QUICK PRIMARY CARE
8550 SW HWY 200
Ocala, FL 34481
(P) 352-854-9110 (F) 352-854-9119

____ Dr. Nidhi Karavadia ____Dr. Narendrakumar Patel ____Dr. Rajnikant Patel

d/b/a

___**Ocala Family Care**
Rajnikant Patel, M.D.
3299 SW 34th St
Ocala, FL 34474
(P) 352-861-1533

___ **Ocala Internal Medicine Associates**
Narendrakumar Patel, M.D.
3299 SW 34th St
Ocala, FL 34474
(P) 352-291-2212

ESTABLISHED PATIENT INFORMATION UPDATE

Today's Date: ____/____/_____

Patient Name: _____ Date of Birth: ____/____/_____ Gender: ☐ M ☐ F

Street Address: _____ _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different then street address): _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____-____-_____ Marital Status: ☐ S ☐ M ☐ W ☐ D E-Mail:_____

Phone Number: _____ Work/Cell Number: _____

Preferred Pharmacy: _____ Pharmacy Number: _____

Preferred Language: ☐ English ☐ Spanish ☐ Hindi ☐ Other: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refused to Answer

Race: ☐ American Indian ☐ Asian ☐ Black/African American ☐ White ☐ Refused to Answer

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____

Insured's Name: _____ Insured's Date of Birth: ____/____/_____

Secondary Insurance: _____ ID#: _____

Insured's Name: _____ Insured's Date of Birth: ____/____/_____

EMPLOYMENT INFORMATION

Employment Status: ☐ Retired ☐ Full-Time ☐ Part-Time

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Employer: _____ Phone: _____

EMERGENCY CONTACTS

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Relationship: _____

HIPAA Information can be disclosed to this emergency contact: ☐ YES ☐ NO

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Relationship: _____

HIPAA Information can be disclosed to this emergency contact: ☐ YES ☐ NO

ANY ADDITIONAL PEOPLE THAT WE ARE ABLE TO DISCLOSE HIPAA INFORMATION PLEASE LIST ALL:

Name: _____ Name: _____

Name: _____ Name: _____

OTHER PHYSICIANS THAT YOU NORMALLY SEE-PLEASE PROVIDE FULL NAME AND THE SPECIALITY:

Dr.:_____ Specialty: _____ What are you seeing the doctor for: _____

Dr.: _____Specialty: _____ What are you seeing the doctor for: _____

Dr.:_____ Specialty: _____ What are you seeing the doctor for: _____

Dr.:_____ Specialty: _____ What are you seeing the doctor for: _____

MEDICATIONS

Current Prescription Medications (Include dosage and frequency):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Current Over the Counter Medications (include dosage and frequency):

_____
_____
_____
_____
_____

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Medication Allergies:

_____
_____
_____

Food Allergies:

_____
_____

Surgeries:

_____
_____

Hospitalizations:

_____
_____

SCREENING FORM

Do you use or have Oxygen/ CPAP/ BiPAP machine? ☐ YES ☐ NO

Do you have any of the following (circle the ones you have):

LIVING WILL / ADVANCED DIRECTIVE / POWER OF ATTORNEY / NONE

Do you walk with a cane or walker? ☐ YES ☐ NO

Review the following list and give the date of the last time you had the tests and where they were performed

Test	Date	Location	Test	Date	Location
Mammogram:			Eye Exam:		
Breast Exam:			PAP Smear:		
Bone Density:			PSA:		
Colonoscopy:			Prostate:		

Review the following list and give the date of the last time you had the tests and where they were performed

Immunizations:	Date	Location	Immunizations	Date	Location
Influenza (FLU) Vaccine			Tetanus Vaccine		

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Shingle (Shingrix) Vaccine			Pneumonia (**Pneumovax 23**) Vaccine		

FEMALES ONLY:

Have you had any pregnancies? ☐ YES ☐ NO How many? _____ How many children do you have?____

Date of last menstrual period? _____ Are you sexually active? ☐ YES ☐ NO

If yes, do you use birth control (type)? _____

MEDICAL HISTORY

CONDITION	SELF	FATHER	MOTHER	SIBLINGS	CHILDREN
ADD/ADHD					
ALCOHOL ABUSE					
ANEMIA					
ANGINA					
ANXIETY					
ARTHRITIS					
ASTHMA					
BLOOD CLOTS					
BLEEDING DISORDERS					
BONE DISORDERS					
BREAST CANCER					
CAROTID ARTERY DISEASE					
CIRCULATORY PROBLEMS					
COLON CANCER					
CROHN'S					
DEAFNESS					
DIABETES					
DEPRESSION					
DRUG ABUSE					
EMPHYSEMA					
EPILEPSY/SEIZURES					
GALL BLADDER DISEASE					
GERD/REFLUX/ULCER					
HEART ATTACK					

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HEART MUMUR					
HEART VALVE DISORDERS					
HEARING LOSS					
HERNIA					
HIGH BLOOD PRESSURE					
HIGH CHOLESTEROL					
IRRITABLE BOWEL SYNDROME					
KIDNEY DISEASE					
LEUKEMIA OR LYMPHOMA					
LIVER DISEASE					
MENTAL ILLNESS					
MIGRAINES					
MITRAL VALVE PROLAPSE/VALVE DISORDERS					
NEUROLOGICAL PROBLEMS					
NICOTINE USAGE					
OSTEOPOROSIS					
PEPTIC ULCER					
PANCREATITIS					
PROSTATE CANCER					
RHEUMATOID DISORDER					
SICKLE CELL DISEASE					
SKIN DISORDERS/SKIN CANCER					
SLEEP APNEA					
STROKE					
THYROID DISEASE					
OTHER CANCERS (SPECIFY):_____					

SOCIAL HISTORY

Do you smoke? ☐ YES ☐ NO If yes, How many? _____ packs per day. For how many years? _____

If no, were you previous smoker? _____ When did you quit? _____ How long did you smoke? _____

Do you drink alcohol? ☐ YES ☐ NO If yes, How much? _____per day

Do you drink coffee? ☐ YES ☐ NO If yes, How much? _____per day

Do you exercise? ☐ Yes ☐ NO If yes, what type? _____ How frequently? _____

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OFFICE POLICY AGREEMENT

(Initial)

_____ **COMMIT TO A MINIMUM OF ONE ROUTINE APPOINTMENT (S) YEARLY**

To provide the quality of care you deserve, we require that all patients have an annual office visit (wellness exam) and annual labs completed once a year. Sick appointments, routine visits and urgent visits are not the same as annual/wellness visits

_____ **TARDINESS TO AN APPOINTMENT MAY CAUSE RESCHEDULING OF YOUR APPOINTMENT**

In the event that you are 10 minutes late to a scheduled appointment, you may be required to reschedule your appointment.

_____ **NO SHOWS/LAST MINUTE CANCELLATIONS/LAST MINUTE RESCHEDULES (LESS THEN 24 -HOURS)**

If you reschedule, cancel or no show to your scheduled appointment with less than 24 hours notice you may be subject to a $25.00 fee that is the patient's responsibility to pay, not the insurances to pay. You will be responsible for this charge and it will need to be paid before any future appointments can be made.

_____ **MEDICATION REFILLS**

Our medical staff does their best to get all medication refills sent to the pharmacies as quickly as possible. Keep in mind that this is sometimes done between seeing patients and sometimes at the end of the day. For this reason we do have a 24 to 48 hour turnaround time frame. Please be mindful of your supply of medications to ensure that you do not run out and allow enough time to get the refills sent successfully to the pharmacy.

By initialing and signing this form, I am in agreement with the above terms, or understand the office policies.

Patient Signature: _____ Date: _____

(Initial)

_____ **NO SHOWS/LAST MINUTE CANCELLATIONS/LAST MINUTE RESCHEDULES**: Providers and staff of Quick Primary Care, PA relies on the pre-scheduled appointments to plan their day to day activities. Last minute reschedules or cancellations and no-shows disrupt the daily flow. If you have to cancel or reschedule your appointment, please provide us with at least 24 hour prior notice. If less than 24 hours notice is not given we may charge a $25.00 fee directly to you. Please

note that this charge will not be billed to any third party (your insurance) but directly to you and you will be responsible for payment of this charge prior to any further appointments.

_____ **RETURNED CHECK**: Checks returned to Quick Primary Care, PA by the bank will be assessed a return check fee, in addition to the original amount of the check. You have ten (10) days to clear up the outstanding check. If you do not pay the check plus the returned check fee in the specified time the check will be sent to the State's Attorney's Office for further collection.

_____ **COLLECTION AGENCY**: In the event your account becomes delinquent and is turned over to a collection agency or attorney, you will be financially responsible for all associated collection fee (s) and legal fee (s) that Quick Primary Care, PA incurs through the process utilized to collect the delinquent balance. Please be aware if your account is turned over to a collection agency you can be discharged from our practice.

_____ **PAYMENT:** Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charges. I understand that it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid for by my insurance or third party payer. Quick Primary Care, PA and all its subsidiaries are covered under this document.

By initialing and signing this form, I am in agreement with the above terms, or understand the office policies.

Patient Name: _____ _____ Date: _____

Subscriber Name: _____

LIVING WILL / ADVANCED CARE DIRECTIVE

Florida statutes require that we provide our patient's with information concerning their rights to a Living Will and or an Advanced Directive.

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An **Advanced Directive** is a witnessed statement made by a competent member regarding his/her wishes or desires in regards to future health care, (for example-provide artificial life support).

A **Living Will** is a formalized version of an Advanced Directive

Please take this information home and carefully review it. If you wish to execute an Advanced Directive or a Living Will, please notify this office on your next visit.

PLEASE CHECK ONE:

_____ I DO NOT HAVE a Living Will/Advanced Care Directive

_____ I HAVE a Living Will/Advanced Care Directive and will provide a copy to this office.

Patient Signature: _____ Date: _____

Printed Name: _____

Witness Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

My signature on this document acknowledges that I have received Quick Primary Care, PA HIPAA Notice of Privacy Practices.

LIFETIME AUTHORIZATION

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Insurance Assignments and Authorization to Release Information

(Initial)

_____ **RELEASE OF INFORMATION**- I, the below named patient, do hereby authorize any physician examining and /or treating me to release to any third payer (such as an insurance company or governmental agencies, e.g. Blue Cross Blue Shield of Florida or Medicare) any medical, psychiatric conditions, alcohol/drug related condition and records concerning diagnosis and treatments when requested by such third party for its use in connection with determining a claim for payment for such treatment and /or diagnosis.

_____ **PHYSICIAN INSURANCE ASSIGNMENT**- I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me or any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charges for these services.

_____ **MEDICARE/MEDICAID**- Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIIXIX of the Social Security Administration division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

_____ **CONSENT FOR TREATMENT**- I, the below named patient hereby give my consent for treatment to all physicians associated with Quick Primary Care, PA

_____ **PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE**. The assignment will remain in effect until revoked by me in writing.

CONSENT TO DISCUSS MEDICAL CONTINTIONS OR RELEASE RECORDS: !, the below named patient, do hereby authorized Quick Primary Care, PA to discuss my medical conditions with, or release my medical records to the below named person (s):

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

MEDICAL RECORDS RELEASE

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Records to be released from: _____ (physician or company)

_____ (address)

_____ (phone number/fax number)

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Patient Name: _____ DOB: _____ SSN:***-**-_____(last four)

I authorize and request the disclosure of all protected information for the purpose of review and evaluation from the above-named doctor or healthcare provider to:

Requesting Provider:

Requested information (if more than 25 pages, please mail):

Dates from _____ to _____

Records to include:

___ All records

___ Office visit notes-last two only

___ Office visit notes-ALL

___ Cardiology reports only

___ Other: _____

___ Lab reports only

___ Radiology reports only

___ Hospital records only

___ Consult notes only

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient. I understand that a copy of this authorization may be used with the same effectiveness as an original.

HIPAA REQUIRED STATEMENTS: I understand the following:

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance to this authorization.
- The information released I response to this may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Signature of Patient or Legally Authorized Representative: _____ Date: _____

Name of Legally Authorized Representative for Patient: _____

Relationship to Patient: