Winter Park Primary Care
PATIENT REGISTRATION FORM

Today's Date:	Date of Birth:

PATIENT INFORMATION

Last name:	First:	Middle:	Suffix:

Social Security #:	Home Phone #:	Cell Phone #:	Preferred mode of contact:	Age:	Sex: ◯ M ◯ F

Email Address:

Street Address:	City/State:	Zip Code:
Occupation:	Employer:	Employer Ph #:

Who referred you:

Previous PCP:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Address (if different):	Phone #.:
Social Security #:	Employer:	Date of Birth:

Please indicate PRIMARY insurance:

Policy#:	Group:	Address:	Phone#:

Please indicate SECONDARY insurance:

Policy#:	Group#:	Address:	Phone#:

IN CASE OF EMERGENCY

Emergency contact:	Relationship to patient:	Best phone#:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Winter Park Primary Care or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(First, Last)*	**Today's Date:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous Doctor:	**Sex:** **Age:**

PERSONAL HEALTH HISTORY

List of Medical Problems:

Surgeries (Can list additional ones on the back)

Year or Age	Surgery	Reason

Other hospitalizations

Year or Age	Reason	Hospital

List your prescribed drugs/vitamins: (can write additional ones on back of this sheet)

Name of Drug	Strength	Frequency Taken

Medication allergies/intolerances:

Name of Drug	Reaction You Had

HEALTH HABITS

Exercise	What exercise do you like to do? How many times/week?			
Alcohol	Do you drink alcohol? How many drinks/week?			
	Is there any family or personal history of alcoholism?			
Tobacco	Do you currently smoke?			
	If not, have you ever smoked?			
	If yes, how much do you smoke per day?	Age started:		
	☐ # of years	☐ Or year quit		
Occupation	Current or previous occupation?			
Sex	Are you sexually active? Do you use any contraception?			
	Sexual preference (circle one): Male Female Both			
Personal	Who do you live with?			
	How many kids do you have? Do any of them live locally?			

FAMILY HEALTH HISTORY

Alive/Age Dead/Age Cause of Death Significant Health Problems (Diabetes/Cancer/Heart?)

Mother ____________________

Father ____________________

Brothers ____________________

Sisters ____________________

WOMEN ONLY

How many times have you been pregnant? Vaginal? Any Miscarriages?		
Any complications during your pregnancies (High BP, Gest Diabetes, Post-Partum Depression, etc)?		
Age at menopause? History of Hormones? How many years did you take them?		
Date of last PAP Smear? Last mammo? Last Bone Density Test?		

MEN ONLY

Do you usually get up to urinate during the night? If yes, how many times?		
Any difficulty with erection? If yes, have you ever tried any medication for it?		
Date of last prostate and rectal exam?		

OTHER SYMPTOMS/ILLNESSES: (Circle all that apply)

Headaches High Cholesterol High Blood Pressure Asthma/Emphysema Kidney Stones Hemorrhoids Depression Anxiety

Stroke Incontinence High Blood Sugar Fatigue Joint Pain Arthritis Constipation Diarrhea Chest Pain Palpitations

Gout Glaucoma Thyroid problem Cough Hay Fever Blood in Urine/Stool Edema Cancer Pneumonia Fractures

Heartburn Eczema Cataracts Neuropathy Sleep Apnea Insomnia Weight Loss Weight Gain Menopausal Symptoms

OTHERS____

HEALTH MAINTENANCE

When did you last have the following?

COLONOSCOPY______________Who did it?_________________________Any polyps?______________________Next due?___________________

EYE EXAM________________Who did it?____

LAST LABS____________________________ LAST PHYSICAL EXAM____

Pneumovax_______________Prevnar______________Shingles Shot______________Tetanus__________________Flu Shot___________________

Name of Specialists: Specialty:

____

____

____

____

____

I specifically consent to the release of any material in your possession, including, if any, existing results of HIV (AIDS) test and any which might address chemical dependence, depression, or other psycho-emotional issues. I understand that I do have the right to limit the release of this information at anytime by putting my request in writing. I do, however, understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

PATIENT SIGNATURE: ___________________________________ Date: ___________________

Name of Pharmacy________________________________Location_________________________________Phone number_____________________

Name/Number of Mail Order Pharmacy____

Do you have a Living Will?_____________Who is your health care surrogate?____

Who do we contact in case of emergency?____Phone #___________________________________

MD SIGNATURE____ DATE_______________________

Winter Park Primary Care
Neha Doshi, MD
942 Lake Baldwin Lane Orlando, FL 32814
Ph (321) 285-6363
Fax (321) 282-6176

COMMUNICATION USE AND DISCLOSURE AUTHORIZATION

Patient's Name: ____ Date of Birth: ____________________

I hereby request the following regarding the use of my personal health information:

1. **You may contact me via the following methods (please check ALL that apply):**

   _____Preferred Phone Number ____
   _____Email Address ____
   _____Ok to leave voicemail? _____ (yes/no)
   _____Ok to text? _____ (yes/no)

2. **You _____MAY or you _____MAY NOT leave detailed messages for me regarding appointments, prescriptions, test results, referral information, billing information or other information pertaining to my treatment and care.**

3. **You may discuss information regarding my treatment and care with the following family/friends:**

Full Legal Name	Relationship	Phone Number

_________________________________ _____________________________
Signature of Patient or Guardian **Date**

_________________________________ _____________________________
Printed Name of Witness/Staff **Signature of Witness/Staff**

WINTER PARK PRIMARY CARE
Neha Doshi, MD
942 Lake Baldwin Lane
Orlando, FLORIDA 32814
Tel: 321.285.6363
Fax: 321.282.6176

EMAIL/TEXTING CONSENT FORM

Federal regulations regarding electronic communication (HIPAA) recognize that patients may want or need to receive communications by email/text, and you have the right to consent to email/text communication. Transmitting patient information by email/text has a number of risks that patients should consider before using them. These include, but are not limited to, the following risks:

Email/texting are at risk of breach by an unintended third party.
Emails/texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
Email senders can easily misaddress an email. Text senders can easily send to an incorrect #.
Email/texting is easier to falsify than handwritten or signed documents.
Backup copies of emails/texts may exist even after the sender or the recipient has deleted them.
Employers and online services have a right to inspect emails transmitted through their systems.
Emails/texts can be intercepted, altered, forwarded, or used without authorization or detection.
Email can be used to introduce viruses into computer systems.
Emails/texts can be used as evidence in court.
Email/text communications containing clinical information will be recorded into the medical record where they will become available to anyone with access to the record.
Per HIPAA, contacting Dr.Neha Doshi, MD by email/text implies implicit consent to email/text communications.

BY SIGNING THE ABOVE I UNDERSTAND AND AGREE TO THE ABOVE.

Check all that apply:

Text OK ______

Email OK ______

____
Patient Name

______________________________________ ______________
Patient Signature Date

Winter Park Primary Care
Neha Doshi, MD

Consent for Evaluation or Treatment

The undersigned hereby consents to evaluation and/or treatment that Dr. Neha Doshi may deem necessary:

____ __________________
Patient, Parent, Legal Guardian or Auth Representative Date

Insurance Assignment

I hereby authorize my insurance benefits to be paid directly to WPPC/Neha Doshi, MD. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

____ __________________
Patient, Parent, Legal Guardian or Auth Representative Date

Medicare Patients Only
Medicare Part B Signature Auth--Lifetime

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical/other information about me to release to the Social Security Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to Winter Primary Care/Neha Doshi, MD to submit a claim to Medicare for payment to me.

_____________________________________ _____________________________________
Patient name Patient Signature

_____________________________________ _____________________________________
Medicare Part B number Date

Advance Directive

- ☐ I HAVE executed an Advance Directive (Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.
- ☐ I HAVE NOT executed an Advance Directive

**Please provide us with copies of the above documents to be included in your medical record

Signature ____ Date__________________

Winter Park Primary Care

Neha Doshi, MD

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”). I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand Winter Park Primary Care’s *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a copy of this Notice.

____

Patient or Authorized Representative Name

____ ______________________

Signature Date

WINTER PARK PRIMARY CARE
Neha Doshi, M.D.

942 LAKE BALDWIN LANE
ORLANDO, FLORIDA 32814
TEL: 321.285.6363
FAX: 321.282.6176

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, we reserve the right to charge a fee of $100 for missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

PATIENT SIGNATURE**(X)**____DATE__________

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AUTHORIZATION TO RELEASE/OBTAIN MEDICAL INFORMATION

______________________________ ________________________ ______________
Patient Printed Name Social Security Number Date of Birth

I hereby authorize the release my medical records TO/FROM Winter Park Primary Care, the office of Dr. Neha Doshi.

Provider's Name: ____________________________

Provider's Telephone: ____________________________

Provider's Fax*:* ____________________________

Please send the following records for the purpose of my continuity of care:

Office Notes Lab Reports Radiology Reports Surgery Reports Hospital Records ALL RECORDS

Other: ____

I specifically consent to the release of any material in your possession, including, if any, existing results of HIV (AIDS) test and any which might address chemical dependence, depression, or other psycho-emotional issues. I understand that I do have the right to limit the release of this information at anytime by putting my request in writing. I request the provider named above promptly honor this request for medical information and/or copies of medical records. A copy of this request is as valid as the original. This authorization and request is valid for a period of one year from the date signed below, unless I request in writing to have this authorization revoked. I do, however, understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

PATIENT SIGNATURE**(X)**____DATE__________

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Controlled Substance Agreement

We are committed to doing all we can to treat your chronic condition. In some cases, controlled substances are used as a therapeutic option in the management of your chronic condition, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The words "we" and "our" refer to Winter Park Primary Care, and the words "I," "you," "me," or "my" refer to you, the patient.

1. All controlled substances must come from the physician whose signature appears below, or during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. I understand that I must tell the physician whose signature appears below, or during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, including over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not see prescriptions for controlled substances from any other physician, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician's knowledge. I also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician, his/her staff, or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy you have selected is:
   Pharmacy Name: _______________________________ Phone: ___________________________
3. You may not share, sell, or otherwise permit others, including spouse or family members, to have access to any controlled substances that you have been prescribed.
4. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility.
5. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below, or during his/her absence by the covering physician, as set for in Section 1 above. I will not use, purchase, or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges.
6. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.
7. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
8. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.
9. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted.
10. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been given to me.

____
PATIENT'S FULL NAME

____
PATIENT'S SIGNATURE DATE

____
PHYSICIAN'S SIGNATURE DATE