

NEW TAMPA PHYSICIANS GROUP

New Patients Registration

Patient Information:

Last Name: _____ First Name: _____ MI: _____
 Patient's SSM# _____ Date of Birth: _____ M/F: _____
 Home Address: _____
 City: _____ Zip Code: _____ Email Address: _____
 Phone Number: _____ Emergency Contact (**Name & Phone**): _____
 Sibings (Name, Age and Sex): _____
 Are Parents Married: _____ Separated: _____ Divorced: _____

	Mother's Information	Father's Information
Name		
Address		
Social Security#		
Date of Birth		
Employer' Name		
Occupation		
Work Phone#	Work: _____	Work: _____
& Cell#	Cell: _____	Cell: _____

Insurance Information: **PLS. INFORM FRONT DESK IF YOU HAVE A SECONDARY INSURANCE**

Primary Insurance Name: _____
 Policy Number: _____ Group Number: _____
 Policy Holder (Name, SSN#, and Date of Birth): _____
 Employer : _____ Insurance Phone Number: _____ 1-800- _____
 Whom may we thank for referring you to us? _____

- 1) I agree to pay in full for all Medical services rendered by the physician at New Tampa Physicians Group as they are received by Me, My pouse of My Dependents.
- 2) Thereby authorize the release of Medical!/ Information for review and Process claim.
- 3) I thereby authorize any insurance company to pay the proceeds of any Benefits due directly to New Tampa Physicians Group / Jaydeep Patel MD, P. A.
- 4) A copy o this Agreement can be considered as an original for Medicaid and Insurance purpose.

Signature: _____ Date : _____

PEDIATRICS PATIENT QUESTIONNAIRE

PREGNANCY AND BIRTH:

Mother's age at pregnancy: _____

Any Illness during pregnancy: _____

Medication during pregnancy: _____

Smoking/Alcohol/Street drug during pregnancy: _____

Was baby born early /late/ on time: _____

Type of delivery: _____

Birth Weight: _____ Length: _____

Complication: Y/ N _____

Problem with baby at birth? Y/ N _____

PAST MEDICAL HISTORY:

Allergic to medication ? Y / N

Allergic to Food? Y / N

Allergic to Animals? Y/ N

Allergic to insect bites? Y/ N

Any medications taken on regular basis?

_____ Immunization up to date? Y / N

Hospitalization (Where-When-Why)?

Surgeries (Where-When-Why)?

Chicken pox: Y/ N

Asthma /Wheezing Y / N

Eczema: Y / N

Recurrent ear infections: Y / N

Seizure: Y /N Anemia: Y/N

Hearing problems: Y/N

Bleeding Problems: Y/N

NUTRITION:

Food Allergies: Y/N _____

Appetite good? Y/N

DEVELOPMENT AND BEHAVIOR

Age at which child

Walked: _____ Toilet Trained;

Talked before age 2? Y/N

Learning problems? Y /N

Behavior problems? Y /N

Problems in school? Y/N

FAMILY MEDICAL HISTORY:

List all blood relative of your child who has any of the above problems.

Use abbrev. (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother' Father, (FM) Father'mother, (FF) Father' Father, (A) Aunt, (U) Uncle, (C) Cousin

Asthma: _____

Sudden Infant Death _____

Early Deafness _____

Seizures: _____

Diabetes: _____

Birth Defects: _____

Cystic Fibrosis: _____

Cancer: _____

Mental Retardation: _____

Anemia/ Blood Disorder: _____

Migraine: _____

Heart Disease before age 50: _____

High blood pressure: _____

High Cholesterol: _____

Arthritis: _____

Drug Problems: _____

Alcoholism: _____

AIDS: _____

Completed by: _____

Date: _____

Patient's Name: _____

NEW TAMPA PHYSICIANS GROUP

1. I hereby authorize _____ to disclose the following information from the health record of :

Patient name: _____ D. O. B. _____

Doctor's Address _____

Telephone: _____ Fax: _____

Covering the period (s) of health care:

From (date) _____ to: (date) _____

2. Information to be disclosed :

_____ Complete health records	_____ Discharge summary
_____ History & physical	_____ Progress notes
_____ Consultation reports	_____ Laboratory tests
_____ X- ray reports	_____ STD information
_____ Other _____	

I understand that this will be information relating to (check if applicable).

_____ Acquired Immunodeficiency Syndrome (AIDS) human Immunodeficiency virus (HIV) information.
_____ Behavioral health service/ psychiatric care
_____ Treatment for alcohol and/ or drug abuse

3. This information is to be disclosed to : New Tampa Physicians Group
10311 Cross Creek Blvd, Suite B, Tampa, FL 33647.
Tel : (813) 994- 7670 Fax : (813) 994-7640

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one year from date signed.

4. The facility, its employees, officers and physicians are hereby released from any Legal responsibility or liability for disclosure of the above information to the Extent indicated and authorized herein.

Signed:

(Patient or Legal representative)

Date _____

(Signature of Witness)

Date _____

NEW TAMPA PHYSICIANS GROUPS

CONSENT TO TREAT FORM

I, _____ give my permission for the following person (s) to

Bring my child _____, D.O.B. _____

To the doctors office for treatment.

Name:

Relation:

Patent Signature: _____

NEW TAMPA PHYSICIANS GROUP

A copy of New Tampa Physicians Group Privacy Practices is available at the Front Desk.

Acknowledgment of Receipt of Notice of Privacy Practices:

PATIENT:

I, _____ have received notice of Privacy Practices from **NEW TAMPA PHYSICIANS GROUP**,

SIGNATURE

DATE

PRINT NAME

GUARDIAN:

In Lieu of Patient Signature, I, _____ have received notice of Privacy Practices from **NEW TAMPA PHYSICIANS GROUP**.

SIGNATURE

DATE

PRINT NAME

RELATION TO PATIENTS

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the excellent treatment of all of our patients, and we will always do our best to provide excellent care as in most medical practices, medical fee reimbursements continue to decrease while our costs continue to increase. We have implemented this Patient Financial Policy to help control costs so that we can always provide high – quality medical care.

PRIVATE INSURANCE AND SELF PAY

Payment at the time of service is required for office visits, unless other arrangements are made in advance.

We are happy to assist you in billing your insurance company for all procedures and requesting the insurance company to remit the payments directly to our office. Of course, you are responsible for the annual deductible and any co-pay insurance requirements at the time of treatment. As well as any difference between the amount of our fee and the amount received from your insurance company (indemnity insurance as well as coverage under a letter of protection).

You are also responsible for calling your insurance company to verify that we are health care providers for your insurance plan before making an appointment with our practice (this is vital to the reimbursement rate).

HMO, PPO

If an HMO covers you or PPO and we are not the primary care physician your insurance company may not pay for the treatment, and then of course, you will then be responsible for payment. Make sure, before making an appointment with our office, that we are the primary care physicians of your child/ children.

MEDICAID

We participate with Medicaid and fully cooperate with all of the rules and regulations. However, you are responsible for payment, if the Medicaid number is not eligible or not on file.

I have read the Patient Financial Policy and agree to abide by its terms, as well as authorize my insurance company to forward the Explanation of Benefits and related payments directly to the physician's office.

X _____ Date _____
Signature of Patient

X _____ Date _____
Signature of Patient/Guardian