WESLEYCHAPEL
INTERNAL MEDICINE AND PEDIATRICS
Manish Shah MD, FAAP

HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Occupation:		
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

Review of systems: If you answer yes to any of the questions below, please explain.

GENERAL			
1. Unexplained weight loss	☐ Yes ☐ No What was the magnitude of this weight loss? 0-5 lbs.☐ 5-15 lbs.☐ 15-25 lbs. ☐ >25 lbs. ☐		
2. Unexplained weight gain	☐ Yes ☐ No	5. Night Sweats	☐ Yes ☐ No
3. Chronic Fatigue	☐ Yes ☐ No	6. Fever or chills	☐ Yes ☐ No
4. Change in appetite	☐ Yes ☐ No	7. Any type of cancer	☐ Yes ☐ No
HEART/VASCULAR			
8. Chest pain or pressure	☐ Yes ☐ No	15. Calf pain with exercise	☐ Yes ☐ No
9. Chest pain with exertion	☐ Yes ☐ No	16. Varicose veins	☐ Yes ☐ No
10. Heart Attack	☐ Yes ☐ No	17. Phlebitis	☐ Yes ☐ No
11. Rapid/Irregular heartbeats	☐ Yes ☐ No	18. Stroke	☐ Yes ☐ No
12. Fainting/Lightheadedness	☐ Yes ☐ No	19. High blood cholesterol	☐ Yes ☐ No
13. High blood pressure	☐ Yes ☐ No	20. High blood triglycerides	☐ Yes ☐ No
14. Rheumatic fever	☐ Yes ☐ No		
EYES			
21. Decrease in vision	☐ Yes ☐ No	24. Color blindness	☐ Yes ☐ No
22. Double vision	☐ Yes ☐ No	25. Cataracts	☐ Yes ☐ No
23. Glaucoma	☐ Yes ☐ No	26. Serious injury to eye	☐ Yes ☐ No
EAR-NOSE-THROAT			
27. Hearing loss	☐ Yes ☐ No	31. Ruptured eardrum	☐ Yes ☐ No
28. Prolonged exposure to loud noise	☐ Yes ☐ No	32. Snoring	☐ Yes ☐ No
29. Ringing in ears	☐ Yes ☐ No	33. Sinus infection	☐ Yes ☐ No
30. Chronic ear infections	☐ Yes ☐ No	34. Allergy related nasal congestion	☐ Yes ☐ No
BONE & JOINT			
35. Chronic joint & muscle pain	☐ Yes ☐ No	38. Arthritis	☐ Yes ☐ No
36. Low back pain	☐ Yes ☐ No	39. Gout	☐ Yes ☐ No
37. Swollen/stiff joints	☐ Yes ☐ No		
ENDOCRINE			
40. Thyroid disease	☐ Yes ☐ No	41. High blood sugar ☐ Yes ☐ No	42. Diabetes ☐ Yes ☐ No

PULMONARY			
43. Chronic cough or phlegm	☐ Yes ☐ No	48. Pneumonia	☐ Yes ☐ No
44. Wheezing	☐ Yes ☐ No	49. Emphysema	☐ Yes ☐ No
45. Asthma	☐ Yes ☐ No	50. Coughed up blood	☐ Yes ☐ No
46. Tuberculosis	☐ Yes ☐ No	51. Shortness of Breath	☐ Yes ☐ No
47. Bronchitis	☐ Yes ☐ No		
GASTROINTESTINAL			
52. Ulcer disease	☐ Yes ☐ No	59. Diarrhea caused by milk/lactose intolerance	☐ Yes ☐ No
53. Frequent heartburn	☐ Yes ☐ No	60. Blood in stools	☐ Yes ☐ No
54. Vomited blood	☐ Yes ☐ No	61. Black stool	☐ Yes ☐ No
55. Gallbladder trouble	☐ Yes ☐ No	62. Hemorrhoids	☐ Yes ☐ No
56. Abdominal Pain	☐ Yes ☐ No	63. Colon Polyps	☐ Yes ☐ No
57. Jaundice, hepatitis, or cirrhosis	☐ Yes ☐ No	64. Chronic constipation	☐ Yes ☐ No
58. Frequent diarrhea	☐ Yes ☐ No		
NEUROPSYCHIATRY			
65. Loss of consciousness	☐ Yes ☐ No	71. Difficulty sleeping	☐ Yes ☐ No
66. Vertigo	☐ Yes ☐ No	72. Depression	☐ Yes ☐ No
67. Memory problems	☐ Yes ☐ No	73. Anxiety	☐ Yes ☐ No
68. Seizures or epilepsy	☐ Yes ☐ No	74. Nervous breakdown	☐ Yes ☐ No
69. Frequent headaches	☐ Yes ☐ No	75. Psychiatric or psycho-logical counseling	☐ Yes ☐ No
70. Numbness or tingling of arms, legs, or face	☐ Yes ☐ No		
HEMATOLOGY			
77. Anemia	☐ Yes ☐ No	79. Previous blood transfusion	☐ Yes ☐ No
78. Bleeding disorder	☐ Yes ☐ No	80. Enlarged or swollen lymph nodes	☐ Yes ☐ No
DERMATOLOGY			
81. Skin Rash	☐ Yes ☐ No	86. Mouth sores that won't heal	☐ Yes ☐ No
82. Skin cancer	☐ Yes ☐ No	87. Psoriasis	☐ Yes ☐ No
83. Shingles/herpes zoster	☐ Yes ☐ No		
84. Skin sores that won't heal	☐ Yes ☐ No		

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY						
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?				☐ Yes	☐ No
	Would you like information on the preparation of these?				☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

NUTRITIONAL SUPPLEMENT INFORMATION

Are you presently taking any type of nutritional supplements (vitamins, minerals, herbs, amino acids, fish oils, etc)?	☐ Yes	☐ No
Name the supplements that you are presently taking:		
Who recommended you take these supplements?		
Where did you purchase these supplements?		
If this practice offered an advanced, high quality line of supplements, would you consider purchasing them?	☐ Yes	☐ No
If this practice offered a simple genetic test to determine what supplemental regimen is best for you, based on your genetic variations,		
Would you consider doing it?	☐ Yes	☐ No
If this Practice offered a comprehensive weight management program, would you consider it?	☐ Yes	☐ No
If this practice offered a nutrition education program to improve your dietary habits, would you consider it?	☐ Yes	☐ No
By appointment with one of our staff?	☐ Yes	☐ No
By a class exclusively for our patients?	☐ Yes	☐ No

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Cell Phone: ( )	Employer:	Employer phone no.: ( )

Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Aetna ❑ Blue Cross ❑ Cigna ❑ Citrus H/C ❑ Medicaid

❑ Medicare ❑ Medipass ❑ Tri-Care ❑ United health Care ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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 [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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INTERNAL MEDICINE AND PEDIATRICS
Manish Shah MD, FAAP

2038 Ashley Oaks Circle, Suite 102, Wesley Chapel, FL 33544
Phone: 813-929-3622 Fax: 813-929-3620

Office Policies

Last updated 9/2018

Dear Patient or Parent/Guardian,

As a part of ongoing effort to make being at our office a pleasurable experience, we have adopted some standard policies to ensure your continued satisfaction with our services.

1. We are here to take care of you. **The office is open Monday – Friday from 8am to 5pm**.
2. We will make every attempt to see you when you are ill on the same day or the next day. Dr. Shah will occasionally overbook appointments for this purpose.
3. We attempt sincerely to see you on time. If the wait to be seen is expected to exceed 30 minutes, you should and will be notified. Please be patient as we do try to make room for everyone in the schedule when they are ill.
4. If you are unable to keep an appointment, we ask that you re-schedule at least 24 hours prior to your appointment time. If you no-show for an appointment or cancel within 24 hours of the appointment time, there will be a **no-show/untimely cancellation fee of $35** charged to your account. Excessive no-shows or untimely cancellations for appointments may result in dismissal from the office at the discretion of Dr. Shah.
5. Please give us at least **1-week notice for medication refills**. (Most prescription refill requests are done within 24-72 hours of your phone call.)
6. You should always receive a call regarding results of labs and other tests that Dr. Shah orders for you. If you do not receive a result, it is imperative that you call the office for the result. Every test is reviewed by a provider. Most labs and tests are reviewed within 24-72 hours of receiving the result. If it has been more than 10 days, please advise us immediately.
7. We do ask that non-health-related paperwork (e.g., FMLA, Disability, and Medicare-required paperwork) be filled out during an office visit. Please understand that these forms take time to fill out accurately, and your presence is necessary. **Please understand also that we charge an additional and separate fee of $35 for the completion of these additional forms.**
8. School Physicals & Gold and Blue forms will be filled out without requiring an additional office visit if the child has been seen here for a well child exam in the last 6 months. Please give us at least 48 hours notice to have these forms completed.
9. **All patients requiring controlled prescriptions will be assessed a $10 fee for every visit requiring a controlled prescription** to help defray the cost of new regulations required for writing controlled prescriptions. This new state regulation went into effect on July 1, 2018.
10. We ask that all children brought to the office act and behave appropriately for their age(s).
11. **Our After-Hours Phone Number to speak with Dr. Shah is (813) 681-0093**, to be used only for urgent medical care needs.
12. **All balances are due at the time of service. We ask that you make arrangements for all balances with us prior to your visit. Services will not be rendered, and you may be rescheduled if payment arrangements are not made. Any balances billed to insurance and not paid by or not covered by insurance, do become patient responsibility, and will be due at the time of service.**

We take pride in our work and our office, and we are always looking for suggestions for improvement. Please feel free to drop off any suggestions to our office. Any confidential requests can be discussed with Dr. Shah directly. Thank you, and Welcome to Wesley Chapel Internal Medicine and Pediatrics.

Patient Name (Please Print): _____

Parent/Guardian Name (if applicable): _____

Patient/Guardian Signature: _____ Date: _____

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Acknowledgement of Receipt of

Notice of Privacy Practices

By signing this document, I acknowledge that I have received a copy of *Wesley Chapel Internal Medicine & Pediatrics PA's* Notice of Privacy Practices.

_____ _____ _____
Name (Please Print) Signature Date

If signing as a parent or guardian, please print the name of the patient below.

_____
Name (if minor or unable to sign)

**** FOR INTERNAL OFFICE USE ONLY ****

Date Acknowledgement received: _____
Or
Reason(s) Acknowledgement was/were not obtained:

_____

_____

_____

_____

_____ _____ _____
Name (Please Print) Signature Date

WESLEYCHAPEL
INTERNAL MEDICINE AND PEDIATRICS
Manish Shah MD, FAAP

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our practice, we will always keep your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In case an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for these copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request,but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier document, but will add additional information.

You have a right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of health and Human service 200 Independence Avenue, S.W. , Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy officer, Dr. Shah, phone number 813-929-3622.

This notice goes into effect as of the opening of this office in April 2006.

PLEASE SIGN BELOW TO INDICATE THAT YOU HAVE READ OUR NOTICE OF PRIVACY PRACTICES.

X _____

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2038 Ashley Oaks Circle, Suite 102, Wesley Chapel, FL 33544
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Permission to Disclose Information

Due to the **Health Insurance Portability and Accountability Act (HIPAA)**, we are not allowed to disclose your health information to anyone without your written permission.

Please list below the names of those whom you will allow us to share your health information.

Name (Please Print):	**Relationship:**

Patient Name (Please Print): _____

Patient/Guardian Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

Previous Name: Social Security #:

I request and authorize
(Name of Previous Doctor):

(Previous Dr.'s Phone #) **(Previous Dr.'s Fax #)**

To release healthcare information of the patient named above to:

Name: Wesley Chapel Internal Medicine & Pediatrics

Address: 2038 Ashley Oaks Circle Suite #102

City: Wesley Chapel State: FL Zip Code: 33543

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

☐ All healthcare information

☐ Other:

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

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Patient Name: _____

Please tell us how you heard about Our Practice:

- ☐ Patient Referred (please tell us who, and we will send them our gratitude): _____
- ☐ Physician Referred: _____
- ☐ Insurance Company (Website): _____
- ☐ Newspaper Ad (name of newspaper): _____
- ☐ Yellow Pages: _____
- ☐ Internet Search (please indicate Yahoo, Google, etc.): _____
- ☐ Other (please indicate): _____

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Patient Portal

Convenient, safe, and secure patient connectivity website allows you to communicate with your provider's office anytime—day or night.

Our goal is to be your first choice in patient healthcare by providing convenience and accessibility to our practice. **The Patient Portal offers our patients online health services that include the ability to request appointments, request medication renewals, access medical information, and access laboratory results.**

Your medical information is available to you on this website and is secure. Our company and its affiliates, suppliers, and other third parties mentioned on this site are neither responsible nor liable for any direct, indirect, incidental, consequential, special, exemplary, punitive, or other damages (including, without limitation, those resulting from lost profits, lost data, or business interruption) arising out of or relating in any way to the site, site-related services and products, content, or information contained within the "site," and/or any hyperlinked website, whether based on warranty, contract, tort, or any other legal theory, and whether or not advised of the possibility of such damages. Your sole remedy for dissatisfaction with the site, site-related services, and/or hyperlinked web sites is to stop using the site and/or those services applicable law may not allow the exclusion or limitation of incidental or consequential damages, so the above limitation or exclusion may not apply to you.

Patient Name (Please Print): _____

Patient/Guardian Signature: _____ Date: _____

Email Address (Please Print Clearly): _____

☐ **Decline Portal Use** (Please still print your name, sign, and date above)