Premier
ADULT MEDICAL CARE

Simrita Sidhu, MD
Ramnik Banwatt, MD
Internal Medicine

Tel (352) 597 1011 4428 Commercial Way, Spring Hill FL 34606 Fax (352) 597 7803

Dear Patient,

Thank you for choosing Dr. Sidhu and Dr Banwatt to provide your Primary Medical Care. Our practice strives to provide the very best in medical care in a friendly environment.

Please fill out the attached forms to give us essential information needed to provide your care. It may be helpful to fill the forms at home prior to your visit if you have a complicated medical history.

Please note ours is a joint practice with Dr. Sidhu and Dr. Banwatt. You will be assigned principally to one physician but will be seen intermittently by the other physician depending on coverage and availability.

On behalf of the doctors and staff at Premier Adult Medical Care I extend a warm welcome.

Sincerely Yours

Simrita Sidhu, MD

Check List of things to bring on your First Visit

Completed Forms

- ☐ Registration Form
- ☐ Practice Policy Agreement
- ☐ Hipaa Privacy Form
- ☐ History Forms

Essential Other Items

- ☐ Medication bottles
- ☐ Insurance cards
- ☐ Photo Identification
- ☐ Cash / Credit Card (no checks on first visit)

Helpful other items

- ☐ Copies of old records (if possible)
- ☐ Copies of Advanced Directive / DNR / HealthCare Proxy forms if you already have these.

Premier ADULT MEDICAL CARE

REGISTRATION / INSURANCE INFORMATION

PATIENT INFORMATION

FIRST _____ MI ____ LAST NAME _____ DATE OF BIRTH ____/____/_____ SOCIAL SEC. NUMBER _____-_____-_____ EMAIL ADDRESS _____

PATIENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

SEX ☐ Male ☐ Female RACE ☐ Caucasian ☐ Hispanic ☐ African American ☐ Native American ☐ Asian ☐ Other_____

HOW DID YOU HEAR ABOUT OUR PRACTICE

☐ Another patient ☐ Hospital ☐ Magazine - Name
☐ Physician ☐ Google Search ☐ Internet website - Name
☐ Insurance Plan ☐ Other _____

TELEPHONE PREFERENCE

	Telephone #	Preferred Contact #	May leave appointment reminders
Home		☐	☐ Yes ☐ No
Mobile		☐	☐ Yes ☐ No
Work		☐	☐ Yes ☐ No

☐ I understand a mobile number is not considered a secure or private line.

EMERGENCY CONTACTS / PRIVACY

First Name	Last Name	Relationship	Tel #	Alternative Tel #	Emergency Contact (X)	May Receive Private Medical Information
					☐	☐ Yes ☐ No
					☐	☐ Yes ☐ No

GUARANTOR INFORMATION IF NOT THE PATIENT

FIRST _____ MI ____ LAST NAME _____ DATE OF BIRTH ____/____/____ ( ) _____ _____ HOME TEL NUMBER ( ) _____ _____ WORK TEL NUMBER

PATIENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ SOCIAL SEC. NUMBER _____ ___ _____

INSURANCE ASSIGMENT OF BENEFITS

☐ I have NO medical insurance and will pay in full today by Cash or Credit Card
or
☐ I have Insurance to cover part or all of the charges and I request payment of authorized Medicare/ Health Insurance benefits be made directly to Premier Adult Health Care Inc for any medical services provided by the practice or any of its physicians. I authorize Premier Medical Care and its employees to release any medical information about me to Medicare / My Health Plans and its agents and any secondary insurance, if required or requested to determine benefits or payment. I further expressly agree and acknowledge that my signature on this document authorizes Premier Medical Care to submit claims for benefits, for services rendered without obtaining my signature on each and every claim to be submitted for myself and that I will be bound by this signature as though I the undersigned had personally signed the particular claim.

Signed _____ Print name (if not patient) _____ Date _____

Premier ADULT MEDICAL CARE

PRACTICE POLICIES

FINANCIAL RESPONSIBILITY

This forms a binding agreement between PRACTICE and the responsible party. The responsible party may be the patient or another individual who is financially responsible for payment of medical bills. We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

- The responsible party must, Inform the office of current address and phone number.
- Present all current insurance cards.
- Pay any required copayment.
- Verify at each visit that your demographic information is correct.
- Pay any additional amount owed within 30 days of receiving a statement from our office (When we receive an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you.)
- We accept Visa, Mastercard and Discover. We do not accept personal checks on the first visit.
- Processing and Bank fees will be charged for all returned checks.

MISSED APPOINTMENTS AGREEMENT

A scheduled appointment means that this time is reserved only for you. We request that if you cannot make your appointment that you give us advanced notice at least 24 hours prior to your appointment. We will remind you of your appointment one business day before it is scheduled. If you miss an appointment the first one is a courtesy, for subsequent missed appointments without notice you will be changed a $25.00 administration fee. This is not a charge that will be billed or paid by your insurance carrier.

PRESCRIPTION REFILL AGREEMENT

Prescriptions for long term/routine medication are usually written to provide adequate supply until your next routine appointment. If you are going to run out before your scheduled visit you agree to telephone the office 7 days prior to running out and additional prescription will be sent to your pharmacy. NO routine refills will be given on weekends or during evening hours. We will not do telephone refills for patients who are not regularly following up with Dr. Sidhu.

Permission is given to obtain history of all past prescriptions from external sources.

By signing below, I understand and agree to comply with the above practice policies / statements.

Print _____ _____/_____

Name of Patient Responsible party / relationship if NOT the patient.

Signature (Responsible party) _____ Date_____

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HIPAA FORM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Print Name of Patient _____

I acknowledge that I have received, read and understood the 'Notice of Health Information Privacy Practices' and consent to disclosure of Protected Health Information under the terms outlined above, and that this information is provided to me in compliance with the requirement of federal law under the Health Insurance Portability and Accountability Act (HIPAA).

_____ _____ _____

Signature of Patient Witness Print name and sign Date / Time

_____ _____

Printed Name / Signature of Authorized Representative Relationship to patient

OFFICE USE ONLY - DOCUMENTATION OF GOOD FAITH EFFORTS

The patient was provided with a copy of this notice and a good faith effort was made to obtain a written acknowledgement of receipt of the same but could not be obtained because

☐ *The patient refused*

☐ *The patient was unable to sign or initial because of* _____

☐ *There was a medical emergency and consent will be obtained as soon as possible.*

☐ *Other* _____

Signature of employee _____ *date and time* _____

Premier
ADULT MEDICAL CARE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Information Requested From:	Information Disclosed To:
Name :	Premier Medical Care
Address:	4428 Commercial Way,
	Spring Hill, FL 34606
Fax # :	Phone# (352) 597-1011 Fax (352) 597-7803

INFORMATION TO BE DISCLOSED

I request the following information to be sent	SUPER-CONFIDENTIAL INFORMATION
(check)	**Initial**
☐ Hospital and ER Records	_____ HIV Testing and Treatment
☐ Physician Office Records	_____ Psychiatric Documentation
☐ All Imaging, Lab and Test results.	_____ Drug and Alcohol Abuse Diagnosis or Treatment

PURPOSE OF DISCLOSURE (*please specify):*
For Continuation of Medical Care under Premier Adult Health Care Inc.

AUTHORIZATION:
I understand that:

1. This authorization **will** remain in effect unless withdrawn by me in writing or until I am no longer a patient with this practice.
2. I may refuse to sign this authorization which is strictly voluntary. However I will not hold Premier Adult Health Care Inc or its physicians or staff liable for any medical consequences resulting from withholding of requested information.
3. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I acknowledge, and hereby consent to such, that the above requested protected health information may be release to Premier Adult Health Care Inc. dba Premier Medical Care.

Patient/Guardian Representative Signature: _____ Date: _____

Patient(Guardian) Representative Printed Name:_____ Relationship to Patient: _____

MEDICAL HISTORY – PAGE1

Internal Medicine *4428 Commercial Way, Spring Hill FL 34606`*

Patient Name_____ Today's Date_____
Last, First Middle

Reason for change?
☐ Change of address ☐ Change of Insurance ☐ Not Happy with Communication/ Care ☐ Other _____

QUESTIONS TO ASK THE DOCTOR

Please list these in order of importance. Symptoms e.g. cough, Concerns e.g. "Do I have lung cancer?". It really helps you to get the most out of your visit. Tip: write "personal" if it is of a sensitive nature and you would prefer not to write it down.

1. _____
2. _____
3. _____

How do you rate your overall health? ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Bad

ALLERGIES

Medication / Reaction	Medication / Reaction
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS (or attach medication list)

Medication	Dose (mg)	How Often	Date Started	Medication	Dose (mg)	How Often	Date Started
_____				_____			

PREFERRED PHARMACY

_____

SELF DETERMINATION PREFERENCES

☐ Yes ☐ No	I have a living will (Advance Directive / DNR)
☐ Yes ☐ No	I have a Health Care Surrogate (Health Care Proxy)
☐ Yes ☐ No	I do NOT have either of the above. Would you like to get information on these very improtant issues.

MEDICAL HISTORY – PAGE2

PREVENTIVE HEALTHCARE

HERE IS A LIST OF RECOMMENDED TESTS, VACCINATION AND FREQUENCIES. ADD YOUR PERSONAL INFORMATION BELOW

Flu Shot	Pneumovax	Tetanus / Diphtheria	Mammogram	Pap Smear	PSA	Stool Test for blood	Sigmoidoscopy/ Colonoscopy	Cholesterol Test
Annual	*> 65 or if any serious illness*	*Every ten years*	*Annual Women >40*	*Every 1 to 3 years. age 30- 64*	*Men Age> 50*	*Yearly age > 50-75*	*Age 50-75*	*Annual*

NAMES OF MOST RECENT DOCTORS	SPECIALTY
	PRIMARY CARE

HOSPITALIZATION	DATES / REASON

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Reviewed By _____ Date_____

[ ] SImrita Sidhu,MD
[ ] Ramnik Banwatt,MD

MEDICAL HISTORY – PAGE 3

Internal Medicine *4428 Commercial Way, Spring Hill FL 34606*

Name _____ *Date* _____/_____/_____ *Page 1*

Past Medical History	*Yes*	*No*		*Yes*	*No*		*Yes*	*No*
Abdominal Aneurysm	O	O	GERD / Heartburn	O	O	Migraine Headache	O	O
Angina	O	O	Gout	O	O	Osteoporosis	O	O
Anxiety Disorder	O	O	Heart Failure	O	O	Panic Attacks	O	O
Arthritis	O	O	Heart Attack	O	O	Psoriasis	O	O
Asthma	O	O	Hiatal Hernia	O	O	Peptic Ulcer Disease	O	O
Atrial Fibrillation	O	O	Hormone Replacement	O	O	Rash	O	O
Blood Clots Legs /Lungs	O	O	High Blood Pressure	O	O	Seasonal Allergies	O	O
Blood Transfusion	O	O	High Cholesterol	O	O	Seizures	O	O
Cancer	O	O	Hypothyroidism	O	O	Sleep Apnea	O	O
Carotid Stenosis	O	O	Kidney Stones	O	O	Stroke	O	O
Carpal Tunnel	O	O	Knee Pain	O	O	Thyroid Disease	O	O
Chronic Diarrhea	O	O	Liver Disease	O	O	Urinary Incontinence	O	O
Depression	O	O	Low Back Pain	O	O			
Diabetes	O	O	Macular Degeneration	O	O			

Surgical History	*Yes*	*No*	*Infectious Diseases*	*Yes*	*No*	*Other Medical Conditions or Not Listed*		
Appendix removal	O	O	TURP	O	O	Transplants	O	O
Angioplasty or stent	O	O	Hepatitis B	O	O	Dialysis	O	O
Colostomy	O	O	Hepatitis C	O	O	Amputations	O	O
Gall Bladder removal	O	O	HIV	O	O	Artificial openings (ostomy)	O	O
Heart Bypass	O	O	Pneumonia	O	O			
Hernia Repair	O	O	Rheumatic Fever	O	O	Other_____		
Hysterectomy	O	O	Tuberculosis	O	O			
Hip Replacement	O	O				_____		
Knee Replacement	O	O	*Diagnostic Procedures*	*Yes*	*No*			
Mastectomy	O	O	Breast Biopsy	O	O	_____		
Tonsillectomy	O	O	Upper GI endoscopy	O	O			
Tubal ligation	O	O	Prostate Biopsy	O	O	_____		

Family History

	Mother	Father	Siblings	Children
Breast Cancer	O	O	O	O
Colon Cancer	O	O	O	O
Diabetes	O	O	O	O
Heart Attack	O	O	O	O
Kidney Failure	O	O	O	O
Prostate Cancer	O	O	O	O

Social History

Occupation: O Retired O Working O Disabled O Homemaker O Unemployed
What is or was your occupation _____

Alcohol: O No O Yes How much _____ How many days a week _____

Smoking: O Nonsmoker O Ex Smoker Quit year _____ O Current Smoker
How much? O 1/2ppd O 1ppd O 2ppd O 3ppd
How Long? O 5yrs O 10yrs O 15yrs O 20yrs O 30yrs

Marital Status: O Single O Married O Divorced O Widowed Children: How many _____

MEDICAL HISTORY – PAGE 4

Name _____ *Date* _____/_____/_____ *Page 2*

Review of Current Symptoms

GENERAL

Chills	O Yes	O No
Easy Bruising	O Yes	O No
Fever	O Yes	O No
Night Sweats	O Yes	O No
Swollen Lymph Nodes	O Yes	O No
Unintentional Weight Loss	O Yes	O No

ENDOCRINOLOGY

Cold Intolerance	O Yes	O No
Excessive Thirst	O Yes	O No
Hair Changes	O Yes	O No
Heat Intolerance	O Yes	O No
Skin Changes	O Yes	O No

ALLERGY

Blocked/ Runny Nose	O Yes	O No
Itchy Eyes	O Yes	O No
Post-nasal Drip	O Yes	O No
Sneezing	O Yes	O No

LUNGS

Cough	O Yes	O No
Coughing blood	O Yes	O No
Excessive Sputum	O Yes	O No
Shortness of Breath	O Yes	O No
Wheezing	O Yes	O No

HEART

Ankle Swelling	O Yes	O No
Chest Pain	O Yes	O No
Palpitations	O Yes	O No

GI TRACT

Abdominal Pain	O Yes	O No
Change in Bowel Habits	O Yes	O No
Constipation	O Yes	O No
Diarrhea	O Yes	O No
Difficulty Swallowing	O Yes	O No
Heartburn	O Yes	O No
Loss of Appetite	O Yes	O No
Nausea	O Yes	O No
Vomiting	O Yes	O No

NERVOUS SYSTEM

Dizziness	O Yes	O No
Headache	O Yes	O No
Memory Loss	O Yes	O No
Seizures	O Yes	O No
Tingling/Numbness	O Yes	O No
Visual Changes	O Yes	O No
Weakness from Stroke	O Yes	O No

URINARY SYSTEM

Frequent Urination	O Yes	O No
Kidney Stones	O Yes	O No
Painful Urination	O Yes	O No
Slow Urinating	O Yes	O No
Urgency of Urination	O Yes	O No
Urinary Incontinence	O Yes	O No
Waking from sleep to urinate	O Yes	O No

MALE REPRODUCTIVE

Difficulty with Erection	O Yes	O No

FEMALE REPRODUCTIVE

Abnormal Vaginal Discharge	O Yes	O No
Breast Pain	O Yes	O No
Frequent Yeast Infections	O Yes	O No
Hot Flashes	O Yes	O No
Irregular Periods	O Yes	O No
Nipple Discharge	O Yes	O No
Completed Menopause	O Yes	O No
Painful Sex	O Yes	O No
Pelvic Pain	O Yes	O No

BONE / JOINT AND MUSCLE

(Many people have pain as they get older
Please only check if severe or limiting activity)

Back Pain	O Yes	O No
Foot Pain	O Yes	O No
Hand/Wrist Pain	O Yes	O No
Hip Pain	O Yes	O No
Joint Swelling	O Yes	O No
Knee Pain	O Yes	O No
Limping	O Yes	O No
Sciatica	O Yes	O No
Shoulder Pain	O Yes	O No