A. K. Sharma, MD
33049 Professional Drive, Suite 101
Leesburg, FL 34788
Tel: (352) 787 9600 | Fax: (352) 787 8640

NEW PATIENT REGISTRATION FORM

Welcome to Dr. Sharma's office! Please print your information below.

Today's Date:					
PATIENT INFORMATION					
Patient's Last Name:	First:	Middle:	Title/Prefix: (Mr. or Ms. or Other)	Marital Status:	
Social Security No.:	Driver's License No.:		Birth Date: / /	Age:	Sex:
Race:	Ethnicity:		Language(s) Spoken:		
Primary Address:			Home Phone No.: ( )		
			Cell Phone No.: ( )		
City:	State:	ZIP Code:			
Secondary Address (if applicable):			Home Phone No.: ( )		
City:	State:	ZIP Code:			
Occupation:	Employer:		Employer Phone No.: ( )		

Chose Dr. Sharma because/Referred by:

❑ Dr. _____ ❑ Hospital ❑ Insurance Plan ❑ Family ❑ Friend

❑ Website/Internet Search ❑ Other (_____)

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone No.: ( )	Work Phone No.: ( )

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Are you covered by insurance? ❑ Yes ❑ No					
Primary Insurance:	Address:			Telephone No.:	
Subscriber's Name:	Subscriber's S.S. No.:	Birth Date: / /	Group No.:	Policy No.:	Co-Payment: $
Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Secondary Insurance (if applicable):	Address:			Telephone No.:	
Subscriber's Name:	Subscriber's S.S. No.:	Birth Date: / /	Group no.:	Policy No.:	Co-Payment: $

ASSIGNMENT & RELEASE & PAYMENT AGREEMENT

I hereby authorize Dr. A.K. Sharma to provide all treatments he may deem necessary for my care. I understand that it is mandatory to share personal health information with health care provider(s) or other parties who may be responsible for my treatment. A copy of this authorization may be used instead of the original.

I authorize my insurance benefits to be paid to Dr. A.K. Sharma. I consent to the release of appropriate information concerning my care for billing purposes to Medicare and any other insurance carrier(s). I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services and that payment/co-payment/deductibles are due at the time of service, unless prior arrangements have been made.

I understand that Dr. A.K. Sharma emphasizes the prevention of diseases and that I am are required to have a complete physical examination once a year.

If I need to reschedule or cancel an appointment I acknowledge that I will give 24 hours notice and that failure to do so will result in a $25.00 fee.

Patient/Guardian's Signature *Date*

NEW PATIENT HISTORY FORM

Please check or ‘x’ the appropriate boxes below. Make sure to bring your prescription bottles to your appointment.

PAST ILLNESSSES	YES	NO	SOCIAL HISTORY	YES	NO	SURGICAL HISTORY	YEAR
High Blood Pressure			Do you smoke?			Gallbladder	
Heart Disease			If **Yes**, packs per day?			Hysterectomy	
Heart Failure			Do you consume alcohol?			Prostate	
Diabetes			If **Yes**, drinks per week?			Hernia	
Stroke / TIA			Do you exercise?			Heart Bypass	
High Cholesterol			If **Yes**, how often?			Carotid	
Thyroid Disease			Occupation:			Colon	
COPD			Marital Status:			Appendix	
Asthma			**FAMILY HISTORY**			Spine/Disc	
Chronic Bronchitis			Father’s Age:			Other:	
Cancer			Mother’s Age:				
Enlarged Prostate			How Many Sibling(s)?				
Stomach Ulcer / Heartburn			Any history of:				
Colitis / Diverticulosis			❑ Heart Disease ❑ Hypertension			**MEDICATIONS**	**SINCE YEAR**
Arthritis			❑ High Cholesterol ❑ Diabetes				
Anemia			❑ Cancer ❑ Stroke				
Cataracts			❑ Other ____________				
Migraine			**PREVENTION HISTORY**	**YEAR**			
Depression			*Your Last--*				
Osteoporosis			Complete Physical				
Allergic Sinusitis			Mammogram				
Chronic Kidney Disease			Pap Smear				
Neuropathy			Bone Density				
Chronic Back Pain			Prostate/PSA				
Peripheral Arterial Disease			Colonoscopy				
Gout			Tetanus Shot				
ED			Pneumonia Shot				
Menopausal Disorder			Flu Shot				
Other:			Tetanus Shot				
			Stress Test				

ARE YOU SEEING ANY OTHER PHYSICIANS?	ANY ALLERGIES?

_______________________________________ _______________________

Patient’s Name (please print) *Date*

NEW PATIENT PRIVACY FORM

Please read carefully and sign where indicated.

CONSENT & DISCLOSURE

In general, the HIPAA privacy rule gives patients the right to request a restriction on uses and disclosures of their protected health information (PHI). The patient is also provided the right to confidential communications or that a communication of PHI is made by alternative means, such as correspondence to the patient's office instead of home.

I wish to be contacted in the following manner (check all that apply):

Telephone Communication:

❑ Home Phone No. ❑ Work Phone No.

❑ OK to leave detailed message ❑ Leave message with a callback number only

Written Communication:

❑ Home Address ❑ Work Address

❑ OK to mail to home address ❑ OK to mail to work address ❑ Do not mail any personal information

Please list the individuals we can discuss your information with (e.g. treatment, diagnosis, billing, test results, etc.). Their relationship to you and phone no. is required for secure identification. This list includes **spouses**, **children**, and/or **guardians**.

Name: Relationship: Phone No.

1.

2.

Patient/Guardian's Signature *Date*

PRIVACY PRACTICES ACKNOWLEDGEMENT

A.K. Sharma, MD provides his Notice of Privacy Practices both at his office (33049 Professional Drive, Leesburg, FL 34788) and on his website (aksharmamd.com/forms). I acknowledge that I have received it or have been provided an opportunity to review it.

Patient's Name (please print) *Birth Date*

Patient/Guardian's Signature *Date*

REMINDERS FOR YOUR APPOINTMENT

Please remember to bring the following with you:

- ❑ Insurance Card(s)
- ❑ Driver's License
- ❑ Medication Bottles
- ❑ Copies of Labs or Tests You've Recently Had