FAMILY MEDICINE SOLUTIONS, P.A.

SULTAN H. RAHAMAN, M.D.

PATIENT INFORMATION SHEET

Patient Name: _____ (Last) _____ (First) _____ (MI)

Address: _____ (Street) _____ (City, State) _____ (Zip)

Patient's Sex: MALE FEMALE	Date of Birth	Age
Marital Status: MARRIED SINGLE DIVORCED WIDOWED/WIDOWER CHILD		
Race / Ethnicity	Preferred Language	

Patient's Social Security #	Spouse
Primary Phone #	Second Phone #
Email Address	
Emergency Contact	Relationship
Preferred Method of Contact: □ Phone □ Email □ US Mail	

IF PATIENT IS A MINOR, PLEASE FILL OUT THIS SECTION	
Father's Name	DOB
Address	SSN #
Mother's Name	DOB
Address	SSN #

Pharmacy Name:	City:	Phone:
Previous Physician's Name		
Referral Source: INTERNET INSURANCE CO. FRIEND/RELATIVE PHYSICIAN		

COMMERCIAL INSURANCE (PRIMARY)	COMMERCIAL INSURANCE (SECONDARY)
Insured's Name	Insured's Name
Insured's ID #	Insured's ID #
Insured's Group #	Insured's Group #
Insurance Co. Name	Insurance Co. Name
Address	Address
City, State, Zip	City, State, Zip

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, major medical benefits and any other health plans to the assigned physician. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including HIV, substance abuse or psychiatric information which may me found in the record and is necessary to secure payment.

Patient or Responsible Party Signature ★	Date

◇ IF PATIENT IS A MINOR, PARENT OR LEGAL REPRESENTATIVE MUST SIGN ◇

FAMILY MEDICINE SOLUTIONS, P.A., SULTAN RAHAMAN, M.D.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (HIPAA)

Name:	Date of Birth:

I hereby authorize the release or use of my individually identifiable health information ("protected health information") and medical record information by Sultan H. Rahaman, MD (the Practice) in order to carry out treatment, payment, or healthcare operations. You should review the practice's notice prior to signing this consent form. We reserve the right to change the terms of our Notice of Privacy Practices at any time. If we do make changes to the terms of our Notice of Privacy Practices, you may obtain a copy of the revised notice. You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or healthcare operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restrictions, such restrictions are then binding on our Practice.

Notice:

- Federal law says that the Agency cannot share your Health Information without your permission except in certain situations. If you sign this form, you are giving Family Medicine Solutions permission to share your Health Information with the person (e.g. family member, spouse, etc.) you indicate below. You may list more than one person.
- In the event that you are unable to contact the office due to sickness or other issues, the person you designate below will be allowed to call or write on your behalf and receive information in regards to your medication, laboratory results, doctor's orders, or any other information that may be in your chart.
- This authorization is voluntary. You make revoke or change the authorization at any time in writing. Changes cannot be made over the phone.
- Payment, enrollment, or eligibility for benefits for you healthcare will not be affected if you do not sign this authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations.
- You can ask for a copy of this authorization at any time.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are one or more of the following members, legal representatives, guardians, healthcare surrogates or have power of attorney on my behalf.

I give permission to Family Medicine Solutions to share my protected health information with:

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

☐ I do not authorize anyone but myself to receive information.

What is this? This is a list of people who are authorized to call on your behalf and receive information about you. You may want to list a spouse, family member, or care taker who might help you with your doctor's appointments or medications. We do NOT give out your information unless it is requested and it will only be given to those you list on this form.

I WANT FAMILY MEDICINE SOLUTIONS TO SHARE THE FOLLOWING HEALTH INFORMATION

CHECK ALL THAT APPLY	RELEASE INFORMATION IN THE FOLLOWING MANNER
☐ All of my Health Information (Prescriptions, labs, etc.)	☐ Via Email:
☐ HIV/AIDS Information	☐ Via Phone:
☐ Substance Abuse Information	☐ Via Fax:
☐ Mental Health Information	☐ Via Mail:
☐ STD Information	
☐ If patient is under the age of 18, pregnancy information.	

Patient Signature:

Print Name:	Date:

OFFICE USE ONLY: I attempted to obtain the patient's signature, but was unable to do so as documented below:

Date:	Initials:	Reason:

FAMILY MEDICINE SOLUTIONS/SULTAN H. RAHAMAN, M.D. F.A.A.F.P.

PERSONAL HEALTH HISTORY

Name:	**DOB:**	**Age:**

MEDICATIONS: (List all medications you are currently taking)

Medication:	Dosage:	Directions:

SURGERIES:

Year	Type	Inpatient
		Y/N
		Y/N
		Y/N
		Y/N

Have you ever had a blood transfusion? □ Yes (Approximate Date:) □ No

Health Habits			**Occupational Concerns**		**Family History**		
Y/N	Caffeine	(drinks/day)	Stress	Y/N	FAMILY MEMBER	AGE	HEALTH OR CAUSE OF DEATH
Y/N	Tobacco	(packs/day)	Hazardous Substances	Y/N	Father		
Y/N	Drugs	(type/frequency)	Heavy Lifting	Y/N	Mother		
Y/N	Alcohol	(drinks/week)	Contact with Blood/Fluids	Y/N	Brothers		
Y/N	Other		Other	Y/N			
Please indicate if your blood relatives have had any of the following							
Y/N	Obesity		Diabetes	Y/N			
Y/N	Asthma/Hayfever		Heart Disease/Stroke	Y/N	Sisters		
Y/N	Cancer type:		High Blood Pressure	Y/N			
Y/N	Chemical Dependency		Kidney Disease	Y/N			
Y/N	Elevated Cholesterol		Other	Y/N			

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

Signature: _____ Date: _____

FAMILY MEDICINE SOLUTIONS, P.A. / SULTAN H. RAHAMAN, M.D.

REVIEW OF SYSTEMS

Name	DOB	Age

CIRCLE ONLY THE SYMPTOMS YOU HAVE PRESENTLY OR WITHIN THE LAST 12 MONTHS

CONSTITUTIONAL	
Anorexia	Malaise
Chills	Night Sweats
Difficulty Sleeping	Weakness
Fatigue	Weight Gain
Fever	Weight Loss
EYES	
Blurred Vision	Eyelid Edema
Decreased Night Vision	Eyelid Nodule
Double Vision	Eyelid Pain
Dry Eyes	Eyelid Redness
Excessive Tearing	Itchy Eyes
Eye Discharge	Photo-Phobia
Eye Pain	Vision Loss
Eye Redness	Visual Disturbance
Drooping Eyelid	
EARS NOSE THROAT NECK	
Difficulty Swallowing	Mouth Sores
Dizziness	Nasal Congestion
Dry Mouth	Nasal Drainage
Ear Discharge	Nasal Itching
Ear Pain	Nasal Pain
Ear Plugging	Neck Swelling
Nose Bleeding	Postnasal Drip
Eye Tearing	Sneezing
Facial Pain	Snoring
Gum Problems	Sore Throat
Hearing Loss	Tinnitus
Hoarseness	Tooth Pain
Jaw Pain	Vertigo
Facial Swelling	Voice Change
RESPIRATORY	
Chest Tightness	Nocturnal Cough
Cough	Chest Pain
Dry Cough	Labored Breathing
Shortness of Breath	Productive Cough
Coughing Blood	Wheezing

CARDIOVASCULAR	
Chest Pain	Edema
Chest Pressure	Lightheadedness
Leg Pain with Walking	Palpitations
Cold Extremities	Syncope
Diaphoresis	Tachycardia
Shortness of Breath	S.O.B. On Exertion
Low Exercise Tolerance	S.O.B. While Lying Flat
GASTROINTESTINAL	
Abdominal Distention	Heartburn
Abdominal Mass	Vomiting Blood
Abdominal Pain	Incontinence of Stool
Anorexia	Jaundice
Belching	Light Colored Stool
Coffee Ground Emesis	Black Stools
Constipation	Nausea
Diarrhea	Painful Swallowing
Dyspepsia	Rectal Bleeding
Difficulty Swallowing	Rectal Itching
Early Satiety	Rectal Mass
Fecal Urgency	Rectal Pain
Flatulence	Vomiting
GENITOURINARY/NEPHROLOGY	
Abnl Menstrual Bleeding	Vaginal Discharge
Breast Mass	Painful Periods
Breast Pain	Pelvic Pain
Breast Swelling	Rash
Burning w/Urination	Testicular Mass
Blood in Urine	Testicular Pain
Change in Libido	Urethral Discharge
Change in Urine Color	Urinary Frequency
Erectile Dysfunction	Urinary Incontinence
Genital Itching	Urination at Nights
Genital Lesion	Urinary Retention
Genital Pain	Urinary Urgency
Hot Flashes	Irregular Menstrual Cycle

MUSCULOSKELETAL	
Ankle Pain	Joint Swelling
Arm Pain	Joint Warmth
Painful Joints	Leg Pain
Back Pain	Muscle Cramps
Deformity	Muscle Swelling
Elbow Pain	Muscle Weakness
Foot Pain	Muscular Aching
Gait Abnormality	Neck Pain
Hand Pain	Shoulder Pain
Hip Pain	Stiffness
Joint Redness	Wrist Pain
DERMATOLOGICAL	
Arthropod/Insect Bite	Nail Discoloration
Callus	Nail Thickening
Change in Lesion	New Lesion(s)
Bruising	Pigmentation Change
Excessive Sweating	Itching
Hives/Uticaria	Rash
Nail Deformity	Skin Change
NEUROLOGICAL	
Alteration of Consciouness	Weakness
Ataxia	Numbness
Confusion	Tingling in Fingers
Dizziness	Radiating Pain
Headache	Seizure
Impaired Balance	Syncope
Impaired Speech	Tremor
Memory Loss	Paresis
PSYCHIATRIC	
Anxiety	Excessive Sleeping
Binge Drinking	Inability to Concentrate
Depression	Insomnia
Early Morning Awakening	Panic Attacks
Easily Distractable	Substance Abuse Concerns
Excess Energy	Suicidal Thoughts, Plans
Feeling Hopeless	Tearfulness

Diagnoses: Please circle all that apply (currently or in the past)

AIDS/HIV	Breast Lump	Diabetes	Heart Disease	Multiple Sclerosis	Stroke
Alcoholism	Bronchitis	Emphysema/COPD	Kidney Disease	Pacemaker	Suicide Attempt
Anemia	Cancer	Epilepsy/Seizures	Liver Disease	Pneumonia	Tonsillitis
Eating Disorder	Cataracts	Glaucoma	Migraines	Prostate Problems	Tuberculosis
Arthritis	Chemical Dependency	Goiter	Miscarriage	Psychiatric Disorders	Typhoid Fever
Bleeding Disorder	Chicken Pox	Gout	Mononucleosis	Rheumatic Fever	STDS
Hernia	Hepatitis	Hypertension	Ulcers	Asthma	Vaginal Infections

Allergies (To Medications or Substances) : _____

_____

FAMILY MEDICINE SOLUTIONS, P.A.

CONSENT FOR TREATMENT

I, _____, consent to any and all medical care and attention given to me at Family Medicine Solutions, P.A., Sultan H. Rahaman, M.D. This consent includes, but it not limited to, medical and minor surgical intervention, Pap smear, laboratory and diagnostic testing, and elective as well as emergency care as deemed necessary by the treating physician.

I understand that all procedures and recommendations will be explained to me, and if applicable, information will be provided. Additional information regarding any procedure performed can be provided along with detailed information and documentation if requested. If for some reason I do not fully understand the recommended treatment or procedure, I understand that I may ask my physician or staff any questions regarding treatment or recommendation.

Patient Signature ★	Date

ADVANCE DIRECTIVE
(In compliance with the Patient Self-Determination Act)

What is this? In the event you are unable to make medical decisions for yourself, the Advanced Directive is your pre-written request. The law of Florida provides three ways to express your written desires, in advance, so your doctor and family will know how you wanted to be treated in the event you become unable to tell them. An Advance Directive is written instruction relating to the provision of care when the individual is incapacitated.

Do you have an Advance Directive?

- □ Yes
- □ No

If yes, is this directive in the form of:

- □ Living Will
- □ Durable Power of Attorney
- □ Healthcare Surrogate

If you have answered "Yes" to any of the above, please provide this office with a copy for your medical record.

Patient Signature ★	Date

(COMMUNICATION EXCHAGE) IMMUNIZATION/MEDICATION HISTORY CONSENT

I consent for my immunization and medication history records to be obtained and/or shared with the appropriate companies. I am aware that I can choose the OPT-OUT option, if I choose to not share my vaccination information with the State of Florida vaccine program (Florida Shots). I am also aware that the medication history consent allows me physician to obtain a history of my medications and send my medications electronically. My information will remain private and this consent will only allow sharing of information between my physician and the appropriate company (pharmacies) that already has it. (This will ensure faster and more accurate service for the patients.)

Patient Signature ★	Date

□ OPT-OUT of the immunization program. I choose to OPT-OUT of this program. In doing so I'm aware that my physician will not be able to report or update my immunization history.

□ Do not consent to Medication History. (If you choose this option, we will not have the capability to do your prescriptions electronically, as we are now paperless)

What is this? You may leave both of the Opt-Outs above un-checked. If you opt-out out of the above, you are prohibiting the physician from updating your immunization history with the state of Florida and/or having your prescriptions automatically submitted electronically to your preferred pharmacy, which is necessary for our paperless office.

FAMILY MEDICINE SOLUTIONS, P.A.
SULTAN RAHAMAN, M.D.

ACKNOWLEDGMENT FORM

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing the form. As provided in our notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment, and healthcare operations are described in our Notice. You have the right to revoke the consent, in writing, except where we have already made released in reliance on our prior consent.

What is this? By signing this form, you are allowing us to communicate and share your information with your other doctors who are treating you and your insurance company.

	Patient Name
★	Patient Signature
	Date
	Witness Name
	Witness Signature

Office Use Only
I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:

225 N Ronald Reagan Blvd – Suite 101 – Longwood FL 32750 – 407-767-8006 – Fax 407-767-2511