NEW PATIENT REGISTRATION FORM rev 9/11

LAST NAME _____ **FIRST NAME**_____ **INITIAL**____

ADDRESS_____/_____
Street Apt #

_____/_____/_____
Town/City State Zip Code

PHONE NUMBERS:

Home _____ Work _____ Cell_____

NORTHERN ADDRESS_____
Only if different from above STREET

_____
City State Zip

NORTHERN PHONE # _____ **E-MAIL** _____

DATE OF BIRTH_____ **SEX**_____ **SOCIAL SECURITY#**_____

EMERGENCY CONTACT _____/_____/_____
(OTHER THAN SPOUSE) Name Relation Phone #

MARITAL STATUS Circle one M S D W

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INSURANCE INFORMATION

Primary _____ _____
Name of company Name of subscriber

_____/_____
Date of Birth Social Security #
Relation to patient Spouse__Child__Other__

Secondary _____ _____
Name of Company Name of Subscriber

_____/_____
Date of Birth Social Security #
Relation to patient Spouse__Child__Other__

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EMPLOYER NAME _____ **PHONE**#_____

Race: Black__White__Hispanic__Other__ **Ethnicity**: Hispanic__Non Hispanic___
Language_____

ADULT MEDICAL HISTORY rev 4/11

NAME_____

Age: **DOB:** **Sex**:

1. I am allergic to the following (including all medications, food, pollens, etc and any type of reaction_____

_____

2. I am taking the following medications (including over the counter, birth control, etc.)

_____

_____

3. I have had the following surgeries (include dates)_____

_____

4. I have the following medical problems_____

_____

_____

*my last tetanus shot was in year_____

*my last pneumonia shot was in year_____

*my hepatitis B shot was in year_____

My habits

Smoking Yes No How many packs per day _____

Drinking alcohol Yes No How much/often_____

Exercise regularly Yes No How often_____

My occupations

Present_____Past_____

Marital status _____# of children_____

My family medical history

Father_____

Mother_____

Siblings_____

Children_____

FOR WOMEN ONLY

Number of pregnancies_____ Number of abortions_____ live births_____

Miscarriages_____ Last bone density test_____

Date of last pap_____ Date of last mammography_____

Have you ever had abnormal pap_____ abnormal mammography_____?

Have you ever had breast biopsy/surgery _____

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OTHER

Colonoscopy: year of last _____Stool cards done_____

Other information your doctor should know about_____

_____

Do you have a living will or other advanced directives _____

If yes, please provide the office with a copy

If no, do you wish for us to provide you with appropriate documents?

Signature_____Date_____

Shahla Medical Group

88 Terrene Court, Suite 102
Bonita Springs, FL 34135
&
2350 Vanderbilt Beach Road, Suite 101
Naples, FL 34109

PATIENT CONSENT FORM/HIPPA COMPLIANCE

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

I have the right to review the Notice of Privacy Practices prior to signing this consent. Shahla Medical Group reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Shahla Medical Group Privacy Officer at 8800 Terrene Court, Suite 102. Bonita Springs, FL 34135.

With my consent Shahla Medical Group employees may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With my consent Shahla Medical Group employees may mail or e-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 as long as they are marked Personal and Confidential.

I have the right to request that Shahla Medical Group restrict how it uses or discloses my .PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
By signing this form, I am consenting to Shahla Medical Group's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent Shahla Medical Group may decline to provide treatment to me.

_____
Print Patient Full Name

_____ _____
Signature Date

NEW E PRESCRIPTION INFORMATION

WE ARE NOW USING A NEW PROGRAM WHICH SENDS PRESCRIPTIONS ELECTRONICALLY. PLEASE PROVIDE US WITH THE FOLLOWING UPDATED INFORMATION:

LOCAL PHARMACY:

NAME_____

PHONE_____
If available

MAIL ORDER PHARMACY

NAME_____

PHONE_____
If available

LOCATION _____
Required

WHEN YOU NEED A REFILL OF A PRESCRIPTION TO LOCAL PHARMACY, DO NOT CALL US. PLEASE CONTACT YOUR PHARMACY AND THEY WILL SEND REQUEST TO US.

IF YOU NEED A WRITTEN PRESCRIPTION FOR MAIL ORDER, PLEASE TELL US WHEN YOU LEAVE A MESSAGE FOR US.

PATIENT NAME_____
print

SIGNATURE_____DATE_____

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Shahla Medical Group for all my insurance claims related to services received. I agree to pay any and all charges that are not covered by my insurance. I understand that co-pays, deductibles and non- covered services are due at the time of service. I understand that in the event that any claims are denied due to the patient not providing the Shahla Medical Group with all updated insurance information the patient will be responsible for all charges.

Signature of Responsible Party: _____ Date: _____

SHAHLA MEDICAL GROUP

8800 TERRENE COURT STE 102
BONITA SPRINGS, FL 34135

2350 VANDERBILT BEACH RD STE 101
NAPLES, FL 34109

PHONE 239-948-3444
FAX 239-948-9028

Welcome to Shahla Medical Group / **Ziad Shahla, MD, MBA, FACP.**

This letter contains answers to some of the questions most frequently asked by patients entering our practice.

The doctor has privileges at Naples Community Hospital and he makes daily rounds at the North Collier Hospital. We have two offices located in Bonita Springs and Naples, Florida and our phone system is linked to both locations. See above phone and fax numbers.

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Our medical records are electronic and therefore available at both locations.

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Our staff is trained to help patients for either location.

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After making your first appointment, please arrive 10 minutes early with the following information:

- medical history - pharmacy: local and mail order
- insurance card
- Medication list, including Over the Counter, vitamins, and eye drops, etc.
-

Over

For prescriptions, please ask our physicians for any that you need at time of service. We send prescriptions electronically to pharmacies. When a refill is needed, please call the pharmacy and ask for them to request the refill from us. DO NOT CALL OUR OFFICE FOR REFILLS. We will process prescription refills within 24 hours of receipt from pharmacies. NO REFILL REQUESTS FILLED ON WEEKENDS.

When you request a lab order or radiology or other test order, please call and then allow 24 hours for the request to be processed. We prefer that you pick up these orders at either office.

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For the convenience of our patients, we contract with several insurance carriers, but we ask that you contact your insurance in advance to be certain your visit will be covered.

- We accept Medicare assignment.
- We expect payment at time of service for any co-pay determined by your contract with The insurance company.
- If you have HMO insurance **you** are responsible for requesting any referrals or authorizations that are needed for specialists or procedures. Please allow at least **48 hours** for processing. We do **not** do retro referrals.

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If you have a non-urgent medical need, please call our office during office hours. For your convenience, we have a telephone system so that calls can be routed efficiently. If you follow the prompts, you will receive the quickest service. Failure to follow this may result in your call having to be rerouted and therefore take more time. If our staff is not at their phone, because they are seeing patients, you may leave a message. Our response time is within **24 hours**. Therefore, do not leave any medically urgent messages for our staff in their voice mail boxes.

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For any medical records requests, please allow **one week** for processing. There is a charge per page when copies of complete records are requested.

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For **after hours calls**, if you have a medical emergency, please **call 911** and have the emergency professionals give you the quickest care. Once you receive medical care at a hospital, we will be notified or you can call us and we will be available for your follow-up care. Doctors are on call 24/7 for **URGENT medical problems** that **CANNOT WAIT** until office hours.