

Quick Primary Care P.A.
8550 SW Highway 200
Ocala, FL 34481 (352) 854-9110

____ Rajnikant Patel, MD
____ Nidhi Karavadia, MD

____ Narendrakumar Patel, MD
____ Jamie DiPrimo, ARNP

Patient Information:

Patient's Name: _____ SSN: _____

Age: ____ Sex: ____ Date of Birth: ____ / ____ / ____ Marital Status: S M W D

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____) _____ Alternate Phone: (____) _____

Email Address: _____

Employer: _____ Work Phone: (____) _____

Emergency Contact Name: _____

Phone Number: (____) _____ Relation: _____

Race: American Indian/Alaska Native ____ Asian ____ Native Hawaiian ____ White ____

Black/African American ____ Hispanic ____ Other _____

Language: English ____ Spanish ____ Indian (Includes Hindi & Tamil) ____ Other ____

Ethnicity: Hispanic _____ Non-Hispanic _____ Refused to Report _____

Responsible Party Information:

Self: _____ Other: _____ (Please Provide Information If Other Than Self)

Name: _____ Date of Birth: ____ / ____ / ____ Relation: _____

Address: _____ City: _____ State: ____ Zip: _____

SSN: _____ Employer: _____

Work# (____) _____ Home# (____) _____ Alt# (____) _____

I hereby assign all medical, to include major medical benefits, to which I am entitled, including Medicare, and government sponsored programs, private insurances, and any other plan to: Quick Primary Care P.A. This assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid for by my insurance. I hereby authorize said assignee to release all information necessary to secure payment.

****Upon turning in paperwork, please have insurance card(s) license ready****

Person Responsible For Bill, Please Sign Legal Full Name:

Signature: _____ Date: ____ / ____ / ____ Page 1 of 7

Quick Primary Care P.A.

Personal Medical History – 1 of 2

Please Check all That Apply

	Past History	Current History	Never		Past History	Current History	Never
1. Infectious Diseases				6. Musculoskeletal			
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
2. Eyes, Ears, Nose and Throat				7. Hematologic or Oncologic			
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia or Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear Glasses or Contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Visual Problems				Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Describe _____							
3. Cardiopulmonary				8. Neuropsychiatric			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis/pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal Thoughts or Acts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction/Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (Seizures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Gastroenteric				9. Metabolic			
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reflux/GERD/Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Gall Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Birth Defects			
Hepatitis – Type _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Describe _____			
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Irritable/Spastic Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Sexual Health			
Regular Laxative Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Positive HIV Antibody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal PAP Smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Urinary				Breast Lump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystitis/Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DES Exposure (maternal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Infection/Pyelonephritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Testicular Lump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Undescended or Absent Testicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Hydrocele or Varicocele	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Significant Medical Problems: _____

Hospitalization Dates: _____

Surgery History: _____

Signature: _____ Date: ____/____/____ Page 2 of 7

Quick Primary Care P.A.

Personal Medical History -2 of 2 (Continued)

Please Check all That Apply

****Family History: Has any blood relative suffered from any of the following:**

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Epilepsy/Convulsions |
| <input type="checkbox"/> TB And/Or Exposure | <input type="checkbox"/> Gout |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Mental Problems |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Cancer; Please Specify Type _____ | |

Other _____

****Female History:**

- Number of Children: _____ Number of Pregnancies: _____
Menopause: _____ Hysterectomy _____
Sexually Active: YES or NO Birth Control: _____
Last PAP Smear: _____ Last Mammogram _____

**** Social History:**

- Exercise: Type _____ Frequency _____
Cigarette/Tobacco Use: YES / NO Age Started: _____ Avg Number/Day _____ Age Stopped: _____
Alcohol Use: YES / NO Average Drinks / Week _____
Caffeine: (Tea, Coffee, soda) YES / NO Frequency _____
Other Substances: _____

****Allergies**

Are you allergic to any medications, dyes, or shellfish? YES / NO

Drug Allergies / Type of reactions: _____

Signature: _____ Date: ____/____/____ Page 3 of 7

Quick Primary Care P.A.

HIPPA

To our Patients

On April 24th, 2003, the state of Florida passed a Patient Privacy Act. The paperwork that we are asking you to fill out is a Federal Law and must be in all patient charts. If you would like to designate someone to have access to your medical records for any reason, such as appointments, test results, picking up prescriptions, or having any other information in your chart, please list that person on line 3 of the authorization for disclosure of health information form. If you do not wish to have your medical records disclosed to anyone other than yourself and be available to you, please list "self."

Notice of Privacy Act Acknowledgment

I acknowledge that the notice of privacy practices has been given or made available to me upon request by Quick Primary Care P.A.

Advance Directive/Living Will/Power of Attorney

I, _____ notify Quick Primary Care P.A. That I have the following documentation in place for my medical care.

(circle YES or NO for the following)

YES NO I have an Advance directive as of _____

YES NO I have a Living Will as of _____

YES NO I have a Durable Power of Attorney _____

My Power of Attorney is: _____

Signature _____ Date: _____

Witness _____ Date: _____

Quick Primary Care P.A.

Authorization for Disclosure of Health Information

1. I hereby authorize Quick Primary Care P.A., to disclose the following information from the health records of:

Patient Name: _____ Date of Birth _____

Phone Number (____) _____ SSN _____

Address _____ City _____ State _____ Zip _____

Covering the health period From: ___/___/_____ Through ___/___/_____

2. Information to be Disclosed:

_____ Complete Health Record _____ Discharge Summary

_____ History and Physical Exam _____ Progress Notes

_____ Consultation Reports _____ Lab Tests

_____ X-Ray reports _____ Photo/Video/Digital Image

_____ Other (Please Specify) _____

I understand that this will include information relating to (Check if Applicable)

___ Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency (HIV) Infection.

___ Behavioral health service/Psychiatric

___ Treatment of Drug Abuse

3. This information can be disclosed to the following Persons: _____

4. I understand this authorization can be revoked in writing at any time, except to the extent that the action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition; _____

5. Quick Primary Care P.A., its employees, and Physicians, are hereby released from any legal responsibility or liability for disclosure of its above information to the extent indicated and authorized herein.

Signature: _____ Date: ___/___/_____ Page 5 of 7

Quick Primary Care P.A.
EFFECTIVE AUGUST 1, 2008

After the confirmation of your scheduled appointment, any no shows, or canceled appointments, with less than twenty hour prior notice will be charged a \$55.00 fee.

This fee is the patients responsibility and will not be billed to any insurance company.

Please be advised no medication refills or lab results will be given if you have canceled or missed appointments.

Signature _____

Printed Name _____

Date: ___/___/_____

We would like to know how you heard about us:

___ Phone book/Yellow Pages

___ Newspaper _____

___ Physician, if so name _____

___ Friend _____

___ Website _____

___ Other (Circle) INSURANCE, HOSPITAL, HOSPITAL FOLLOWUP.

**Quick Primary Care P.A.
8550 SW Highway 200
Ocala, FL 34481**

Phone: (352) 854-9110 Fax: (352) 854-9119

Authorization For the Release of Health Information

I hereby authorize Quick Primary Care P.A. To receive the following information from the health records of: Patient Name: _____

Date of Birth ___/___/_____ **SSN:** _____

Information to be disclosed:

<input type="checkbox"/> Complete Health Records	<input type="checkbox"/> History and Physical Exam
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Radiology Reports/Images
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Lab Results	<input type="checkbox"/> Other _____

I understand that this will include information relating to (Check if Applicable)

Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency (HIV) Infection.
 Behavioral health service/Psychiatric
 Treatment of Drug Abuse

Signature _____ Date: _____

Witness _____ Date: _____

Previous Health Care Provider's Information:

Name _____

Address _____ City _____ State _____ Zip _____

Phone: (____) _____ Fax (____) _____

ADVANCED DIRECTIVE

1) Living Will Declaration

I, _____, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below. I do hereby declare that if at any time I should have a terminal condition as defined by Florida Statute, and my attending physician has determined that procedures would serve only to artificially prolong the dying process, I direct such procedures to be withheld or withdrawn. It is my wish that I be permitted to die naturally with the administration of medication or performance of the medical procedures deemed necessary to provide me with comfort care or to alleviate pain.

- I DO** **I DO NOT**want to have the tube taken out of my nose or mouth that is connected to a machine that is breathing for me if it has already been inserted.
- I DO** **I DO NOT**want to have the tube that is feeding me removed from my nose, mouth or stomach if it has already been inserted.
- I DO** **I DO NOT**want CPR.
- I DO** **I DO NOT**want a tube placed in my nose or mouth and connected to a machine to breathe for me.
- I DO** **I DO NOT**want a tube in my nose or mouth, or surgically placed in my stomach, that is connected to a hanging bag to give me food.
- I DO** **I DO NOT**want to have a needle or catheter placed in my body and connected to a hanging bag to give me water and other fluids.
- I DO** **I DO NOT**want to die naturally. (To die naturally means I will receive only medicine and treatment that will keep me comfortable. This also means no antibiotics or other treatments that delay my death. I know this care could have side effects that could cause me to die sooner.)

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this declaration shall have no force of effect during the course of my pregnancy.

I understand the full importance of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____	Date ____/____/____
Witness _____	Date ____/____/____
Witness _____	Date ____/____/____

In addition to the provisions of my living will, or instead of a living will, I would like to designate a healthcare surrogate. My healthcare surrogate will have the authority to provide consent for medical treatment and surgical and diagnostic procedures if I am incapacitated and unable to provide such consent myself.

- YES** **NO** **If YES, complete next page; if NO, STOP here.**

2) Healthcare Surrogate Designation

I, _____, would like to name as my healthcare surrogate:

Name _____
Address _____ Zip _____
Phone: (day) _____ (Evening) _____

If my surrogate is unwilling or unable to perform his duties, I wish to designate as my alternate surrogate:
(optional)

Name _____
Address _____ Zip _____
Phone: (day) _____ (Evening) _____

I understand that my healthcare surrogate cannot override any specific wishes I have listed in my living will, but can make healthcare decisions on my behalf in situations not specifically addressed by me in my living will.

Initial: _____

I understand that I need only be incapacitated and unable to make medical decisions for my healthcare surrogate to assume authority.

Initial: _____

I fully understand that this designation will permit my surrogate to make healthcare decisions and to provide, withhold, or withdraw consent on my behalf, to apply for public benefits to defray the cost of healthcare and to authorize my admission to or transfer from a healthcare facility. I further affirm that this designation is not being made as a condition of treatment or admission to a healthcare facility.

Signed _____ Date ____/____/____
Witness _____ Date ____/____/____
_____ Date ____/____/____

One witness CANNOT be a spouse or blood relative. The person designated as surrogate CANNOT be a witness. Keep the original of this document in a safe place where your family and designated surrogates have access to it. Give copies to your designated surrogates, physician, family, minister/rabbi/priest and anyone else you feel is appropriate. Please review annually and initial and date.

Reviewed and updated:

Initial _____ Date _____
Initial _____ Date _____
Initial _____ Date _____