Dear Valued Patient,

On behalf of the physician, associate practitioners and staff of SUNCITY INTERNAL MEDICINE,

I want to welcome you to our organization and thank you for choosing a SUNCITY INTERNAL MEDICINE to care for you and/or your loved ones.

At SUNCITY INTERNAL MEDICINE, we put the patients’ needs first. We are committed to providing you and your family with the highest-quality care and exceptional customer service. Our physicians are committed to promoting good health and guiding patients toward a healthy lifestyle.

Sincerely,



## Shahul Riazudeen, MD

SUNCITY INTERNAL MEDICINE

Ph: (813) 633-1100

Fax: (813) 633-1152

# PATIENT INFORMATION

Patient’s Name (First, Middle, Last): Address:

City: State: Zip Code: Email: Main Contact#: Alternate#: Work#:

Date of Birth: / / Sex: Male Female SS# (optional):

Marital Status : Single Married Divorced Widowed Occupation:

Patient Referred By: Spouse’s Name:

Spouse’s Date of Birth: / /

Main Contact#:

Alternate#:

Emergency Contact: Relationship: Phone#:

Primary Care Physician: Phone#: Referring Physician: Phone#:

Other Patient Information

## Which racial category does the patient most closely identify with?

|  |  |  |  |
| --- | --- | --- | --- |
| African American | Asian | Caucasian | Hispanic |
| Native American | Native Hawaiian | Pacific Islander | Other: (Please Specify) |
| **Ethnicity:** What is the patient’s ethnicity? | Hispanic or Latino | Not Hispanic or Latino |
| **What is the patient’s language of preference?** | English Spanish | Other: (Please Specify) |

Insurance Information

**Primary Insurance:** Policy/ID#

Name of Policy Holder: DOB: / / Group/Acct #: Employer: Employer Address:

City:

State:

Zip Code: Work #:

**Secondary Insurance:** Policy/ID#:

Name of Policy Holder: DOB: / / Group/Acct #: Employer: Employer Address:

City:

State:

Zip Code: Work #:

Complete – Only if Patient is a Minor

Parent/Guardian Name: Parent/Guardian Name:

Relationship: Relationship:

Siblings: DOB: / / Other Siblings: DOB: / /

# GENERAL CONSENT FORM

## Patient Name: Date of Birth: / /

**Assignment of Benefits.** I authorize SUNCITY INTERNAL MEDICINE to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that SUNCITY INTERNAL MEDICINE will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

## Patient Initials:

**Consent for Treatment.** I consent for SUNCITY INTERNAL MEDICINE to administer treatments, tests and/or diagnostic tests to treat my/the patient’s injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient’s blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient’s BBF, SUNCITY INTERNAL MEDICINE may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at SUNCITY INTERNAL MEDICINE’s expense.

## Patient Initials:

**Phone Calls.** By providing contact information, I authorize SUNCITY INTERNAL MEDICINE, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/ employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

**Involvement of Others in Care.** I authorize SUNCITY INTERNAL MEDICINE to discuss my/the patient’s care and medical needs with the following persons:

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Date of Birth(for identification) | Relationship | Phone |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

I DO NOT wish to add an additional contact to discuss my/the patient’s needs. **Patient Initials: May We Contact You By Phone and Leave a Message About Your Care?**

Primary Phone #: Secondary Phone #:

Leave message with contact number only. Leave message with contact number only. Leave message with detailed information. Leave message with detailed information. Do not leave message. Do not leave message.

## Patient Financial Policy

I acknowledge receipt of the “Patient Financial Policy.” **Patient Initials:**

Print Name of Patient or Personal Representative

Signature of Patient or Personal Representative Date

# FINANCIAL POLICY

Patient Name: Patient Date of Birth: / /

 **Please read prior to receiving services.**

SUNCITY INTERNAL MEDICINE recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

* **PAYMENT: Payment is expected at the time of service.** If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks.

## MANAGED CARE: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service.

If your insurance plan requires a referral authorization from a primary care physician please present this at your initial visit. If you request an office visit or surgery without a referral authorization your insurance plan may deem this as **“out of network” or “non covered” treatment**, and you will be responsible for a larger amount or all of the charges. The patient acknowledges that it is the patient’s responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non covered or not authorized by the plan.

* **MEDICARE:** SUNCITY INTERNAL MEDICINE providers are participating providers with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.
* **AUTOMOBILE ACCIDENT PATIENTS:** We do NOT treat automobile accident patients.
* **SECONDARY INSURANCE:** Patient agrees to provide such information. Patient agrees to immediately notify provider of any future additions, changes or deletions in primary or secondary insurance coverage.
* We offer the opportunity to establish a reasonable payment plan if you are not able to pay in full at the time of service. If you have an outstanding balance, we expect you to make payment or payment arrangements before your next scheduled appointment. Non-payment may result in discharge from the practice.
* If you have **Medicaid** coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and **failure to notify us** of Medicaid coverage will result in full financial responsibility for services rendered.
* Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
* We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call **(813) 633-1100**.
* We may charge you a “No Show” fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

## Failure to keep your account balance current may require us to cancel or reschedule your appointment.

SUNCITY INTERNAL MEDICINE firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies please call us at (813) 633-1100.

**NAME: D.O.B.** / /

LAST FIRST M.I.

## OCCUPATION: REASON FOR VISIT TODAY:

**ALLERGIES** (Include medications, foods, xray dyes) or

**NONE KNOWN**

|  |  |  |
| --- | --- | --- |
| **Name of allergen** | **Type of reaction** | **Approximate date** |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |

**CURRENT MEDICATIONS** (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or

**NONE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of medication** | **Dose (mg)** | **How often taken** | **Reason for taking medication** | **Physician prescribing** |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |

**PHARMACY**(list pharmacy most frequently used for prescriptions)

Name: Phone #: Fax #: Address: City: State/Zip: **PREVIOUS HOSPITALIZATIONS** (Include all non surgical hospitalizations. Attach extra sheet if needed **NONE**

|  |  |  |
| --- | --- | --- |
| **Reasons for hospital stay** | **Date (approximate)** | **Hospital or city if known** |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |

**SURGERIES** (Include all surgery in your lifetime. Attach extra sheet if necessary) or

**NONE**

|  |  |  |
| --- | --- | --- |
| **Type of surgery** | **Date (approximate)** | **Hospital or city if known** |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |

**OB/GYN HISTORY:** No. of Pregnancies:

## TOBACCO HISTORY

No. of Deliveries:

Last Menstrual cycle:

Are you an active cigarette smoker? Have you ever been a cigarette smoker?

Yes No

Yes No

If yes, I smoked an average of packs/day for years. I quit in (year)

Do you use other tobacco products? Yes No

If yes, please specify

## ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? Yes No

Do you currently drink alcohol regularly? Yes, currently Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor) Have you ever used intravenous drugs? Yes No

## FAMILY HISTORY

|  |  |  |  |
| --- | --- | --- | --- |
| **Is there a history in your family of:** | **Yes** | **No** | **Affected relative(s)** |
| Heart attack |  |  |  |
| Diabetes |  |  |  |
| Prostate cancer |  |  |  |
| Kidney cancer |  |  |  |
| Kidney stones |  |  |  |
| Other significant disease |  |  |  |

 **NAME: D.O.B.** / /

LAST FIRST M.I.

Please check “X” the complaint(s) or ailment(s) that apply to you. If you are unsure, place a question mark (?)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **General** | Fatigue / Tired |  |  | **Males** | Blood in Urine |
|  | Fever / Chills |  |  | **Only** | Difficulty Achieving Erection |
|  | Headache |  |  |  | Foul Odor in Urine |
|  | Weight Loss |  |  |  | Pain in Testicles |
|  | Weight Gain |  |  |  | Trouble Urinating |
|  |

**Eyes** Difficulty Seeing

|  |  |  |  |
| --- | --- | --- | --- |
| **Females** | Breast Discomfort |  |  |
| **Only** | Irregular Bleeding |  |  |

Other:

Last Menstrual Cycle

|  |  |  |  |
| --- | --- | --- | --- |
| **Head** | Dry Mouth |  |  |
| **Ears** | Hearing Problems |  |  |
| **Nose** | Hoarseness |  |  |
| **Throat** | Lumps/Swelling in Neck |  |  |
|  | Sore Throat |  |  |
|  | Trouble Swallowing |  |  |
|  |
| **Cardiac** | Chest Pain |  |  |
| **(Heart)** | Irregular Heart Beat |  |  |
|  | Pain with Walking |  |  |
|  | Shortness of Breath |  |  |
|  | Swelling in Feet/Ankles |  |  |
|  |
| **Neuro** | Dizziness |  |  |
|  | Fainting |  |  |
|  | Headache |  |  |
|  | Memory Loss |  |  |
|  | Numbness |  |  |
|  | Weakness |  |  |
|  |
| **Respiratory** | Cough |  |  |
|  | Shortness of Breath |  |  |
|  | Use of Inhalers |  |  |
|  | Wheezing |  |  |
|  |
| **Gastro-** | Abdominal Pain |  |  |
| **Intestinal** | Blood in Stool |  |  |
|  | Change in Bowel Habits |  |  |
|  | Constipation |  |  |
|  | Heartburn |  |  |
|  | Loss of Appetite |  |  |
|  | Nausea |  |  |
|  | Vomiting |  |  |
|  |

Painful Intercourse

Post Menopausal Bleeding Trouble Urinating Vaginal Discharge

## Musculoskeletal

Back Pain Joint Pain Muscle Pain Swelling

|  |
| --- |
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| --- |
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Other:

**Skin** Bruising

 Rash

**Mental** Anxiety

**Health** Depression Difficulty Sleeping/Concentrating History of Physical/Mental Abuse Mood Swings

|  |
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Stress

Suicidal

Other:

**Recent Tests/** (Give month/year of last exam in right column.

**Health Maintenance** Check left column if date is estimated.)

Bone Density: Colonoscopy: Diabetic Foot Exam: Eye Exam: Mammogram: Pap Smear: Physical: PSA:

Tetanus Shot: