

Welcome to Health First Internal Medicine Associates

Jay Shaktawat M.D.

PATIENT INFORMATION

Date: _____ - _____ - 20_____ Social Security #: _____ - _____ - _____ Birth Date: _____ - _____ - 19_____

Occupation: _____

Name: _____
Last Name First Name Middle Initial

Address: _____ City: _____ State: FL Zip Code: _____

Home Phone: _____ - _____ - _____ Cell Number: _____ - _____ - _____ Email: _____

Sex: M F Minor Single Married Divorced Widowed

Ethnicity: Caucasian African-American Hispanic Other _____ Language _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone: _____

Payment: Insurance Self Pay Credit Card # _____ Exp. Date: _____ / _____ 3 digit code _____

PRIMARY INSURANCE INFORMATION

Insurance Co. Name: _____ Phone #: _____

Insured's Name: _____ DOB: _____

Policy #: _____ Group #: _____

Address where claims are to be mailed _____

SECONDARY INSURANCE INFORMATION

Insurance Co. Name: _____ Phone #: _____

Insured's Name: _____ DOB: _____

Policy #: _____ Group #: _____

ASSIGNMENT AND RELEASE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO _____ ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE, AND ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS. I AUTHORIZE THE ABOVE DOCTOR AND PROVIDER OR SUPPLIER OF SERVICES IN THIS OFFICE TO RELEASE ANY INFORMATION REQUIRED TO SECURE THE PAYMENT OF BENEFITS.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____

MEDICAL HISTORY FORM

Name: _____ Age: _____ Sex: _____

Medical History

1. Present Illnesses:

2. Any Past Illnesses:

3. Surgeries:

Allergies to Medications? YES / NO If yes, please list:

1. Current Medications:

2. Immunizations: Are you currently on immunizations? YES / NO
Please provide a copy of medical records if available.

Influenza
Pneumonia
Shingles

Social History

1. Married / Single / Divorced / Partnered / Widowed

2. Children? / Ages: _____

3. Smoker: YES / NO _____

4. Alcohol? / Amount: _____ less than 10 drinks/wk _____ ; more than 10 drinks/wk _____

5. Exercise or Sports Yes / No _____

Family History

1. Diabetes: _____

2. High Blood Pressure: _____

3. Heart Disease: _____

4. High Cholesterol: _____

5. Cancer: _____

Dates of your most recent vaccinations:

Influenza	Year:	Reaction: <input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumovax	Year:	Reaction: <input type="checkbox"/> Yes <input type="checkbox"/> No
Tetanus booster	Year:	Reaction: <input type="checkbox"/> Yes <input type="checkbox"/> No
Zoster (Shingles)	Year:	Reaction: <input type="checkbox"/> Yes <input type="checkbox"/> No

Screening Tests:

Test	Date most recently done	Results (if relevant)
Eye examination		
Hearing test		
Cards to check for blood in your stool		
Sigmoidoscopy		
Colonoscopy		

For MEN only:

Test	Date most recently done	Results (if relevant)
Prostate examination (rectal examination)		
PSA blood test (prostate cancer screening)		
If you ever smoked: abdominal ultrasound to check for abdominal aorta aneurysm		
If age 80 or older: bone density test (DXA scan) to check for osteoporosis		

Over the past two weeks, how often have you been bothered by any of the following problems:

Little interest or pleasure in doing things	Feeling down, depressed or hopeless
<input type="checkbox"/> Not at all	<input type="checkbox"/> Not at all
<input type="checkbox"/> Several days	<input type="checkbox"/> Several days
<input type="checkbox"/> More than half the days	<input type="checkbox"/> More than half the days
<input type="checkbox"/> Nearly every day	<input type="checkbox"/> Nearly every day

Have you had a fall in the past year?

Yes No

If yes, please describe the circumstances surrounding the fall:

Did you trip over something? Yes No

Did you have lightheadedness or palpitations prior? Yes No

Did you lose consciousness? Yes No

Were you injured? Yes No

Did you need to see a doctor? Yes No

Were you able to get up by yourself? Yes No

HEALTH FIRST INTERNAL MEDICINE ASSOCS., LLC
DR. JANMEJAY SHAKTAWAT, M.D.
Board Certified Internal Medicine

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Janmejey Shaktawat, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Janmejey Shaktawat, M.D.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, Janmejey Shaktawat, M.D. may call designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others. Also, with my consent, Janmejey Shaktawat, M.D. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Janmejey Shaktawat, M.D. use/disclosure of my PHI to carry out TPO. If I do not sign this consent, the practice may decline to provide treatment to me. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Patient Authorization to Use or Disclose Protected Health Information

I, _____, understand Janmejey Shaktawat, M.D. is authorized by me to use or disclose my PHI for treatment, payment, or other health care operations. I specifically authorize any current employee or owner Janmejey Shaktawat, M.D., or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used/disclosed pursuant to authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so in writing, at any time.

Description of the information to be used/disclosed (Check all that apply)

() The patient's entire medical record

() OTHER: _____

Name of person(s) that my PHI may be disclosed to (Spouse, Family members, Friends, etc. - Must specify by name):

I understand that I have the right to revoke this authorization at any time. In order for the revocation to be effective, Janmejey Shaktawat, M.D., must receive the revocation in writing. I also understand that by signing below I am giving Janmejey Shaktawat, M.D. consent for my treatment and that I agree to all the terms listed above.

PATIENT SIGNATURE: _____ DATE: _____

PRINT PATIENTS' NAME: _____

PRINT NAME OF PATIENT OR LEGAL GUARDIAN: _____

AUTHORIZATION FOR REQUEST/RELEASE MEDICAL RECORDS

RELEASE: Requesting information from another Provider/Practice to us

Patient Name: _____

Date of Birth: _____ Phone Number: _____

I authorize the release of my following protected health information: From: _____

- ALL RECORDS Office Notes Radiology Reports Pathology Reports Laboratory Reports
 EKG Last Office Notes Other

To: Dr. Jay Shaktawat Health First Internal Medicine Associates 1400 US Highway 441 North, Suite 538
 Dr. Clarissa Abrantes 13953 NE 86th Terrace, Suite 101 The Villages,, FL 32159
 Dr Anis Shahmiri Lady Lake, FL 32159
Tel: 352 633 8681 • Fax: 352 385 7574

The purpose of this authorization is for: Medical/Treatment Other (Specify): _____

Signature Date Patient/Representative

If the patient listed above is a minor or unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

Print Name

Relationship to Patient