PRACTITIONER ASSESSMENT AND INFORMATION

Please complete the following form and bring it with you to your appointment. Your doctor will need to review your health risk assessment.

Please bring your insurance card and ALL your **BOTTLES** of medication; both prescribed and over-the-counter.

Thank you,

Dr. Sanjay K. Madan, M.D.

3190 McMullen Booth Road • Suite 201 • Clearwater, FL 33761
Phone 727.669.2969 • Fax 727.669.7460

Sanjay K. Madan MD

Dr. Sanjay K. Madan, M.D.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION:

I hereby authorize Dr. Madan to use or disclose the following information from the health records of the individual who name is described below:

Patient name: ____

DOB: ___________________

Address: ____

City: ___________________

State: ____________ Zip: _________________ Phone number: _______________________

Social Security Number: ______________________________

I authorize the named facility to release medical, mental, alcohol, and/or drug abuse, HIV, AIDS, eating disorders or any other medical information of sensitive nature to the following individuals or organizations.

Name: Dr. Sanjay Madan, MD

Address: 3190 N. McMullen Booth Rd, Suite 201
Clearwater, Florida 33761
Phone: 727-669-2969
Fax: 727-669-7460

The type of information to be used or disclosed is as follows:

- FULL MEDICAL RECORDS
- LAST 2 YEARS OF MEDICAL RECORDS

I understand that if the organization authorized to receive information is not a health plan or health provider, the released information may no longer be protected by the federal privacy act. I understand that I have the right to revoke this authorization at any time. If I revoke this authorization I must do so in writing and present my written revocation to the department listed on the authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy.

SIGN ____ DATE: ______________

(PATIENT OR AUTHORIZED PERSON, EXECUTOR, POA)

Sanjay K. Madan MD

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB:
Home Phone:	Cell Phone:	Work Phone:	
Mailing Address:			
City/State/Zip:			
SS#:	Male ○ Female ○	Single ○ Married ○ Divorced ○ Widowed ○	
Employer:			
Emergency Contact Name:		Relationship:	
Emergency Contact Phone Home:		Cell:	Work:

INSURANCE INFORMATION

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy ID:	Policy ID:
Plan: HMO ○ PPO ○ POS ○ Other ○	Plan: HMO ○ PPO ○ POS ○ Other ○
Relationship to Policy Holder:	Relationship to Policy Holder:

“I understand I am financially responsible for all charges, whether or not paid by said insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give JSA Medical Group consent to perform medical treatment.”

Patient/Guardian Signature:____ Date: _____________________

Sanjay K. Madan MD

PATIENT MEDICAL HISTORY

Last Name:	First Name:	MI:	DOB:
Date of Last Physical Exam:		Previous Physician's Name:	
Previous Physician's Address:			

PAST HISTORY (Personal and Allergies) Have you had any of the following illnesses?

	Yes	No		Yes	No		Yes	No
Amputation	□	□	CVA/TIA	□	□	Measles / Mumps	□	□
Anemia	□	□	Diabetes	□	□	Migraine Headache	□	□
Alcohol Overuse	□	□	Emphysema/COPD	□	□	Nervous Breakdown	□	□
Allergies (other than medications)	□	□	Falls	□	□	Ostomies ____________	□	□
Arthritis	□	□	Gallbladder Disease	□	□	Paralysis	□	□
Asthma	□	□	Gout	□	□	Rheumatic Fever	□	□
Bleeding Disorder	□	□	HIV / AIDS	□	□	Seizures	□	□
Cancer Location __________	□	□	Heart Attack / MI	□	□	Sexually Transmitted Diseases	□	□
Cardiac Arrhythmias Pacemaker _______	□	□	Other Heart Disease (CHF / CAD) _____	□	□	Sickle Cell Anemia	□	□
Chicken Pox	□	□	High Blood Pressure	□	□	Sleep Disorder	□	□
Colitis	□	□	Jaundice	□	□	Stomach Ulcers	□	□
Depression	□	□	Kidney Disease	□	□	Thyroid Disease	□	□
			Hepatitis	□	□	Vascular Disease	□	□

PERSONAL HABITS

1. Have you ever smoked? ○ **YES** ○ **NO** If yes, are you a regular smoker now? ○ **YES** ○ **NO**

   Have you used chewing tobacco? ○ **YES** ○ **NO** If yes, # of yrs? ___ If no, year you quit? _______

2. Do you regularly drink alcohol? ○ **YES** ○ **NO** If yes, how often? ____________________________

OPERATIONS: List & indicate approximate year

____

____

____

SERIOUS INJURIES: List & indicate approximate year

____

____

____

HOSPITALIZATIONS: (Other than operations)

List reasons and approximate dates

____

____

DIAGNOSTIC TESTS/EXAMS:

	DATE	LOCATION/PROVIDER
EYE EXAM:	_________	___________________
FOOT EXAM:	_________	___________________

IMMUNIZATIONS: (Please give date)

Hepatitis B ___________ Flu ________________ Polio ________________ Typhoid _____________

Smallpox _____________ Tetanus _____________ Pneumococcal _______ Chicken Pox _________

... continued PATIENT MEDICAL HISTORY

Last Name:	First Name:	MI:	DOB:

FAMILY HISTORY	SEX	IF LIVING		IF DECEASED	
		AGE	HEALTH	AGE AT DEATH	CAUSE
Father					
Mother					
Brothers/Sisters	M O F O				
	M O F O				
	M O F O				
Husband/Wife					
Sons/Daughters	M O F O				
	M O F O				

Check if any blood relative has or had any of the following and enter their relationship to you:

	Yes	No	Relationship to you		Yes	No	Relationship to you
Arthritis	□	□		High Blood Pressure	□	□	
Asthma	□	□		Intestinal Polyps	□	□	
Bleeding Tendency	□	□		Kidney Disease	□	□	
Cancer	□	□		Leukemia	□	□	
Colitis	□	□		Migraine	□	□	
Congenital Heart Disease	□	□		Nervous Breakdown	□	□	
Diabetes	□	□		Rheumatic Fever	□	□	
Emphysema	□	□		Sickle Cell Anemia	□	□	
Epilepsy	□	□		Stomach Ulcers	□	□	
Goiter	□	□		Stroke	□	□	
Gout	□	□		Suicide	□	□	
Hay Fever	□	□		Tuberculosis	□	□	
Heart Attack	□	□		Other	□	□	

MEDICATIONS

□ Asthma Wheezing Medicine	□ Sleeping Pills/Tranquilizers
□ Aspirin, Bufferin, Anacin, Tylenol or Similar Products	□ Thyroid Medicine
□ Blood Pressure Pills	□ Stomach/Digestive Medicine
□ Cortisone, Prednisone	□ Weight-Reducing Pills
□ Cough Medicine	□ Blood Thinners or Coumadin
□ Digitalis or Heart Medicine	□ Dilantin or Seizure Medications
□ Hormones	□ Water Pills or Diuretics
□ Insulin or Diabetic Pills	□ Antibiotics
□ Anemia Medications	□ Phenobarbital/Barbiturates
□ Laxatives	□ Vitamins
	□ Other Prescription or Over-the-Counter Drugs

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PATIENT MEDICATION HISTORY

Last Name:	First Name:	MI:	DOB:

List each medication; its dosage and how often you take it, including vitamins and herbal supplements.

MEDICATION	DOSAGE	HOW OFTEN?	WHEN STARTED?

Are you allergic to any medications?: **YES** O **NO** O If yes, please list medications and reactions.

MEDICATION	REACTION

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PATIENT SOCIAL/LIFESTYLE HISTORY

Last Name:	First Name:	MI:	DOB:

SOCIAL/LIFESTYLE HISTORY		Primary Language ______________
Do you feel lonely?	YES O NO O	
Is there someone that lives in your residence?	YES O NO O	If yes, please list name and relationship:
Type of residence		Apartment □ Mobile Home □ House □ One-Story □ Two-Story Assisted Living □ Facility Name: ____________ Other: _________
Durable medical equipment	YES O NO O	Wheelchair _____________ Oxygen __________________ Walker _____________ Nebulizer __________________ Cane _____________ CPAP/BIPAP __________________ Other ____
Can you afford medicines?	YES O NO O	Potential Referral to Patient Assistance Program
Transportation provided by?		
NUTRITIONAL HISTORY		
Are you able to purchase food?	YES O NO O	
Weight lbs.: ______________		Height ft: ___ in: ___ Weight changes in past 6 mo.? Y O N O
Current Diet Plan		
EXERCISE/ACTIVITY:		
Current Activity	How Often?	
Physical Limitations		
ACTIVITIES OF DAILY LIVING:		
Do you require assistance to bathe or groom?	YES O NO O	If yes, please explain:
Do you require assistance for your toilet needs?	YES O NO O	If yes, please explain:
Do you have urine leakage?	YES O NO O	If yes, please explain:
Do you require assistance to eat?	YES O NO O	If yes, please explain:
Do you have hearing loss?	YES O NO O	Do you wear hearing aids: Y O N O Last hearing exam date: ____________________________
Additional Comments:		

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PATIENT PREVENTATIVE SERVICE HISTORY

Last Name:	First Name:	MI:	DOB:

PREVENTATIVE SERVICE HISTORY		
Preventative Services	**Date Rec'd**	**Findings and Recommendations**
Bone Mass Measurement (Density)		
Colorectal Cancer Screening • Colonoscopy (not high-risk) • Fecal Occult Blood Test	 __________ __________	
Diabetes Screening • Hg AIC • Foot Exam • Eye Exam	 __________ __________ __________	Cataracts ☐ Other ___________________
Glaucoma Screening		Glaucoma ☐
Prostate Cancer Screening • Digital Rectal Exam (DRE) • Prostate Specific Antigen Test (PSA)		
Mammogram Screening • Mammogram		

____________________________________ ____________________________________

Date Reviewed Physician Signature

*** After review of the Practitioner Assessment, please remember to code **99420**

Sanjay K. Madan MD

HIPPA
NOTICE OF PRIVACY PRACTICES

DR. SANJAY K. MADAN, M.D. HAS A POLICY OF COMPLYING WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA). OUR OBJECTIVE IS TO BE 100% COMPLIANT AT ALL TIMES. THE FOLLOWING METHOD OF OPERATION WILL BE USED TO ENSURE PRIVACY OF A PATIENT'S PROTECTED HEALTH INFORMATION (PHI).

1. **Based on HIPPA guidelines, your medical records may be transferred to another care provider upon your signed authorization. Records will not be transferred without your signed authorization.**
2. **After review of your records, if you disagree with any of the documents in the records, you have the option of writing your own documentation to be placed in the chart.**
3. **If an appointment with another medical provider is required, only the necessary information will be provided.**
4. **If you elect to not allow any member of your family access to your records, you have the right to notify our office. That notice must be in writing. If you wish to provide access to your records to a designated individual, you may also provide that notice in writing.**
5. **Our office will not provide any information about you or your medical condition to any other party, other than medical providers to whom you have been referred for treatment, without your specific consent.**
6. **If you are chosen to be part of any research program, you will be required to sign additional authorization & releases so that your PHI may be used in the program.**
7. **Under HIPPA rules, we may use necessary PHI from your medical records to file insurance claims on your behalf. Your authorization and insurance assignments allow the practice to file insurance on your behalf.**
8. **There will be certain circumstances where public health authorities many require a copy of your records. They are authorized under law to collect that information and we are required to furnish that information; a copy of your PHI. You may review your records by scheduling a time with our office.**
9. **All efforts will be taken to ensure that your PHI will not be shared with any unauthorized persons.**
10. **If you are on active military duty or are called to active military duty, under federal law we are required to supply a copy of your records.**

If you should have any questions concerning any of the above, please contact any of the staff at Dr. Sanjay K. Madan, M.D.

______________________________ ______________________________

Signature Date