"Care with Science and Compassion"

Dr. Jayadeva Chowdappa

Welcome New Patients,

Thank you for choosing Apollo Medical Group as your Primary Care Physician. Enclosed you will find the New Patient Registration Paperwork Please complete as much of it as possible and bring it in to the office with you to your first appointment. Also, please bring your insurance cards along with a valid photo ID to your appointment on ____.

Please bring ALL medications AND over the counter supplements, vitamins and herbs you're currently taking. Please also bring a list of all the doctors you've seen in the last 5 years, so we can help you complete the medical record release requests.

Plan on arriving to your appointment at least 20 minutes early for your first appointment, so we can complete the registration process.

Remember, by choosing our office as your partner in care, we're available by phone for questions or concerns 7 days a week. After hours, our phones are answered by our Answering Service who will page the doctor for you. In the event of a non-life threatening emergency or sickness, please contact our office first so we may direct your care in the most expedient way.

Thank you for choosing Apollo Medical Group,

Dr. Jayadeva Chowdappa

3535 Little Road, Trinity, FL 34655 | Phone: (727) 375-0848 | Fax: (727) 375-5548

"Care with Science and Compassion"

Patient Information

Today's Date: ____________________

❍ Male ❍ Female Ethnicity:_____________ Race:____________ Language:___________

Last Name:____________________ First Name:___________________ Middle:_________________

Social Security Number: ___________________ Date of Birth:______________________ Age:_____

E-Mail Address:_________________________________ Marital Status: S M D W SEP

Address: ____ City:___________________________

State: ___________________ Zip:____________ Home Phone Number:_______________________

Cell Phone Number: ________________________ Work Phone Number: ______________________

Secondary Address:____

Employer: ____________________________ Address: ______________________________________

Notify in Case of Emergency:

Name:______________________ Relationship:____________ Phone Number:___________________

Name:______________________ Relationship:____________ Phone Number:___________________

Insurance Information: (Please present card(s) at time of check-in)

Primary:___________________________________ Secondary: _______________________________

Policy #: __________________________________ Policy #:_________________________________

Group #: __________________________________ Group #:_________________________________

Guarantor: (Name) __________________________ DOB:_____________ SSN:__________________

Pharmacy

Name: ____________________________________ Phone Number: ___________________________

Location:____

3535 Little Road, Trinity, FL 34655 | Phone: (727) 375-0848 | Fax: (727) 375-5548

“Care with Science and Compassion”

Patient Health History

Patient Name:____________________ SSN#:________________________ Date:________________

Age:________ DOB:____________________ Reason for today’s visit: _________________________

Symptoms/Problems - Check all symptoms you currently have or have had.

General
- ❑ Chills
- ❑ Fever
- ❑ Depression
- ❑ Anxiety
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Sweats

Neurological
- ❑ Dizziness
- ❑ Fainting
- ❑ Forgetfulness
- ❑ Headache
- ❑ Numbness
- ❑ Tremors

Muscle | Joint Pain
- ❑ Arms
- ❑ Feet
- ❑ Neck
- ❑ Back
- ❑ Legs
- ❑ Hands
- ❑ Shoulders
- ❑ Hips

Cardiovascular
- ❑ Chest Pain
- ❑ High Blood Pressure
- ❑ Irregular Heart Beat
- ❑ Low Blood Pressure
- ❑ Poor Circulation
- ❑ Rapid Heart Beat
- ❑ Swelling of Ankles

Endocrine
- ❑ Excessive Thirst
- ❑ Too Hot/Cold
- ❑ Tired/Sluggish

Genitourinary
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Lack of Bladder Control
- ❑ Painful Urination
- ❑ Nighttime Urination
- ❑ Urine Retention

Respiratory
- ❑ Shortness of Breath
- ❑ Cough
- ❑ Sputum Blood
- ❑ Wheezing
- ❑ Tightness
- ❑ Pain When Breathing

Women Only
- ❑ Abnormal PAP
- ❑ Bleeding Between Period
- ❑ Breast Lump
- ❑ Extreme Menstrual Pain
- ❑ Hot Flashes
- ❑ Nipple Discharge
- ❑ Vaginal Discharge
- ❑ Last PAP ____________
- ❑ Last Mamo ___________
- ❑ Bone Density _________

Gastrointestinal
- ❑ Poor Appetite
- ❑ Bloating
- ❑ Bowel Changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal Bleeding
- ❑ Vomiting

Men Only
- ❑ Breast Lump
- ❑ Lump in Testicles
- ❑ Erection Difficulties
- ❑ Penis Discharge

Skin
- ❑ Bruise Easily
- ❑ Hives
- ❑ Itching
- ❑ Mole-changes
- ❑ Rash
- ❑ Scars
- ❑ Sore That Won’t Heal

Eye, Ear, Nose, Throat
- ❑ Bleeding Gums
- ❑ Blurred Vision
- ❑ Crossing Eyes
- ❑ Difficulty Swallowing
- ❑ Double Vision
- ❑ Earache
- ❑ Ear Discharge
- ❑ Hay Fever
- ❑ Hoarseness
- ❑ Loss of Hearing
- ❑ Nose Bleeds
- ❑ Persistent Cough
- ❑ Ears Ringing
- ❑ Sinus Problems
- ❑ Swollen Glands

"Care with Science and Compassion"

Patient Name:____________________ DOB:________________________ Date:_________________

Conditions/Illness - Check all symptoms you currently have or have had.

- ❑ Aids
- ❑ Alcoholism
- ❑ Alzheimer's Disease
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Blood Clot
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chronic Pain
- ❑ Diabetes
- ❑ Eating Disorder
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
  - ❑ A
  - ❑ B
  - ❑ C
- ❑ Hernia
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Liver Disease
- ❑ Migraines
- ❑ Miscarriage
- ❑ Multiple Sclerosis
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Prostate Problems
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Vaginal Infection
- ❑ Venereal Disease

Medications - List any medications along with the strength and how often you take it (including over-the-counter medications)

________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________

Allergies - (Food, Environmental and Medication)

________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________

"Care with Science and Compassion"

FAMILY HEALTH HISTORY

Relation Age	State of Health	Age of Death	Cause of Death	Blood Relatives Only
Father ________	________	________	________	Cancer ________
Mother ________	________	________	________	Chemical Dependency ____
Sister ________	________	________	________	Diabetes________
________	________	________	________	Heart Disease ________
________	________	________	________	Stroke ________
Brother ________	________	________	________	High Blood Pressure ______
________	________	________	________	Kidney Disease ________
________	________	________	________	Tuberculosis ________

Hospitalizations/Surgeries/Serious Illness/Injuries

Year	Hospital	Reason for Hospitalization

Health Habits - Check which substance(s) you use and answer questions

❏ Caffeine ❏ Coffee ❏ Tea ❏ Soda How Many Cups/Day________

❏ Tobacco ❏ Cigarettes ❏ Cigars ❏ Pipe How Many Per Day________ How Long__________

❏ Previous Tobacco Use What Kind_________ When Did You Stop__________________________

❏ Recreational Drugs What Kind_________ How Often_________ How Long_________

❏ Alcohol Use What Kind_________ How Often_________ How Long_________

Have You Ever Been or Are You Currently A Victim of Abuse? _________________________________

Have You Ever Had A Blood Transfusion? ❏ Yes ❏ No If So, Give Date:________________________

Diet/Exercise

Type of Diet:________________________ Do You Exercise? ❏ No ❏ Minimal ❏ Moderate

Other (If yes, please provide a copy for our records)

Spiritual or Cultural Preference? ❏ Yes ❏ No

Living Will ❏ Yes ❏ No

Healthcare Proxy ❏ Yes ❏ No

Durable Power of Attorney? ❏ Yes ❏ No

Do Not Resuscitate ❏ Yes ❏ No

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of AMG responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_______________________________________

Print Name: _____________________________________ Date:_______________________________________

"Care with Science and Compassion"

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Patient Date of Birth: ______________

Address: ____

City: ______________________________ State: ________ Zip: __________

Phone Number: ____

RELEASE TO:

Name: Apollo Medical Group Address: 3535 Little Road

Fax Number: 727-375-5548 City, State and Zip: Trinity, Florida 34655

I REQUEST COPIES OF MY MEDICAL RECORDS FOR MY PHYSICIAN

From: ______________________ Fax: ______________________

Type of Information to be released. Please select from the following:

- ❏ Discharge Summary
- ❏ History and Physical
- ❏ Operative Reports
- ❏ Consultation Reports
- ❏ Emergency Room Reports
- ❏ Radiology Reports
- ❏ Laboratory Reports
- ❏ EKG, ECHO, STRESS, CATH
- ❏ Pathology
- ❏ Office Visit/Progress Notes

Specify the Date/Time Period for the Information Selected:

From: ______________________ To: ______________________

**I understand that the information to be released may contain reference to any drug, alcohol, psychiatric AND/OR mental health conditions. Please initial: _______

Notice of Right and Other Information

You may revoke this authorization at any time by notifying Apollo Medical Group in writing of your intent. To revoke this address: 3535 Little Road | Trinity, FL 34655

Signature: ______________________ Date: ______________________

"Care with Science and Compassion"

PERMISSION FOR TREATMENT

I, the undersigned, herby voluntarily consent to medical care/diagnostic treatment and/or minor surgical treatment by **AMG Dr. Chowdappa** which is deemed advisable and necessary in the diagnosis/treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past or present medical records that are needed for my treatment from any prior healthcare providers.

Signature: ________________________________ Date:________________________________

AUTHORIZATION AND ASSIGNMENT

I request that the payment of Authorized Medicare/Insurance Benefits be made to me or on my behalf for any services furnished by **AMG Dr. Chowdappa**. I authorize any holder of medical information about my release to CMS/Insurance Carriers and it's agents any information needed to determine these benefits or benefits related to services.

Signature: ________________________________ Date:________________________________

DESIGNATED RELATIVE

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment and healthcare operations) with:

Please list the family members of significant others, if any whom we may inform about your medical condition and/or in case of an emergency.

Name:________________________________Relationship:__________ Phone Number:____________

Name:________________________________Relationship:__________ Phone Number:____________

Name:________________________________Relationship:__________ Phone Number:____________

Name:________________________________Relationship:__________ Phone Number:____________

Messages may be left on my answering machine regarding my health and/or appointments made.

❑ Yes ❑ No

Signature: ________________________________ Date:________________________________

HIPPA PRIVACY NOTICE

I have received a copy of AMG-Dr. Chowdappa privacy notice.

❑ Yes ❑ No

Signature____________________________Print Name:__________________________Date:_______

"Care with Science and Compassion"

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I, ____, whose signature appears below, authorize Apollo Medical Group, P.A. and it's affiliated providers to view my external prescription history via the RXHub Service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here and it may include prescriptions back in time for several years.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

Patient: ____________________________________ Date:___________________________________

Witness:____________________________________ Date:___________________________________

3535 Little Road, Trinity, FL 34655 | Phone: (727) 375-0848 | Fax: (727) 375-5548

"Care with Science and Compassion"

Date:___________________________

As your health care provider, we are trying to insure your compliance with the preventative Care Guidelines for various conditions such as Cancer, Diabetes, and Osteoporosis. Please read through the list below and answer accordingly. If you do not remember the exact date of a test, you may put the approximate month and year. Thank you.

Colonoscopy ❑ Yes ❑ No

If yes, date and performing doctor:____

Stool Cards ❑ Yes ❑ No

If yes, date:____

Mammogram ❑ Yes ❑ No

If yes, date and performing doctor:____

Are You A Diabetic? ❑ Yes ❑ No

If yes, date of last eye exam:_______________________Where:_______________________

If yes, date of lab work:_______________________Facility:_______________________

Have You Had A Bone Density Test (DEXA) ❑ Yes ❑ No

If yes, date_______________________Facility:_______________________

Women's Wellness Exam ❑ Yes ❑ No

If yes, date and performing doctor:____

Signature_______________________ Print Name:_______________________

"Care with Science and Compassion"

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or healthcare operations (TPO) and for other purposes that are permitte or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related care services.

Uses and Disclosures of Protected Health Information

Our protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purposes of healthcare services to you, to pay your health care bills to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to whom you have been referred to ensure the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may required that your relevant protected health care information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations

We may use or disclose, as-needed, your protected health information in order to support the business activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorizations. These situations include as required by law, Public health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation. Research, Criminal Activity, Military Activity, and National Security, Worker's Compensation, Inmates, Required Uses and Disclosures, Under the law, we must make disclosures to you and when required by

"Care with Science and Compassion"

the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other permitted and required uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken any action in reliance on the use or disclosure indicated in the authorization.

<u>Your Rights</u>

Following is a statement of your rights with respect to your protected health information.

<u>You have the right to inspect and cop your protected health information.</u> Under the federal law, however, you may not inspect or copy the following records, psychotherapy notes, information complied in reasonable anticipation of , or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to the protected health information.

<u>You have the right to request a restriction of your protected health information.</u> This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care professional.

<u>You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,</u> upon request, even if you have agreed to accept this notice alternatively i.e; electronically.

<u>You may have the right to have your physician amend your protected health information.</u> If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

<u>You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.</u>

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

“Care with Science and Compassion”

Complaints

You may complain to us to the secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Print Name:____________________________ Signature:_________________________Date:___________

3535 Little Road, Trinity, FL 34655 | Phone: (727) 375-0848 | Fax: (727) 375-5548

"Care with Science and Compassion"

LET'S TALK

Patient Name:____Date:__________

During today's visit, use this handout as a guide to discuss health concerns or needs with your doctor or healthcare provider.

Falls	Yes	No
Have you fallen in the past year?	☐	☐
Do you feel unsteady standing or walking?	☐	☐
Do you worry about falling?	☐	☐
Do you use a cane or walker?	☐	☐
Bladder Control	**Yes**	**No**
Is bladder control a problem for you?	☐	☐
In the past 60 days, has urine leakage changed your daily activities or interfered with your sleep?	☐	☐
If urine leakage is a problem for you, would you be willing to try:		
• Medications	☐	☐
• Exercise	☐	☐
• Surgery	☐	☐
Medications	**Yes**	**No**
Remembering to take your medications can sometimes be challenging. In the last two weeks, have you forgotten to take your medications?	☐	☐
Understanding how and when to take medication, as well as knowing what it is prescribed for, is important. Do you have any questions?	☐	☐
Some medications are difficult to afford, even with help from co-payments. Do you have any specific medications that are too expensive.	☐	☐
Every medication has the potential to have side effects. Do you have any unanswered worries or questions related to your medication side effects.	☐	☐

"Care with Science and Compassion"

LET'S TALK

Physical Health			
How often does physical health interfere with your daily activities?	☐ Almost Never	☐ Occasionally	☐ Frequently
How often do you choose to take the elevator or stairs?	☐ Almost Never	☐ Occasionally	☐ Frequently
Approximately how many days each week are you physically active?	☐ 0-1 Days	☐ 2-3 Days	☐ 4 or More
Are you as active as other persons your age?	☐ Yes	☐ No	
Emotional Health			
How would you describe your emotional health?	☐ Almost Never	☐ Occasionally	☐ Frequently
How many hours of sleep do you typically get each night?	☐ Almost Never	☐ Occasionally	☐ Frequently
In the last month, have you accomplished less than you would like or been more careless at work or while performing daily activities?	☐ Yes	☐ No	
In the last month, has your emotional health (feeling anxious or depressed) interfered with your daily activities?	☐ Yes	☐ No	

This is for informational purposes only and does not replace treatment or advice from a healthcare professional. If you have questions, please talk with your healthcare provider. Talk to your healthcare provider before beginning an exercise program or making any changes to your diet.

Signature:____ Date:____________

3535 Little Road, Trinity, FL 34655 | Phone: (727) 375-0848 | Fax: (727) 375-5548