REGISTRATION FORM

PATIENT INFORMATION			
Patient's Name Last:	First:	MI:	Single / Mar / Div / Sep /Wid
Date of Birth:	Age	❑ M ❑ F	Patient's Email:
Street address:			
State:	City:		Zip:
Phone (Primary):		Phone (Secondary)::	
Ethnicity: Hispanic or Latin / Non-Hispanic or Latin / Would like to not record			Primary Language:
Race: American Indian or Alaska Native / Asian / Native Hawaiian or other Pacific Black or African American / American White / Hispanic / Other			
INSURANCE INFORMATION			
Insurance Plan Name:			
Member #			
EMPLOYMENT INFORMATION			
Employer:		Occupation:	
PHARMACY PREFERENCE			
Pharmacy Name:		Phone:	
Street address:		City:	

I understand at least 3 business days notice must be given for prescription refills.

PATIENT/GUARDIAN/POA PLEASE SIGN:_____________________________DATE:_____________

Name________________________________ DOB _______ Date__________

New Patient Health History - To become part of medical record

Previous doctor:__________________________ Referred to the practice by:__________________________

Reason for Visit: (Please list your major medical concerns):

Medications: List your prescribed and over the counter drugs, such as vitamins					
Drug Name	Strength	Frequency	Drug Name	Strength	Frequency

PAST MEDICAL HISTORY Please check any of the following that you have been diagnosed with.

□ Anorexia/Bulimia
□ Anemia
□ Anxiety/Depression
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Blocked Heart Arteries (IHD)
□ Blood Clots
□ Bronchitis
□ Cancer Type:___________
□ Cataracts
□ Chronic Constipation
□ Colon Polyps
□ COPD
□ Macular Degeneration
□ Degenerative Disc Disease
□ Diabetes/Pre-Diabetes
□ Diverticulitis
□ Emphysema

□ Frequent Urinary Infections
□ Gallstones
□ GERD - Reflux
□ Glaucoma
□ Gout
□ Headaches
□ Heart Attack (MI)
□ Heart Failure (CHF)
□ Heart Murmur
□ Hemorrhoids
□ Hepatitis
□ Herniated Disc
□ High Blood Pressure (HTN)
□ High Cholesterol/Triglycerides
□ Hyperthyroidism
□ Hypothyroidism
□ Inflammatory Bowel Disease (IBD)
  □Ulcerative colitis
  □Crohn's
□ Insomnia
□ History of Blood Transfusion

□ Irritable Bowel Syndrome (IBS)
□ Kidney Disease (Renal Insufficiency)
□ Kidney Stones (Nephrolithiasis)
□ Meningitis
□ Obesity
□ Osteopenia
□ Osteoporosis
□ Peripheral Vascular Disease/Poor Circulation
□ Pneumonia
□ Prostate Enlargement (BPH)
□ Rheumatic Fever
□ Seasonal Allergies
□ Seizures
□ Sleep Apnea
□ Stroke (CVD)
□ Tuberculosis (TB)
□ Varicose Veins
□ Ulcers / Gastrointestinal (Peptic Ulcer)
□ Alcohol Abuse Quit Date: ________
□ Substance Abuse Quit Date: ________

□ Any Others____

Allergies			
Drug Name	**Reaction You Had**	**Drug Name**	**Reaction You Had**
1.		**3.**	
2.		**4.**	

Women's Health

Last Menstrual Peroid: ________________
Abnormal PAP's? ________________
Age at first period: ________________

Number of Pregnancies: ________________
Number of Miscarriages: ________________
Number of Abortions: ________________
Number of C-Sections: ________________

Name______________________________ DOB _______ Date_________

Surgical / Procedure History – Please check any of the following you have had, and list the month/year performed.

	Year		Year		Year
□ Appendectomy	_________	□ C-Section	_________	□ Joint Surgery	_________
□ Bunionectomy	_________	□ Cataract Removal	_________	□ Cardiac Bypass	_________
□ Carotid Surgery	_________	□ Hemorrhoidectomy	_________	□ Gallbladder Removal	_________
□ D&C	_________	□ Hip Replaced/Repair	_________	□ Hernia Repair	_________
□ Lumpectomy	_________	□ Kidney Stones	_________	□ Cardiac Stents	_________
□ Lasik Surgery	_________	□ Hip Replacement	_________	□ Thyroidectomy	_________
□ Tonsillectomy	_________	□ Prostate Removed	_________	□ Knee Replacement	_________
□ Tubal Ligation	_________	□ Ovaries Removed (Oophorectomy)	_________	□ Vasectomy	_________
□ Uterus Removal (Hysterectomy)	_________			□ Back Surgery	_________

□ Any Others ____

Other Hospitalizations – Please list any other hospitalizations that you have had		
Reason	Date	Hospital

Family History			
Relation	**Age**	**Age at death**	**Significant Health Problems**
Father		**N/A**	
Mother		**N/A**	
Sister		**N/A**	
Brother		**N/A**	
(Other)		**N/A**	

Physicians you have recently seen			
Name of physician	**Specialty**	**Reason**	**Last visit-Mo/Yr**

HEALTH MAINTENANCE If you have had any of the following performed, please check the box and list the month/year

□ Last Physical Exam ___________________________
□ Last EKG ___________________________
□ Last Eye Exam ___________________________
□ Labs including a Cholesterol Screen ______________

□ Colonoscopy ___________________________
□ Fecal Occult Blood Test (Blood in stool) _____________

□ Shingles Vaccine (Zostavax) ______________________
□ Human Papilloma Virus Vaccine (HPV-Gardasil) ______
□ Vaccines Against Hepatitis ________________________
□ Influenza Vaccine _______________________________

□ Mammogram (Females Only) ________________
□ Clinical Breast Exam (Females Only) _________
□ Pap Smear (Females Only) ________________
□ Bone Density ______________________

□ PSA (Males Only) __________________________

□ Tetanus Diphtheria (Td) _____________________
□ Tetanus Diphtheria Pertusis (Tdap) ____________
□ Pneumonia Vaccine (Pneumovax) _____________
□ TB Screening ______________________________

Name______________________________ DOB _______ Date_________

SOCIAL HISTORY

Are you a: □ Current Smoker □ Former Smoker □ Non smoker

If a current smoker, how often do you use cigarettes? □ Every day □ Some days but not every day

If a current smoker, how many cigarettes a day do you smoke? ____________

If a former smoker amount smoked per day(e.g. packs)?______ How long did you use tobacco?:______ Quit Date? _______

Are you sexually active? □ Yes □ No □ Never Do you use condoms? □ Yes □ No
Sexual Partners: □Male □Female □ Both
Do you have any history of STD's? □ No □ Yes If yes, what type? ________________

Do you use illicit drugs? □ No □ Yes Type: __________________
Do you have a history of drug addiction? □ No □ Yes Type: __________________

How often did you have a drink containing alcohol in the past year?
□ Never □ Monthly or less □ 2 to 4 times/month □ 2 to 3 times/week □ 4 times or more/week

How many drinks did you have on a typical day when you were drinking in the past year?
□ 1-2 drinks □ 3-4 drinks □ 5-6 drinks □ 7-9 drinks □ 10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?
□ Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily

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How many drinks containing caffeine do you take in typical day?_________

Number of Children - Sons _______ Daughters______ Ages of Children: ____

Have you ever been, a victim of domestic violence? □ No □ Yes

Regular Exercise □ Yes □ No Type:___________________________ Frequency:_____________

Currently Living with? □ Alone □ Sibling □ Spouse □ Children □ Parents □ Significant Other □ Friend/Roommate

What is your current marital status? □ Single □ Married □ Divorced □ Widowed □ Other: ___________________

Your Occupation: ______________________________ If retired, prior occupation: ____________________________

Do you have pets? □ Yes □ No If yes please describe: ____________________________

Hobbies/interests and physical activities: ____

The CDC recommends that everyone be screened for the risk of HIV. Do you have any concerns about possible exposure that you would like to discuss or be tested for? □ Yes □ No

Do you have special dietary preferences/restrictions? □ No □ Yes If yes, what type? ______________________

Please indicate any spiritual/religious preferences/restriction: ____

If you use any other medical suppliers (oxygen, CPAP, home health, etc.) please list those company names below:

____

Name____________________________ DOB _______ Date_________

Please check any of the following symptoms that you are currently experiencing or have experienced in the last 7-10 days.

GENERAL
□ Recent Fever
□ Excessive Fatigue
□ Unexplained Weight Loss/Gain

EYES
□ Discharge
□ Pain or Burning
□ Blurred Vision
□ Loss of Sight
□ Itching or Watering

BREAST
□ Pain
□ Lumps
□ Nipple Discharge

RESPIRATORY
□ Cough
□ Coughing up Blood
□ Shortness of Breath
□ Wheezing
□ Snoring

REPRODUCTIVE-WOMEN
□ Irregular Periods
□ Spotting between periods
□ Vaginal discharge/burning/itching
□ Unusually painful periods
□ Pain/Trouble during intercourse

REPRODUCTIVE-MEN
□ Discharge from Penis
□ Pain or Swelling of Testicles
□ Pain/Trouble during intercourse
□ Problems with Erection

MENTAL HEALTH
□ Thoughts of Suicide
□ Marital Problems
□ Trouble Sleeping
□ Panic Attacks
□ Anxiety
□ Thoughts of Harming Others

SKIN
□ Change in Nails
□ Lumps
□ Recurrent Rashes
□ Sores that will not heal or bleed
□ Moles that are changing

EARS
□ Hearing Loss
□ Ringing
□ Earache
□ Feeling of Ear Fullness

MOUTH & THROAT
□ Dry Mouth
□ Soreness or Bleeding in mouth area
□ Sore Throat
□ Mouth Ulcers
□ Hoarseness
□ Dental Issues

ENDOCRINE
□ Unusual intolerance of heat
□ Unusual intolerance of cold
□ Excessive Thirst
□ Excessive Hunger

URINARY
□ Pain/Burning with Urination
□ Frequent Urination
□ Blood in Urine
□ Trouble starting to Urinate
□ Waking up to Urinate
□ Leakage of Urine
□ Change in Stream

NERVOUS SYSTEM
□ Headaches
□ Seizures/Convulsions
□ Fainting Spells
□ Frequent Memory Loss
□ Weakness
□ Shakiness or Tremor
□ Loss of Sensation/Numbness
□ Feeling of Tingling in Limb
□ Speech Difficulty

NOSE & SINUSES
□ Bleeding
□ Nasal Congestion
□ Sneezing
□ Loss of Sense of Smell

NECK
□ Pain
□ Lumps

CARDIOVASCULAR
□ Abnormal/Irregular Heart Beat
□ Chest Pain
□ Awaken at night with breathing problems
□ Passing Out
□ Shortness of Breath
□ Swelling of Ankles
□ Leg Pain/Resting
□ Leg Pain/Walking

GASTROINTESTINAL
□ Unable to eat certain foods
□ Loss of Appetite/Weight
□ Food sticks in throat
□ Painful Swallowing
□ Heartburn
□ Indigestion
□ Vomiting
□ Nausea
□ Vomiting Blood
□ Abdominal or Stomach Pain
□ Diarrhea
□ Constipation
□ Recent Change in Bowel Habits
□ Blood in Stools
□ Black Stools

MUSCULOSKELETAL
□ Joint Pain
□ Joint Stiffness
□ Muscle Soreness

BLOOD DISORDERS
□ Easy Bruising
□ Excessive Bleeding

Patient Signature:____

Patient Name:_________________________________ **Date of Birth:**_____________________

PATIENT SELF-DETERMINATION QUESTIONNAIRE
YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance.

- Declaration to Decline Life-Prolonging Procedures
  - ☐ 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

If you have a living will and/or an assigned health care surrogate we will gladly make a copy of your documents and place it in your chart.

PATIENT PRIVACY QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: ______________________________ Name: ____________________________________

Address: ____________________________ Address: __________________________________

Phone Number: ________________________ Phone Number: _____________________________

Relationship: _________________________ Relationship: ______________________________

II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

- Name: ____________________ Phone #: ________________
- Name: ____________________ Phone #: ________________

III. I confirm my understanding that all correspondence from our office will be sent in a sealed envelope marked “CONFIDENTIAL”:

IV. I agree that confidential messages (i.e., appointment reminders) may be left on the telephone answering machine or voicemail at the phone number that I have provided.

V. I confirm that I am fully aware that a cell phone is not a secure or private line.
____

PATIENT/GUARDIAN/POA PLEASE SIGN:_________________________________ **DATE:**___________

Name____ DOB ______________

Annual Wellness Questions /(COA)

Please list any specialists that you are seeing and any medical equipment providers being used:

Text

Do you have any of the following? (*Risk Factors)

Hypertension   Diabetes   Current Tobacco Use   High Cholesterol

Family History of Colon Cancer   Family History of Breast Cancer

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During the past two weeks, have you been bothered by any of the following problems? (*PHQ2)

Little interest or pleasure in doing things:	YES	NO*
Feeling down depressed or hopeless:	YES	NO*

During the past few weeks what has been your highest level of physical activity?

VERY LIGHT   LIGHT   MODERATE*   HEAVY   VERY HEAVY

Advanced Care Planning (*enter)

Do you have a:

Living Will?	YES	NO	NOT SURE
Health Surrogate?	YES	NO	NOT SURE
Do Not Resuscitate Order ?	YES	NO	NOT SURE

Do you have any problems with leakage of urine?(*bladder control)   YES   NO*

IF YES:

When you cough/sneeze or strain?	YES	NO	(Stress)
You feel like you need to rush in order to avoid leakage?	YES	NO	(Urge)

Fall Risk Assessment

Have you fallen in the last 12 months: (If yes : how many times?)	YES	NO*
Do you or have you been advised to use a cane or walker:	YES	NO*
Do you sometimes feel unsteady while walking:	YES	NO*
Do you steady yourself by holding on to furniture:	YES	NO*
Are you worried about falling:	YES	NO*
Do you have trouble stepping up onto a curb:	YES	NO*
Do you often have to rush to the toilet:	YES	NO*
Have you lost some feeling in your feet:	YES	NO*
Do you take medicine that makes you feel light headed:	YES	NO*
Do you take medicine to help you sleep or improve your mood:	YES	NO*
Do you often feel sad or depressed:	YES	NO*

Name____ DOB ______________

Functional Status Assessment
Circle any of the following tasks that you need help with:

Grooming	Dressing	Toilet use	Housework	**None of these***
Preparing meals	Eating	Walking	Bathing	Taking Medication

(* Assess: cognitive status / ambulatory status / sensory status)

Systemic and Comprehensive Pain Assessment:

Are you experiencing daily pain? YES NO*

If yes – Where is the pain? ____________________

How severe is the pain? MILD MODERATE SEVERE

Psychosocial Risk Assessment:

AUDIT-C

How often did you have a drink containing alcohol in the past year?

Never | Monthly or less
Two to four times a month | Two to three times a week
Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

None, I do not drink | 1 or 2
3 or 4 | 5 or 6
7 to 9 | 10 or more

How often did you have six or more drinks on one occasion in the past year?

Never | Less than monthly
Monthly | Weekly
Daily or almost daily

Is your home free of throw rugs, poor lighting or a slippery bathtub/shower?	YES*	NO
Does your home have grab bars in the bathroom?	YES*	NO
Does your home have handrails on stairs and steps?	YES*	NO
Does your home have functioning smoke alarms?	YES*	NO

(*Add Body Mass in assessment / BMI and BP CPT codes ---- Delete one pain/Adv dir/Fall code)

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH		Phone	

RELEASE TO: (Rajani Medical Group, LLC is the recipient of the records)					
Name	**Rajani Medical Group, LLC Attn: Medical Records**		Fax	**727 726 0529 (Please mail if more than 20 pages)**	
Address	**2812 SAINT MARKS DRIVE**				
City/State Zip	City **DUNEDIN**	State **FL**		Zip **34698**	

OBTAIN RECORDS FROM: (Who is Releasing the Records)			
Name		Phone	
Address			
City/State Zip	City	State	Zip

For the Following Purposes: Continued Medical Care

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/ or Medical Records, If Such Information And/or Records Exist:

X	Last 2 years of office notes and reports				
X	Last Colonoscopy Report	X	ALL Diagnostic Imaging	X	Last Eye Exam Report
X	Medication List	X	Transcribed Hospital Reports	X	ALL Laboratory Reports
	Others Listed Here:				

The Following Items Must Be INITIALED to Be Included in the Use And/or Disclosure:

_______ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases
_______ Mental Health Information and/or Records
_______ Domestic Violence
_______ Genetic Testing Information and/or records
_______ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:
_______ Other: ____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.
I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.
Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in twelve (12) Months from the Date of Signing or until (Insert Date): ____________________.

Print Patient's Name: ______________________________ Date: ______________________

Signature of Patient or Patient's Legal Representative: ______________________________

Print Name of Legal Representative (if applicable): ______________________________

Relationship to patient: ______________________