

## CHILD HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.  
Please complete this to the best of your abilities as this will help us to better care for your child.

<b>NAME</b> (Last, First, M.I.): _____	<input type="checkbox"/> M <input type="checkbox"/> F	<b>DATE OF BIRTH:</b> _____
<b>FORM COMPLETED BY</b> (Name & Relationship): _____		<b>DATE COMPLETED:</b> _____

### Birth History ☐ Don't know birth history

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_ Delivered at (Name of hospital): \_\_\_\_\_

Was the delivery ☐ Vaginal ☐ Cesarean  
If Cesarean, why? \_\_\_\_\_

Was an NICU stay required? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Full term? ☐ Yes ☐ No If not full term, how many weeks? \_\_\_\_\_

Was the initial feeding ☐ Yes ☐ No How many weeks? \_\_\_\_\_

Did your baby go home with mother from the hospital? ☐ Yes ☐ No  
If no, please explain: \_\_\_\_\_

During pregnancy, did mother Use tobacco ☐ Yes ☐ No  
Use alcohol ☐ Yes ☐ No  
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatals  
If yes, please specify:  
What: \_\_\_\_\_  
When: \_\_\_\_\_

Were there any prenatal or neonatal complications? ☐ Yes ☐ No  
If yes, please explain: \_\_\_\_\_

### General Health History

Where has your child gone for checkups? \_\_\_\_\_ Date of last visit to Doctor: \_\_\_\_\_  
Name of Dentist? \_\_\_\_\_ Date of last dental visit: \_\_\_\_\_

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ Don't know Explain \_\_\_\_\_

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ Don't know Explain \_\_\_\_\_

Has your child had any surgery? ☐ Yes ☐ No ☐ Don't know Explain \_\_\_\_\_

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ Don't know Explain \_\_\_\_\_

Is your child allergic to medications or drugs? ☐ Yes ☐ No ☐ Don't know Explain \_\_\_\_\_

Any reactions to shots? ☐ Yes ☐ No ☐ Don't know Explain \_\_\_\_\_

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ Don't know Explain \_\_\_\_\_

Is your child taking any medications? ☐ Yes ☐ No ☐ Don't know If yes, please list the medications: \_\_\_\_\_

### Household, Safety, & Environment

Where does the family live? ☐ House ☐ Apartment ☐ Mobile Home  
☐ Other: \_\_\_\_\_

Who takes care of the child most of the time?  
☐ Parent ☐ Relative ☐ Babysitter ☐ Daycare ☐ Other: \_\_\_\_\_

Please list below all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

What is the child's living situation if not with both biological parents?  
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody  
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? \_\_\_\_\_

Have you ever suspected your child to have been mistreated? ☐ Yes ☐ No

Are there any guns in the home? ☐ Yes ☐ No

What type of drinking water does the home have?  
☐ City / County ☐ Well ☐ Bottled

Language(s) spoken in the home? \_\_\_\_\_

Is there a working smoke detector on each floor? ☐ Yes ☐ No

Does anyone in the household smoke? ☐ Yes ☐ No

## Feeding & Nutrition

Is your child's appetite usually good? ☐ Yes ☐ No

Any colic, spitting, or feeding problems? ☐ Yes ☐ No

For infants, please select one of the following sources of nutrition: ☐ Breastfed  
☐ Bottle-fed; type of formula: \_\_\_\_\_

Does your child eat things that are not food? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

## Development & Behavior

At what age did your child sit alone? \_\_\_\_\_

At what age did your child walk alone? \_\_\_\_\_

Did your child say words by 18 months? ☐ Yes ☐ No

At what age was your child toilet trained? \_\_\_\_\_

Does your child wet the bed? ☐ Yes ☐ No

Does your child have trouble sleeping? ☐ Yes ☐ No

Does your child play well with others? ☐ Yes ☐ No

Has your child repeated a grade in school? ☐ Yes ☐ No

What grade level is your child in at school? \_\_\_\_\_

What kind of grades is your child getting in school? A's B's C's D's F's

## Biological Family History

Have any family members had any of the following conditions?

Autoimmune disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Childhood hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Heart disease (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
High cholesterol / takes cholesterol medication	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Dental decay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Cancer (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Diabetes (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Mental illness / Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Developmental disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____
Tobacco use	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Who _____	Comments _____

Additional family history? \_\_\_\_\_  
(include relationship to patient) \_\_\_\_\_  
\_\_\_\_\_

## Past History

Does your child have, or has your child ever had any of the following conditions?

Chickenpox	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Frequent ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Problems with ears or hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Problems with eyes or vision	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Any heart problem or heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Anemia or bleeding problem	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Blood transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____

## Past History (continued)

Organ transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Malignancy / Bone marrow transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Frequent abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Constipation requiring doctor visits	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Recurrent urinary tract infections and problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Congenital cataracts / Retinoblastoma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Metabolic / Genetic disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Kidney disease or urologic malformations	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Bed-wetting (after 5 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Sleep problems; Snoring	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Chronic or recurrent skin problems (e.g., acne, eczema)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Frequent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Convulsions or other neurologic problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Thyroid or other endocrine problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
History of serious injuries/fractures/concussions	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Use of alcohol or drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Tobacco use	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
ADHD / Anxiety / mood problems / Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Developmental delay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Dental decay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
History of family violence	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Sexually transmitted infections	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
(For girls) Problems with her periods	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Explain _____
Has had her first period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Age of first period? _____
Any other significant problem(s)?	_____	
	_____	
	_____	

## Nutritional Supplement Information

Is your child presently taking any type of nutritional supplements? ☐ Yes ☐ No  
 (Such as vitamins, minerals, herbs, amino acids, fish oils, etc.)?

Please name the supplements the patient is presently taking. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Who recommended you to take these supplements? \_\_\_\_\_  
 Where did you purchase these supplements? \_\_\_\_\_

If this Practice offered an advanced, high-quality line of supplements, would you consider purchasing them? ☐ Yes ☐ No

If this Practice offered natural alternatives to prescriptions, when applicable, would you be interested in these alternatives? ☐ Yes ☐ No

If this Practice offered a comprehensive weight management program, would you consider it? ☐ Yes ☐ No

If this Practice offered a nutrition education program to improve your dietary habits, would you consider it? ☐ Yes ☐ No

By appointment with one of our staff? ☐ Yes ☐ No

By a class exclusively for our patients? ☐ Yes ☐ No

FORM COMPLETED BY (PLEASE PRINT NAME)

RELATIONSHIP TO PATIENT

DATE COMPLETED



# WESLEYCHAPEL

INTERNAL MEDICINE AND PEDIATRICS

Manish Shah MD, FAAP

## REGISTRATION FORM

Today's date:				PCP:			
<b>PATIENT INFORMATION</b>							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ( )		
P.O. box:		City:		State:		ZIP Code:	
Cell Phone: ( )		Employer:			Employer phone no.: ( )		
<b>Referred to clinic by (please check one box):</b>				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other		
Other family members seen here:							
<b>INSURANCE INFORMATION</b>							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:	Employer address:			Employer phone no.: ( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Aetna	<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Cigna	<input type="checkbox"/> Citrus H/C	<input type="checkbox"/> Medicaid	
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medipass	<input type="checkbox"/> Tri-Care	<input type="checkbox"/> United health Care		<input type="checkbox"/> Other		
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
<b>IN CASE OF EMERGENCY</b>							
Name of local friend or relative (not living at same address):			Relationship to patient:		Home phone no.: ( )	Work phone no.: ( )	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.							
Patient/Guardian signature				Date			



# WESLEYCHAPEL

## INTERNAL MEDICINE AND PEDIATRICS

Manish Shah MD, FAAP

2038 Ashley Oaks Circle, Suite 102, Wesley Chapel, FL 33544

Phone: 813-929-3622 Fax: 813-929-3620

### Office Policies

Last updated 9/2018

Dear Patient or Parent/Guardian,

As a part of ongoing effort to make being at our office a pleasurable experience, we have adopted some standard policies to ensure your continued satisfaction with our services.

1. We are here to take care of you. **The office is open Monday – Friday from 8am to 5pm.**
2. We will make every attempt to see you when you are ill on the same day or the next day. Dr. Shah will occasionally overbook appointments for this purpose.
3. We attempt sincerely to see you on time. If the wait to be seen is expected to exceed 30 minutes, you should and will be notified. Please be patient as we do try to make room for everyone in the schedule when they are ill.
4. If you are unable to keep an appointment, we ask that you re-schedule at least 24 hours prior to your appointment time. If you no-show for an appointment or cancel within 24 hours of the appointment time, there will be a **no-show/untimely cancellation fee of \$35** charged to your account. Excessive no-shows or untimely cancellations for appointments may result in dismissal from the office at the discretion of Dr. Shah.
5. Please give us at least **1-week notice for medication refills**. (Most prescription refill requests are done within 24-72 hours of your phone call.)
6. You should always receive a call regarding results of labs and other tests that Dr. Shah orders for you. If you do not receive a result, it is imperative that you call the office for the result. Every test is reviewed by a provider. Most labs and tests are reviewed within 24-72 hours of receiving the result. If it has been more than 10 days, please advise us immediately.
7. We do ask that non-health-related paperwork (e.g., FMLA, Disability, and Medicare-required paperwork) be filled out during an office visit. Please understand that these forms take time to fill out accurately, and your presence is necessary. **Please understand also that we charge an additional and separate fee of \$35 for the completion of these additional forms.**
8. School Physicals & Gold and Blue forms will be filled out without requiring an additional office visit if the child has been seen here for a well child exam in the last 6 months. Please give us at least 48 hours notice to have these forms completed.
9. **All patients requiring controlled prescriptions will be assessed a \$10 fee for every visit requiring a controlled prescription** to help defray the cost of new regulations required for writing controlled prescriptions. This new state regulation went into effect on July 1, 2018.
10. We ask that all children brought to the office act and behave appropriately for their age(s).
11. **Our After-Hours Phone Number to speak with Dr. Shah is (813) 681-0093**, to be used only for urgent medical care needs.
12. **All balances are due at the time of service. We ask that you make arrangements for all balances with us prior to your visit. Services will not be rendered, and you may be rescheduled if payment arrangements are not made. Any balances billed to insurance and not paid by or not covered by insurance, do become patient responsibility, and will be due at the time of service.**

We take pride in our work and our office, and we are always looking for suggestions for improvement. Please feel free to drop off any suggestions to our office. Any confidential requests can be discussed with Dr. Shah directly. Thank you, and Welcome to Wesley Chapel Internal Medicine and Pediatrics.

Patient Name (Please Print): \_\_\_\_\_

Parent/Guardian Name (if applicable): \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# WESLEYCHAPEL

INTERNAL MEDICINE AND PEDIATRICS

Manish Shah MD, FAAP

2038 Ashley Oaks Circle, Suite 102, Wesley Chapel, FL 33544

Phone: 813-929-3622 Fax: 813-929-3620

## Acknowledgement of Receipt of Notice of Privacy Practices

**By signing this document, I acknowledge that I have received a copy of *Wesley Chapel Internal Medicine & Pediatrics PA's* Notice of Privacy Practices.**

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**If signing as a parent or guardian, please print the name of the patient below.**

\_\_\_\_\_  
Name (if minor or unable to sign)

=====

**\*\* FOR INTERNAL OFFICE USE ONLY \*\***

**Date Acknowledgement received:** \_\_\_\_\_

**Or**

**Reason(s) Acknowledgement was/were not obtained:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# WESLEYCHAPEL

## INTERNAL MEDICINE AND PEDIATRICS

Manish Shah MD, FAAP

### *Notice of Privacy Practices*

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our practice, we will always keep your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In case an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for these copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier document, but will add additional information.

You have a right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of health and Human service 200 Independence Avenue, S.W. , Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy officer, Dr. Shah, phone number 813-929-3622.

This notice goes into effect as of the opening of this office in April 2006.

PLEASE SIGN BELOW TO INDICATE THAT YOU HAVE READ OUR NOTICE OF PRIVACY PRACTICES.

X \_\_\_\_\_



# WESLEYCHAPEL

INTERNAL MEDICINE AND PEDIATRICS

Manish Shah MD, FAAP

2038 Ashley Oaks Circle, Suite 102, Wesley Chapel, FL 33544

Phone: 813-929-3622 Fax: 813-929-3620

## **Permission to Disclose Information**

Due to the **Health Insurance Portability and Accountability Act (HIPAA)**, we are not allowed to disclose your health information to anyone without your written permission.

**Please list below the names of those whom you will allow us to share your health information.**

**Name (Please Print):**

**Relationship:**

_____	_____
_____	_____
_____	_____

Patient Name (Please Print): \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**WESLEYCHAPEL**

INTERNAL MEDICINE AND PEDIATRICS

Manish Shah MD, FAAP

2038 Ashley Oaks Circle, Suite 102, Wesley Chapel, FL 33544

Phone: 813-929-3622 Fax: 813-929-3620

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

I request and authorize

(Name of Previous Doctor): \_\_\_\_\_

(Previous Dr.'s Phone #) \_\_\_\_\_

(Previous Dr.'s Fax #) \_\_\_\_\_

To release healthcare information of the patient named above to:

Name: Wesley Chapel Internal Medicine & Pediatrics

Address: 2038 Ashley Oaks Circle Suite #102

City: Wesley Chapel

State: FL

Zip Code: 33543

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

☐ All healthcare information

☐ Other: \_\_\_\_\_

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_



# WESLEYCHAPEL

INTERNAL MEDICINE AND PEDIATRICS

Manish Shah MD, FAAP

2038 Ashley Oaks Circle, Suite 102, Wesley Chapel, FL 33544

Phone: 813-929-3622 Fax: 813-929-3620

Patient Name: \_\_\_\_\_

Please tell us how you heard about Our Practice:

- ☐ Patient Referred (please tell us who, and we will send them our gratitude): \_\_\_\_\_
- ☐ Physician Referred: \_\_\_\_\_
- ☐ Insurance Company (Website): \_\_\_\_\_
- ☐ Newspaper Ad (name of newspaper): \_\_\_\_\_
- ☐ Yellow Pages: \_\_\_\_\_
- ☐ Internet Search (please indicate Yahoo, Google, etc.): \_\_\_\_\_
- ☐ Other (please indicate): \_\_\_\_\_



# WESLEYCHAPEL

INTERNAL MEDICINE AND PEDIATRICS

Manish Shah MD, FAAP

2038 Ashley Oaks Circle, Suite 102, Wesley Chapel, FL 33544  
Phone: 813-929-3622 Fax: 813-929-3620

## Patient Portal

Convenient, safe, and secure patient connectivity website allows you to communicate with your provider's office anytime—day or night.

Our goal is to be your first choice in patient healthcare by providing convenience and accessibility to our practice. **The Patient Portal offers our patients online health services that include the ability to request appointments, request medication renewals, access medical information, and access laboratory results.**

Your medical information is available to you on this website and is secure. Our company and its affiliates, suppliers, and other third parties mentioned on this site are neither responsible nor liable for any direct, indirect, incidental, consequential, special, exemplary, punitive, or other damages (including, without limitation, those resulting from lost profits, lost data, or business interruption) arising out of or relating in any way to the site, site-related services and products, content, or information contained within the "site," and/or any hyperlinked website, whether based on warranty, contract, tort, or any other legal theory, and whether or not advised of the possibility of such damages. Your sole remedy for dissatisfaction with the site, site-related services, and/or hyperlinked web sites is to stop using the site and/or those services applicable law may not allow the exclusion or limitation of incidental or consequential damages, so the above limitation or exclusion may not apply to you.

Patient Name (Please Print): \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Email Address (Please Print Clearly): \_\_\_\_\_

☐ **Decline Portal Use** (Please still print your name, sign, and date above)