
Seizures	O Yes	O No
Tingling/Numbness	O Yes	O No
Visual Changes	O Yes	O No
UROLOGY		
Nocturia	O Yes	O No
Kidney Stones	O Yes	O No
Frequent Urination	O Yes	O No
Slow Urinating	O Yes	O No
Painful Urination	O Yes	O No
Urinary Incontinence	O Yes	O No
Urgency of Urination	O Yes	O No
STDs	O Yes	O No
MALE REPRODUCTIVE		
Difficulty with Erection	O Yes	O No
FEMALE REPRODUCTIVE		
Abnormal Vaginal Discharge	O Yes	O No
Breast Pain	O Yes	O No
Frequent Yeast Infections	O Yes	O No
Hot Flashes	O Yes	O No
Irregular Menses	O Yes	O No
Nipple Discharge	O Yes	O No
Dyspareunia	O Yes	O No
Pelvic Pain	O Yes	O No
MUSCULOSKELETAL		
Joint Pain	O Yes	O No
Joint Swelling	O Yes	O No
Back Pain	O Yes	O No
Sciatica	O Yes	O No
Leg Claudication	O Yes	O No

Premier ADULT MEDICAL CARE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Information Requested From:	Information Disclosed To:
Name	Premier Adult Medical Care
Address	4428 Commercial Way,
	Spring Hill, FL 34606
Phone#	Phone# (352) 597-1011 Fax (352) 597-7803

INFORMATION TO BE DISCLOSED (please specify)

DESCRIPTION	DATES	DESCRIPTION	DATES	DESCRIPTION	DATES
☐ Admission .Form		☐ Invasive procedure		**Super-confidential Information**	
☐ Physician Dictated Reports		Documentation		☐ HIV Testing	
☐ Physician Orders		☐ Medication Sheets		☐ HIV & AIDS Documentation	
☐ Physician Progress Notes		☐ X-ray Films		☐ Psychiatric Documentation	
☐ ER Documentation		☐ Pathology Slides		☐ Alcohol & Drug Abuse	
☐ X-ray Reports		☐ Other:_____		Documentation	
☐ Laboratory Reports		☐ Other:_____			
☐ EKG(s)		☐ Other._____			
☐ Operative Documentation		☐ Entire Medical Record			

PURPOSE OF DISCLOSURE (*please specify):*

☐ Continuing care with another physician or hospital ☐ Personal Copy ☐ Other *(please specify):*

AUTHORIZATION:

I understand that:

1. This authorization **will** remain in effect for 30 days.
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
3. I may refuse to sign this authorization and that it is strictly voluntary.
4. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
5. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
7. I will receive a copy of this form if I so request

I acknowledge, and hereby consent to such, that the protected health information released may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. 1 also acknowledge I have read the above and authorize the disclosure of the protected health information as stated.

Patient/Guardian Representative Signature: _____ Date: _____

Patient(Guardian) Representative Printed Name:_____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

"To be maintained iii the permanent medical record or department for 6 years"