# 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:_____

| | | |
|---|---|---|
| Influenza | Year: | Reaction: ☐ Yes ☐ No |
| Pneumovax | Year: | Reaction: ☐ Yes ☐ No |
| Tetanus booster | Year: | Reaction: ☐ Yes ☐ No |
| Zoster (Shingles) | Year: | Reaction: ☐ Yes ☐ 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 WOMEN only:**

| Test | Date most recently done | Results (if relevant) |
|---|---|---|
| Mammogram | | |
| Pap smear | | |
| Bone density test (DXA scan) to check for osteoporosis | | |

**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

**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 |
|---|---|
| ☐ Not at all<br>☐ Several days<br>☐ More than half the days<br>☐ Nearly every day | ☐ Not at all<br>☐ Several days<br>☐ More than half the days<br>☐ 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, Janmejay 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 Janmejay Shaktawat, M.D.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, Janmejay 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, Janmejay Shakawat, 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 Janmejay 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 Janmejay 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 of Janmejay 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 this 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 patients 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, Janmejay Shaktawat, M.D., Must receive the revocation in writing. I also understand that by signing below I am giving Janmejay 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
☐ Dr. Clarissa Abrantes
☐ Dr Anis Shahmiri

☐ Health First Internal Medicine Associates
13953 NE 86th Terrace, Suite 101
Lady Lake, FL 32159

Tel: 352 633 8681 • Fax: 352 385 7574

☐ 1400 US Highway 441 North, Suite 538
The Villages,, FL 32159

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

_____ _____ Patient/Representative

Signature Date

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