NEW PATIENT PACKET

NAME: **DATE: ___/ ____/____**

MEDICAL HISTORY

ALLERGIES	REACTION

CURRENT MEDICATIONS

NAME	DOSE	START	ENDING	WHO PRESCRIBED

PREVENTIVE CARE

	YEAR COMPLETED	WHERE	PHYSICAN
EYE EXAM			
LABS (BLOOD WORK)			
COLONOSCOPY			
MAMMOGRAM			
GYNECOLOGICAL EXAM			
PAP SMEAR			
LAST MENSTRUAL CYCLE			
PREGNANCIES			
BIRTHS			
MISCARRIAGES			
BONE DENSITY			
PROSTATE EXAM			
PROSTATE SPECIFIC ANTIGEN (PSA)			

DO YOU HAVE A LIVING WILL
DO YOU HAVE A DNR OR FILE

NEW PATIENT PACKET

NAME:

VACCINATIONS

NAME	DATE
TETANUS	
INFLUENZA VACCINE	
ZOSTAVAX	
SHINGLES	
MENINGITIS	
YELLOW FEVER	
POLIO	
PNEUMONIA VACCINE	
HEP A	
HEP B	
COVID19 VACCINE	

FAMILY HISTORY

ALIVE OR DECEASED & ANY MEDICAL CONDITIONS

MOTHER	
FATHER	

OTHER HEALTH ISSUES

TOBACCO USE	DO YOU SMOKE CIGARETTES? YES OR NO HOW MANY YEARS IF YES? HOW MANY PACKS A DAY IF SO? ____
CURRENTLY: HOW MANY YEARS OF SMOKING? HOW MANY PACKS?	_____ _____
PAST: QUIT DATE _____	HOW MANY PACKS PREV SMOKED?
DO YOU USE OTHER TYPES OF TOBACCO? YES OR NO	PIPE CIGAR SNUFF CHEW
DO YOU DRINK ALCHOL? YES OR NO	BEER WINE LIQUOR # OF DRINKS/WEEK:
DO YOU USE MARIJUANA OR RECREATIONAL DRUGS? YES OR NO	HAVE YOU EVER USED NEEDLES TO INJECT DRUGS? YES OR NO

NEW PATIENT PACKET

NAME:

SEXUAL ACTIVITY

	ARE YOU SEXUALLY ACTIVE? YES OR NO
HOW MANY SEXUAL PARTNERS?	**MALE OR FEMALE?**
BIRTH CONTROL METHOD	**NONE** **CONDOM** **PILL/PATCH/INJ/IUD** **VASECTOMY** **TUBAL**

EXERCISE

DO YOU EXERCISE REGULARLY? YES OR NO
WHAT TYPE OF EXCERSISE?
HOW LONG DO YOU EXERCISE?

SLEEP

HOW MANY HOURS DO YOU SLEEP EACH NIGHT? **DO YOU HAVE PROBLEMS FALLING ASLEEP OR STAYING ASLEEP?**

SPECIALIST	NAME	LAST VISIT
CARDIOLOGY		
GASTRO		
OB/GYN		
NEUROLOGY		
UROLOGY		
PULMONARY		
PODIATRY		
ENT		
INFECTIOUS DISEASE		
DERMATOLOGY		
ONCOLOGIST		
OTHER		

NEW PATIENT PACKET

NAME:

PREVENTIVE CARE

HAVE YOU HAD ANY FALLS IN THE PAST YEAR?	**YES OR NO**	**HOW MANY FALLS?**
DO YOU HAVE ANY FRACTURES DUE TO THE FALL?	**YES OR NO**	**WHERE ARE THEY LOCATED?**
IF YOU ARE HAVING PAIN AT THIS TIME WHAT IS YOUR PAIN SCALE?	**1-10**	**WHERE IS PAIN?**
DO YOU USE MEDICAL EQUIPMENT SUPPLIES AT HOME?	**WHAT TYPE OF EQUIPMENT?**	
DO YOU HAVE A MEDICAL LIVING WILL?	**YES OR NO**	
DO YOU HAVE A POWER OF ATTORNEY?	**YES OR NO**	**WHO IS YOUR POWER OF ATTORNEY?**
DO YOU HAVE A HEARING PROBLEM?	**YES OR NO**	**WHICH EAR?**
DO YOU NEED HELP WITH ANY OF THEFOLLOWING? **1. MEAL PREP** **2. DOING HOUSEWORK** **3. DRESSING YOURSELF** **4. BATHING YOURSELF** **5. EATING** **6. WALKING** **7. TRANSPORTATION**	 **YES OR NO** **YES OR NO** **YES OR NO** **YES OR NO** **YES OR NO** **YES OR NO** **YES OR NO**	

HAVE YOU HAD ANY SURGERIES? _____

MEDICAL HISTORY?

_____

_____

_____

_____

_____

_____

NEW PATIENT PACKET

REGISTRATION FORM

TODAYS DATE: _____/_____/____

PATIENT LAST NAME: _____ PATIENT FIRST NAME_____
MIDDLE NAME_____ SR/JR OTHER_____

PREFFERED NAME –(if different) _____

SEX: MALE/FEMALE Date of Birth: ____/_____/_____

SOCIAL SECURITY #_____-____-_____

Address: _____

INSURANCE _____ MEMBER ID#_____

Home Phone Cell Phone Work Phone

EMAIL ADDRESS: _____@_____.COM/NET/ORG OR NO EMAIL

MARRIED SINGLE SEPERATED DIVORCED WIDOW

RACE:

□ American Indian or Alaska Native □ Asian □ Black or African American

□ Native Hawaiian or Other Pacific Islander □ White □ Unknown □ Other _____

□ Refuse

PRIMARY LANGUAGE:

□ English □ Spanish □ Other _____ □ Refuse

ETHNICITY:

□ Hispanic or Latino □ Non-Hispanic or Non-Latino □ Unknown □ Refuse

MEDICAL INFORMATION:

Who was your previous Medical Doctor?

Address:

Phone:

EMERGENCY CONTACT:

NAME
RELATION
ADDRESS

PHONE NUMBER

NEW PATIENT PACKET

HOW WERE YOU REFERRED TO OUR OFFICE? (Mark all that apply)

□ Doctor (Name:) □ Friend/Relative (Name:)

□ Newspaper □ Radio/Television □ Internet □ Yellow Pages □ Reputation □ Website

□ Insurance □ social media (ex. Facebook) □ Health Fair/Expo □ Drive By □ Previous Patient

SPRING HILL PRIMARY CARE LLC

DR. LAKSHMI KOLLI

10500 SPRINGHILL DRIVE, SPRING HILL, FL 34608

PHONE: (352) 835-7155 FAX: (352) 835-7199

NAME: **DATE:**

AGREEMENT OF OFFICE POLICIES REGUARDING PAIN MANAGEMENT

DR. LAKSHMI KOLLI HAS DECIDED NOT TO TREAT MY PAIN MANAGEMENT OR PRESCRIBE PAIN MEDICATION TO PATIENTS WHO TAKE THEM FOR ANYTYPE OF CHRONIC CONDITIONS.THIS IS DUE TO THE ONGOING CONTROVERSIES REGUARDING PAIN MANAGEMENT AND THE PRESCRIBING OF PAIN MEDICATIONS. AS YOU KNOW, WE HAVE YOUR BEST INTERESTS AND SAFETY IN MIND. WE FEEL THAT A PAIN MANAGEMENT SPECIALIST WILL BEST MEET YOUR PAIN MANAGEMENT NEEDS. WE HAVE A LIST OF PAIN MANAGEMENT SPECIALIST FOR YOU TO CHOSE FROM. PLEASE ASK FROM DESK STAFF.

PLEASE CALL AS SOON AS POSSIBLE FOR AN APPOINTMENT WITH A PAIN MANAGEMENT SPECIALIST AS THERE WILL BE NO EXCEPTIONS TO THIS POLICY

BY MEANS OF SIGNING THIS LETTER I _____

AGREE NOT TO ASK FOR ANY PAIN MEDICATION FOR IF I DO, THAT I WILL BE GROUNDS FOR INSTANT TERMINATION FROM THIS PRACTICE.

FULL NAME (PRINT) _____ DOB _____

SIGNATURE_____ DATE SIGNED_____

NEW PATIENT PACKET

SPRING HILL PRIMARY CARE LLC

DR. LAKSHMI KOLLI

10500 SPRINGHILL DRIVE, SPRING HILL, FL 34608

PHONE: (352) 835-7155 FAX: (352) 835-7199

FINANCIAL AGREEMENT

I AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, REGUARDLESS OF MY INSURANCE STATUS AND THAT SPRING HILL PRIMARY CARE WILL BILL MY INSURANCE AS A COURTESY ONLY.

I AGREE THAT THERE WILL BE A $25 CHARGE FOR EVERY NO-SHOW OR SAME-DAY CANCELATIONS.

I UNDERSTAND THAT IT IS MY RESPONSIBILTY TO VERIFY AND UNDERSTAND MY HEALTH INSURANCE PRIOR TO RECEIVING MEDICAL SERVICES PROVIDED.

I AUTHORIZEDTHE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR MY INSURANCE OR REIMBURSEMENT CONCERNS.

I AGREE THAT THE REFILLS FOR PRESCRIPTIONS WILL TAKE UP TO 7 DAYS AND I SHOULD NOT WAIT UNTIL I AM OUT OF MEDICATION TO REQUEST A REFILL ON MY MEDICATIONS.

I AGREE LAB RESULTS WILL NOT BE DISCUSSED OVER THE PHONE.

I AGREE NO REFERRALS WILL BE GIVEN WITHOUT AN APPOINTMENT.

I AGREE AND ACCEPT THE ABOVE TERMS

SIGNATURE_____

DATE _____

NEW PATIENT PACKET

SPRING HILL PRIMARY CARE LLC

DR. LAKSHMI KOLLI

10500 SPRINGHILL DRIVE, SPRING HILL, FL 34608

PHONE: (352) 835-7155 FAX: (352) 835-7199

PERMISSION FOR TREATMENT

I, THE UNDERSIGNED, HEREBY VOLUNTARILY CONSENT TO MEDICAL CARE, DIAGNOSTIC TREATMENT AND OR MINOR SURGICAL TREATMENT BY DR. LAKSHMI KOLLI DEEMED ADVISABLE AND NECESSARY IN THE DIAGNOSIS AND 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 AND PRESENT MEDICAL RECORDS THAT ARE NEEDED FOR ANY OF MY TREATMENT FROM ANY PRIOR OR CURRENT HEALTHCARE FACILITY.

SIGNATURE_____ DATE_____

AUTHORIZATION AND ASSIGNMENT

REQUEST THAT THE PAYMENT OF AUTHORIZED MEDICARE/ INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF FOR ANY SERVICES FURNISHED BY DR. LAKSHMI KOLLI. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO CMS/INSURANCE CARRIERS AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS RELATED TO SERVICES.

I HEREBY AUTHORIZE DR. LAKSHMI KOLLI TO FURNISH INFORMATION TO CMS /INSURANCE CARRIERS CONCERNING MY MEDICAL CONDITIONS, ILLNESS AND TREATMENT TO DETERMINE THE BENEFOTS FOR RELATED SERVICES. I HEREBYAUTHORIZE(ASSIGN) MY INSURANCE CARRIER(S)/CMS TO MAKE PAYMENT DIRECTLY TO DR. LAKSHMI KOLLI FOR MEDICAL DIAGNOSTIC, SURGICAL BENEFITS PAYABLE FOR THE SERVICES RENDERED.I UNDERSTAND THAT ANY UNPAID BALANCE NOT COVERED BY MY POLICY WILL BE PAYABLE TO ME. I UNDERSTAND AND AGREE (REGARDLESS OF MY INSURANCE STATUS), THAT I AM ULTIMATELY RESPSIBLE FOR ANY BALANCE OF OFFICE VISITANY PROFESSIONAL SERVICES RENDERED. I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL ALSO NOTIFY YOU OF ANY CHANGES IN MY STATUS OR CHANGES IN THE ABOVE INFORAMTION.

SIGNATURE: _____ DATE _____

NEW PATIENT PACKET

DR. LAKSHMI KOLLI

10500 SPRINGHILL DRIVE, SPRING HILL, FL 34608

PHONE: (352) 835-7155 FAX: (352) 835-7199

HEALTHCARE SURROGATE

Name_____ DATE _____-

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate, as my surrogate for health care decisions:

Name_____

Street Address_____

City State Zip_____

Phone_____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name_____

Street Address _____

City State Zip _____

Phone_____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

MESSAGES MAY BE LEFT ON MY ANSWER MACHINE REGARDING MY HEALTH AND MY APPOINTMENTS MADE.

SIGNATURE_____ DATE _____

HIPPA PRIVACY NOTICE

I HAVE RECEIVED A COPY OF DR. LAKSHMI KOLLI'S PRIVACY NOTICE

SIGNATURE _____ DATE_____

NEW PATIENT PACKET

CURRENT MEDICAL CONDITIONS

1. _____
2. _____
3. _____
4. _____
5. _____

PLEASE LIST BELOW IF YOU HAVE ANY OTHER MEDICAL CONDITIONS

ANY QUESTIONS OR CONCERNS FOR DR. KOLLI?

WHAT PHARMACY WOULD YOU LIKE TO USE FOR PRESCRIPTIONS?
(Can be changed at any time)

Name: _____

Street Address: _____

City State Zip: _____

Phone Number: _____