DIPAK SHAH, M.D., P.A.

WELCOME TO OUR PRACTICE

It is our sincere pleasure to welcome you as a patient.
For your convenience, our office hours are
8 am – 5 pm Monday thru Friday.
We are closed for lunch from 1 pm – 2 pm.

As part of the preventative care that we practice,
all new patients are given a complete physical examination
which takes 45 minutes of your time.
Please call us at your earliest convenience so
we can schedule you for an appointment.

Our doctors and nurse practitioners
look forward to provide you with quality medical service
in the most courteous and efficient manner possible.

Please bring all your medications to your initial examination.
If you have any further question, please do not hesitate to contact our office.

Thank You!

UNIVERSITY MEDICAL CARE 14701 N. FLORIDA AVENUE, TAMPA, FL 33613
PH. (813) 265-2066 FAX (813) 960-4615
VALRICO MEDICAL CARE 143 N. OAKWOOD AVENUE, BRANDON, FL 33510
PH. (813) 685-4617 FAX (813) 685-7105
CITRUS PARK MEDICAL CARE 6328 GUNN HIGHWAY, TAMPA, FL 33625
PH. (813) 964-8526 FAX (813) 964-8536
WESLEY CHAPEL MEDICAL CARE 2800 WINDGUARD CIRCLE, STE 102, WESLEY CHAPEL, FL 33544
PH. (813) 345-8515 FAX (813) 345-8517

PATIENT INFORMATION

Name:	Date of Birth:
Address One:	Country of Birth:
Address Two:	Social Security:
City	Sex:
State: Zip:	Language:
Home Phone:	Employer:
Work Phone:	Emergency Contact:
Cell Phone:	Emergency Phone:
Marital Status:	Emergency Relationship:

GUARANTOR INFORMATION

Name:	Date of Birth:
Address One:	Social Security:
Address Two:	
City	
State: Zip:	Employer:
Home Phone:	Employer Address:
Work Phone:	Employer City:
Cell Phone:	Employer State: Zip:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate:	Certificate:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:

Permission to Release Information to: (please list names of person(s) whom we can release medical / personal information to) _____

_____

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my provider when they accept assignment.

Authorization to Release Medical Information: I hereby authorize my provider to release any information necessary for my course of treatment.

_____ _____

Signed (patient or parent if minor) **Date**

Financial Policy

We consider payment of services to be the responsibility of the patient-physician relationship. Therefore, we would like to share our payment policy expectations with you to ensure understanding and compliance.

We participate with various insurance companies and managed care plans, which we will file on your behalf directly to the insurance carrier for payment, less any co-payments, coinsurance, deductibles and non-covered benefits.

Please make sure that on your commercial managed plans, you choose us as your primary care physicians. If we are not the doctors of choice we will not be able to see in the office. Also, be sure that your insurance is active before making an appointment or you will be charged the full cost of the office visit.

Payment is expected at the time of service.

ON ALL RETURNED CHECKS FOR NON-SUFFICIENT FUNDS, there is a $25.00 fee charged back to the patient. We will be unable to accept any personal checks until the account balance and associated service fees are paid in full. If this is a repeated offense, we will be unable to accept any further checks.

By signing below, I have read and understood the payment terms and my obligations within the Financial Policy. Please let us know if you have any additional questions or concerns.

_____ _____

Signature of Patient / Person responsible for Account Date

Assignment of Benefits and Privacy Practices Acknowledgement

* HMO, PPO, Commercial Insurance, Healthease and Medicaid

I request that payment of authorized benefits be made on my behalf to the rendering physicians for any services furnished to me. I agree to comply with the terms of my insurance coverage, including payment of my co-payment at the time services are rendered, payment of any portion of charges that my insurance carrier determines to be my responsibility, upon receipt of my monthly statement.

Signature: _____ Date: _____

* Medicare insurance

I request that payment of authorized Medicare benefits be made on my behalf to the rendering physicians for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I agree to pay any portion of my charges that my Medicare carrier determines to be my responsibility.

Signature: _____ Date: _____

*All Patients:

I acknowledge receipt or offer to have a copy of the Notice of Privacy Rights and Practices.

Signature: _____ Date: _____

University Medical Care

14701 N. Florida Avenue, Tampa, FL 33613
Phone: Office: 813.265.2066 Fax: 813.960.4615

I authorize the named healthcare provider to release the information or records specified to upon requested in person or by mail to the address / fax number specified at the time of the request.

Provider **Patient Info**

Records to: Patient:

Records from: SSN: DOB:

Phone / Fax:

- ☐ Admission of history and physical
- ☐ Office notes
- ☐ Lab reports
- ☐ Radiology X-rays
- ☐ Consults
- ☐ Hospital
- ☐ Medication
- ☐ All the above

This information to be released for the purpose of:

- ☐ Continuation of care
- ☐ Other : _____

This authorization will expire one year from the date of signature below. I understand that I can revoke this authorization at anytime by writing to the healthcare provider, but that revoking this authorization will not affect disclosure made or actions taken before the revocation is received. Federal privacy regulations will no longer apply to the information disclosed, and that may redisclose the information. A copy of this authorization may be utilized with the same effectiveness as original.

Patient: Date:

PATENT SELF DETERMINATION ACT QUESTIONNAIRE

DON'T LOSE YOUR RIGHT TO DECIDE!

You cannot remove all uncertainty about your future healthcare needs but by having an advance directive you can have the peace of mind that comes from making your wishes know in advance!

Declaration To Decline Life-Prolonging Procedures (Living Will)

[ ] I have made a Living Will.

[ ] I do **NOT** have a Living Will.

Health Care Surrogate

[ ] I have designated a Health Care Surrogate.

[ ] I have **NOT** designated a Health Care Surrogate.

Durable Power of Attorney

[ ] I have appointed a Durable Power of Attorney for Health Care Decisions.

[ ] I have **NOT** appointed a Durable Power of Attorney for Health Care Decisions.

_____
(Patient Name)

_____ _____
(Signature of Patient or Representative) (Date)

If you have any further questions, you can contact your family attorney, local hospital, or local medical association for additional information.

PATIENT'S PERSONAL HSTORY

Name: _____ Date: _____

Your current medical problem:

_____

Date of last physical examination: _____ Referred by: _____

Have you had any of the following illness?

	Yes	No		Yes	No
Rheumatic Fever	☐	☐	Cancer	☐	☐
Angina	☐	☐	Frequent Kidney	☐	☐
Rheumatic Fever	☐	☐	or Bladder		
Heart Attack	☐	☐	Infections	☐	☐
Other Heart			Nervous		
disease	☐	☐	Breakdown	☐	☐
High Blood			Thyroid disease	☐	☐
Pressure	☐	☐	Stomach Ulcers	☐	☐
Anemia	☐	☐	Gallbladder		
Kidney disease	☐	☐	disease	☐	☐
Gout	☐	☐	Hepatitis	☐	☐
Hay Fever	☐	☐	Colitis	☐	☐
Asthma	☐	☐	Arthritis	☐	☐
Frequent Lung			Migraine		
infections	☐	☐	headache	☐	☐
Emphysema	☐	☐	Other	☐	☐
Diabetes	☐	☐	_____		

Operations: List and indicate approximate year.

_____

_____

_____

_____

Hospitalizations (other than operations): List reasons and approximate dates.

_____

_____

_____

_____

Serious Injuries (Other than the above):
List and give approximate dates.

_____

_____

_____

_____

Diagnostic X-Rays/Tests: List and give approximate dates.

_____

_____

_____

_____

Immunizations: Please give date.

Smallpox _____ Polio _____

Typhoid _____ Tetanus _____

Are you allergic to any medications: Yes ☐ No ☐

If yes, please list medications and the reaction you had to them:

_____

_____

_____

_____

FAMILY HISTORY

NAME	If Living		If Deceased	
	Age	**Health**	**Age at Death**	**Cause**
Father				
Mother				
Brothers / Sisters (Circle Sex) M F				
M F				
M F				
M F				
M F				
Husband / Wife				
Sons / Daughters (Circle Sex) M F				
M F				
M F				
M F				
M F				

PERSONAL HABITS

Check if you regularly smoke:

Cigarettes: Number per day _____ Pipe ☐ Cigars ☐

How long have you been smoking? _____ years

Check if you regularly drink:

Hard Liquor 1-3 oz. per day ☐ Over 3 oz. per day ☐

Beer 1 bottle per day ☐ 2 bottles ☐ 3 or more ☐

Wine 1 glass per day ☐ 2 glasses ☐ 3 or more ☐

Do you drink coffee? Yes ☐ No ☐ 3 or more ☐

Do you have difficulty sleeping?

Never ☐ Often ☐ Sometimes ☐

Do you wake up very early in the morning without apparent Cause and find it difficult to fall asleep again?

Frequently ☐ Occasionally ☐ Rarely ☐

MEDICATIONS

Check the following, if any, you are regularly taking:

Asthma or wheezing medication	☐
Thyroid medicine	☐
Aspirin, Bufferin, Anacin, Tylenol or similar products	☐
Stomach or digestive medication	☐
Blood pressure pills	☐
Blood thinners or Coumadin	☐
Weight reducing pills	☐
Prednisone, steroids	☐
Dilantin	☐
Cough medicine	☐
Water pills, diuretics	☐
Digitalis or heart medicine	☐
Antibiotics	☐
Hormones or birth control pills	☐
Phenobarbital or barbiturates	☐
Insulin or diabetic pills	☐
Vitamins	☐
Iron or medications for blood	☐
Laxatives	☐
Sleeping pills or tranquilizers	☐
Other drugs or injections (List below)	☐

_____

_____

_____

OCCUPATIONAL	**Yes**	**No**
Are you presently employed?	☐	☐
If yes, do you have more than one job?	☐	☐
Do you work more than 60 hours a week?	☐	☐
Does your work involve unusual work, exposure to dust, noise, radioactivity, etc.?	☐	☐
Do you get along poorly with your fellow employees and / or your supervisor?	☐	☐
Are you retired?	☐	☐
If retired, have you had difficulty adjusting to retirement?	☐	☐
Are you unable to perform any work because of disability?	☐	☐
Are you dissatisfied with your present type of work?	☐	☐

MARITAL / FAMILY		
Has there been a recent change in your marital status?	☐	☐
Are there any problems with your married life?	☐	☐
Do you have any sex problems?	☐	☐
If a widow or widower, have you had difficulty adjusting to your spouse's death?	☐	☐
Do you have any serious problems with your children?	☐	☐
Is your present home life causing unhappiness?	☐	☐
Have there been any deaths in your family or among close friends in the past year?	☐	☐
Does anyone in your family have a serious illness or disability?	☐	☐
Does anyone in your family have a drug or alcohol problem?	☐	☐

SOCIAL HISTORY		
Have you recently lived or traveled outside the U.S.?	☐	☐
Did you complete high school education?	☐	☐
Did you attend and/or complete college?	☐	☐
Were you rejected from the Military Service?	☐	☐
Have you even been rejected for life or health insurance or had to pay an extra premium?	☐	☐
Do you eat less than three meals a day?	☐	☐
Do you have special food customs or restrictions?	☐	☐
Have you ever been treated for drinking problem?	☐	☐
Do you exercise less than three times a week?	☐	☐
Are you active in political, community or church activities?	☐	☐
Do you have a hobby or hobbies?	☐	☐

If yes, please identify below:

_____

REVIEW OF SYSTEMS

A. General	Yes	No
Do you worry a lot about your health?	☐	☐
Do you usually feel tired or worn out?	☐	☐
Do you feel depressed a lot of the time?	☐	☐
Have you recently noticed that heat or warm weather bothers you?	☐	☐
Have you recently been drinking more water or fluids?	☐	☐
Has there been any unusual weight gain or loss recently?	☐	☐

B. Skin		
Have you noticed:		
any change in the color of your skin?	☐	☐
any skin rashes or itching?	☐	☐
unusual dry skin?	☐	☐
any growth on your skin that bothers you?	☐	☐
any sores or wounds that do not heal?	☐	☐
any change in color or size of warts?	☐	☐

C. Eyes		
Have you had:		
any pain in your eye?	☐	☐
glaucoma?	☐	☐
blurry vision?	☐	☐
halos around lights?	☐	☐
change in vision?	☐	☐

D. ENT		
Do you have:		
any trouble hearing?	☐	☐
ringing or buzzing in your ears?	☐	☐
earaches or discharge from your ears?	☐	☐
a lot of nasal stuffiness?	☐	☐
drainage down the back of your throat?	☐	☐
frequent or severe nosebleeds?	☐	☐
persistent hoarseness?	☐	☐
a lump in your throat?	☐	☐
a sore tongue or mouth?	☐	☐
bleeding gums?	☐	☐

E. Respiratory		
Do you have:		
frequent chest colds?	☐	☐
a constant or bothersome cough?	☐	☐
coughing of blood	☐	☐
sputum or phlegm between colds?	☐	☐
difficulty breathing?	☐	☐
Have you noticed any wheezing or whistling in your chest?	☐	☐

F. Cardiovascular	Yes	No
Do you have pain, tightness or pressure in the front or back of your chest?	☐	☐
If yes, is it when walking fast, working Hard, or when excited?	☐	☐
Have you even been told that your Electrocardiogram was abnormal?	☐	☐
Do you have swelling of your feet or ankles?	☐	☐
Does your heart ever beat fast or irregularly?	☐	☐
Do you have cramps in the calf muscles when you walk?	☐	☐
Do you ever awaken at night with severe difficulty breathing?	☐	☐
Do your fingers or toes ever get cold, become numb, get very white or bluish?	☐	☐

G. Gastrointestinal		
Have you recently had any change in your eating habits?	☐	☐
Are there any special foods that cause you to be upset or have stomach pains, nausea, etc.?	☐	☐
Do you tend to burp a lot?	☐	☐
Have you recently noted any trouble swallowing?	☐	☐
Are you bothered with constipation?	☐	☐
Do you have frequent loose stools or diarrhea?	☐	☐
Do you pass a lot of gas?	☐	☐
Do you have a poor appetite?	☐	☐
Do you ever wake up at night with feeling of fullness underneath your breast bone?	☐	☐
Have you ever passed blood from your rectum?	☐	☐
Have you ever had black or tarry stools?	☐	☐
Have you noticed any recent changes in your bowel movements?	☐	☐
Do you take laxatives regularly?	☐	☐
Do you have frequent nausea and / or vomiting?	☐	☐

H. Genitourinary		
Do you have:		
anything wrong with your genitals?	☐	☐
burning or pain when you urinate?	☐	☐
to pass water frequently?	☐	☐
to pass more water than you used to?	☐	☐
trouble passing water?	☐	☐
ever blood in your urine?	☐	☐
trouble with loosing urine when you cough or sneeze?	☐	☐
a problem dribbling urine?	☐	☐

I. Musculoskeletal	Yes	No
Do you have a problem with back pain?	☐	☐
Do you have pain in your legs or feet?	☐	☐
Does back pain interfere with your work or activities?	☐	☐
Do you have joint pain or stiffness?	☐	☐
Do you have trouble walking or using your hip or knee joints?	☐	☐

J. Central Nervous System		
Do you have frequent or sever headaches?	☐	☐
Do you often have spells or dizziness or faintness or lightheadedness?	☐	☐
Have you ever seen double?	☐	☐
Do you sometimes lose track of what happens around you for a short time?	☐	☐
Do you sometimes lose the ability to speak for a few seconds?	☐	☐
Have you recently fainted, blacked out or lost consciousness?	☐	☐
Do you have trouble remembering recent events?	☐	☐
Have you ever had convulsions or fits?	☐	☐
Do you have numbness or tingling in your head, arms or legs?	☐	☐
Do you consider yourself a nervous person?	☐	☐
Do you cry a lot for no reason?	☐	☐
Have you ever thought about committing suicide?	☐	☐
Do you ever hear voices or see people when no one is around?	☐	☐
Do you ever have a feeling that someone is trying to harm you?	☐	☐

H. Genitourinary (cont.)	Yes	No
Have you had an operation to prevent pregnancy? (Vasectomy or sterilization, such as tubal ligation?)	☐	☐
Men, do you have prostate gland trouble?	☐	☐
Do you have to get up at night to urinate?	☐	☐
If yes, how many times? _____		

K. Women only		
Did your menstrual periods start before you were 10?	☐	☐
Did your menstrual periods start after you were 15?	☐	☐
Are your menstrual periods irregular?	☐	☐
Are your periods less frequent than every four weeks?	☐	☐
Are your periods more frequent than every four weeks?	☐	☐
Do you use more than 10 pads or have to use a super size pad or tampon for your periods?	☐	☐
Do you pass clots with your periods?	☐	☐
Do you become bloated or gain weight just before your periods?	☐	☐
Have you passed menopause or change?	☐	☐
If yes, at what age? _____		
Do you have hot flashes?	☐	☐
Have you had any lumps in your breasts?	☐	☐
Have you had any discharge from your nipples?	☐	☐
Have you ever used an intrauterine device (IUD)?	☐	☐
Have you used other birth control measures?	☐	☐
How many pregnancies did you have? _____		
How many live births did you have? _____		
Did you have any abortions or miscarriages?	☐	☐

ADDITIONAL COMMENTS

_____

_____

_____

_____

_____