SandBay
PRIMARY & URGENT CARE

Patient's Last Name:	First Name:	Middle :	Marital status (circle one) Single / Married / 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

Ethnicity:	☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refuse to Report/Unreported	Social Security No. _____	Primary Language:	☐ English ☐ Spanish ☐ Other, specify :_____

RACE:						
☐ American Indian or Alaska Native	☐ White	☐ Asian	☐ African American	☐ Native Hawaiian or other Pacific	☐ Refuse to report/Unreported	☐ Other _____

Street address:	City:	State:	ZIP Code:	Email:	Web Enable : YES / NO

Mailing Address (if different than physical address) P.O. box:	City:	State:	ZIP Code:

Home Phone: ☐ Y ☐ N Can leave message. ( )	Cell Phone: ☐ Y ☐ N Can leave message. ( )	Work Phone: ☐ Y ☐ N Can leave message. ( )

Living Situation: ☐ Own home	☐ Condo or apartment	☐ Retirement home
☐ Assisted Living	☐ Nursing home	☐ W/family member
☐ Senior Citizen Housing	☐ Mobile home	☐ Other, specify

How did you hear about us (please check all that apply):	☐ Directory	☐ Family/Friend	☐ Facebook	☐ Flyer	☐ Google Search
☐ Hospital Referral	☐ Insurance Plan	☐ Kings Point	☐ Mailer/Postcard	☐ News of Sun City Center	☐ The Observer News	☐ The Pointer

Preferred Pharmacy: Address:	Mail Order Pharmacy:

BILLING & INSURANCE INFORMATION

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

Is this person a patient here? ☐ Yes ☐ No Relationship:

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐ Medicare	☐ Aetna	☐ BayCare Health Plans	☐ Blue Cross Blue Shield	☐ CarePlus	☐ Coventry
☐ Devoted Health	☐ Freedom/Optimum	☐ Humana	☐ Simply	☐ Tricare	☐ United Health Care	☐ Other

Subscriber's name (if different than patient):	Subscriber's S.S. no.:	Birth date: / /	Policy no./Member ID:	Group no.:	Co-pay: $

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

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

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

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize medical services be rendered to me by Sandbay Primary and Urgent Care. I authorize my insurance benefits be paid directly to Sandbay Primary and Urgent Care for services rendered. I understand that I am financially responsible for any balance. I also authorize Sandbay Primary and Urgent Care or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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NAME: _____ GENDER: _____ DOB: _____ DATE: _____
ALLERGIES: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____
_____ _____ _____
_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: _____	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period	Date: _____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____
_____ _____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

Continued on other side.

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type:

_____ Are you sexually active? ☐Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder Cancer: _____	Depression	High Cholesterol	Osteoporosis
Anemia	COPD/ Emphysema Dementia	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma		DVT (Blood Clot) Heart	Kidney Disease	Thyroid Disorder
Arthritis		Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder Cancer: _____	Depression	High Cholesterol	Osteoporosis
Anemia	COPD/ Emphysema Dementia	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma		DVT (Blood Clot) Heart	Kidney Disease	Thyroid Disorder
Arthritis		Disease	Migraines	

Other: _____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____

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HIPAA

PATIENT ACKNOWLEDGEMENT OF RECEPT OF NOTICE OF PRIVACY PRACTICES & CONSENT
LIMITED AUTHORIZATION & RELEASE FORM

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes your spouse, children, step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____ Phone number: _____
Name: _____ Relationship: _____ Phone number: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST MY MEDICAL RECORDS BE SENT TO OTHER ATTENDING DOCTOR/ FACILITY IN THE FUTURE.

NOTICE OF PRIVACY PRACTICES

I have been provided with a copy of the Notice of Privacy Practices of Provider and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Provider. The Notice of Privacy Practices for Provider is also posted in the waiting room. This Notice of Privacy Practices also describes my rights and duties of the Provider with respect to my protected health information.

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.

- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

Inital: _____

Date: _____

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Policies

APPOINTMENT POLICY:

✓ 24-hour notice is required to reschedule or cancel appointment. NOTE: If the proper notice in not given to cancel or reschedule an appointment, there is a "NO-SHOW fee of $30.00 for a follow-up appointment and $10.00 "NO-SHOW" fee for blood work.

✓ Patients who arrive late for an appointment will be asked to wait to see the doctor until there is sufficient time to complete the visit/ appointment or the Patient may be asked to reschedule the appointment.

OFFICE FEES FOR MEDICAL RECORDS: COPIES/FORMS/REPORTS

✓ $1.00 per page for copies up to 25 pages, $0.25 per page per copy for 26 pages and more.

✓ Request of medical records/forms a minimum of 5 business days is required.

TELEPHONE MESSAGE POLICY

✓ If necessary telephone messages will have a 48 hour response time.

PRESCRIPTION REFILL POLICY

✓ Approved prescription refills require a 3-5 business days notice.

REFERRAL POLICY

✓ Referrals require a seven business days notice.

✓ Appointments are required for a referral request.

I understand that I am responsible for all charges incurred whether or not paid by the Insurance Company. I agree and understand that I may be also charged a 1.5% interest fee per month on any unpaid balances, and that I also responsible for any costs incurred in collection of the said balance should collection become necessary. I have read and understand the above information and agree to comply

Consent for Treatment

In this document, "I" and "my" refer to the patient, and "Provider" refers to SandBay.

I consent to the use or disclosure of my protected health information by Provider for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Provider. I understand that analysis, diagnosis or treatment of me by Provider may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Provider is not required to agree to the restrictions that I may request. However, if Provider agrees to a restriction that I request, the restriction is binding on Provider.

I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____

Date of Signing

ADVANCE DIRECTIVE QUESTIONNAIRE

Patient Name _____**DOB**:_____

SandBay Primary & Urgent Care would like to encourage all patients to have an Advance Directive on file with our office.

Under the Patient Self-Determination Act of 1990, each individual has the right to determine the course of his/her medical care and treatment. You make these choices now so that when you become unable, your decisions are known. Advance Directives only take effect if, in the future, you lose the capacity to speak for yourself. It has no effect on your current health care as long as you are able to speak for yourself.

Advance Directives for Health Care consist of three parts:

Health Care Proxy: Designates another person to make medically related decisions for you.
Living Will: Designates your future health care treatment choices.
Other Wishes: Designates your wishes regarding Death, Organ Donation and Autopsy.

You may, at any time, complete any section and our office will keep a copy of your wishes on file for you. If you are not ready today please ask at any time for the form. We will review this annually with you.

Circle One

Do you have a living will? YES NO
Do you have a Health Care Proxy? YES NO
If no, would you like the form to fill out? YES NO
If yes, would you like to have a copy in our chart for you? YES NO

I am not ready to fill out this form. Please ask me about this in the future. _____

_____ _____
Patient Signature Date