

Dr. Amit Aggarwal, M.D.  
Dr. Alka Aggarwal, M.D.



Dr. Joseph Geffen, D.O.  
Brandon Still, ARNP

## New Patient Registration

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Former Name (if any): \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: M or F SSN: \_\_\_\_\_

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### Contact Information:

Cell Phone #: \_\_\_\_\_

Email address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

#### How would you like us to contact you?

- Cell Phone
- Home Phone
- Email
- Text
- Mail

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Insurance Information

Name of Primary Insurance: \_\_\_\_\_

Name of Secondary Insurance (if any): \_\_\_\_\_

#### Patient Relationship to Insurance Subscriber:

- Self (The health insurance is in my name)
- Spouse (The health insurance is in my spouse's name)
- Daughter/Son (The health insurance is in my parent's name)
- Other (The health insurance is under someone else's name)

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**Primary Insurance Subscriber Information (If different than patient):**

**\*\*Only fill this part out if the insurance is not primarily in your name\*\***

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Former Name (if any): \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: M or F SSN: 

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Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Best Phone #: \_\_\_\_\_

**Demographic Information**

<b>Ethnicity:</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Hispanic or Latino</li><li><input type="checkbox"/> Non-Hispanic or Latino</li><li><input type="checkbox"/> Decline to Specify</li></ul>	<b>Race:</b> <ul style="list-style-type: none"><li><input type="checkbox"/> American Indian or Alaska Native</li><li><input type="checkbox"/> Asian</li><li><input type="checkbox"/> Black of African American</li><li><input type="checkbox"/> Native Hawaiian or Pacific Islander</li><li><input type="checkbox"/> White</li><li><input type="checkbox"/> Decline to Specify</li></ul>
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Preferred Language: \_\_\_\_\_

**1) Emergency Contact Information:**

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

Relationship to Patient: \_\_\_\_\_

Best Phone #: \_\_\_\_\_

**2) Emergency Contact Information:**

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

Relationship to Patient: \_\_\_\_\_

Best Phone #: \_\_\_\_\_

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**MEDICAL HISTORY**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Mail Order Pharmacy Name: \_\_\_\_\_ Pharmacy #(\_\_\_\_) \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Local Pharmacy Name: \_\_\_\_\_ Pharmacy #(\_\_\_\_) \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

**Medication ALLERGIES?**

- None
- I'm allergic to the following medications:

Name of Medication	Allergic Reaction

**PAST MEDICAL HISTORY**

- Asthma
- Thyroid Problems
- High Blood Pressure
- Heart Attack
- Heart Failure
- Angina
- High Cholesterol
- Heartburn/GERD
- Ulcers
- Cancer (\_\_\_\_\_)
- Diabetes
- Degenerative Arthritis
- Rheumatoid Arthritis
- Kidney Stones
- Kidney Disease/Failure
- Osteoporosis
- Tuberculosis
- Gout
- Fibromyalgia
- Chronic Pain
- Lung Disease
- Colitis
- Metabolic Disorder
- Stroke
- Dementia
- Depression
- Anxiety
- HIV/AIDS
- Hepatitis

Have you had any surgeries? Please list type and approximate date:

\_\_\_\_\_

\_\_\_\_\_

Have you ever been hospitalized? N or Y (for what): \_\_\_\_\_

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**MEDICAL HISTORY CONTINUED**

List prescription, over-the-counter and herbal medications you currently take. Include the dose and direction of each:


Check the immunizations you've had. Please give the approximate date for each.

- |  |  |
|--|--|
| <input type="checkbox"/> Tetanus _____   | <input type="checkbox"/> Shingles _____  |
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Influenza _____ |

**FAMILY MEDICAL**

	<u>Father</u>	<u>Mother</u>	<u>Child</u>	<u>Sibling</u>	<u>Grandparent</u>	<u>Other</u>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: type _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SOCIAL HISTORY**

Do you smoke? Y or N If yes, how much do you currently smoke? \_\_\_\_\_  
 Did you ever smoke? Y or N How many years? \_\_\_\_\_  
 Number of alcoholic drinks you consume per week? \_\_\_\_\_  
 Do you use street drugs? Y or N If yes, which ones? \_\_\_\_\_

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**MEDICAL HISTORY CONTINUED**

**Relationship Status:**

<input type="checkbox"/> Single
<input type="checkbox"/> Married
<input type="checkbox"/> Partnered
<input type="checkbox"/> Separated
<input type="checkbox"/> Divorced
<input type="checkbox"/> Widowed

**Previous PCP:**

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

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

**Specialists:**

DOCTOR NAME:	SPECIALITY:

Do you work outside the home? Y or N Occupation? \_\_\_\_\_

*I was referred to Lake America Family Physicians by:* \_\_\_\_\_

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



**AUTHORIZATION TO RELEASE INFORMATION**  
**AND TO PAY BENEFITS TO LAKE AMERICA FAMILY PHYSICIANS, LLC**  
**& CONSENT FOR TREATMENT**

I hereby authorize Lake America Family Physicians, LLC (LAFP), and its employees and agents to release my medical records documenting my examination and treatment, including AIDS related testing, psychiatric or substance abuse information, upon valid request.

I hereby assign payment directly to Lake America Family Physicians, LLC for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I agree to be financially responsible to Lake America Family Physicians, LLC for all charges in the event that I have no insurance or my insurance is rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility. I understand and acknowledge that if Lake America Family Physicians, LLC files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 45 days. I acknowledge that any amounts quoted as my "out-of-pocket costs" are only an estimate and that the exact determination of my financial responsibility will be made after my insurance company processes the claim. Payment is expected at the time of service. Methods of payment accepted include check, cash and credit card. I further agree to pay all costs of collection, including reasonable attorney's fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the State of Florida.

I hereby request and authorize all doctors, nurses, technicians or affiliated medical personnel, hospitals and health care facilities to furnish all records and reports, including x-rays, photostat copies, and abstracts or excerpts of all records, and any other information requested relating to any hospitalizations, examinations, treatments, tests or opinions concerning any condition for which I am presently being treated, including AIDS related testing, psychiatric or substance abuse information. A copy of this authorization shall be as valid as the original of this document.

**GENERAL CONSENT TO TREATMENT**

By signing below, I (or my authorized representative on my behalf) authorize LAFP physicians, practitioners and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

**RIGHT TO REFUSE TREATMENT**

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

\_\_\_\_\_  
PLEASE PRINT PATIENT'S FULL NAME

\_\_\_\_\_  
PATIENT'S/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE



Lake America Family Physicians
HIPAA AUTHORIZATION FORM

Patient's Full Name

Patient's Social Security Number/Medical Record Number

Address

Patient's Date of Birth

City, State Zip Code

Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

- 1. The following specific person/class of person/facility is authorized to use or disclose information about me:
- Previous PCP:
- Specialists:
- Specialists:
- Specialists:
- Specialists:
- Hospital:

- 2. The following person (or class of persons) may receive disclosure of protected health information about me:

Lake America Family Physicians 865 Oakley Seaver Dr Clermont, FL 34711
(T): 352-432-3939 (F): 352-432-3908

- 3. The specific information that should be disclosed is (please give dates of service if possible):

Three horizontal lines for providing specific information to be disclosed.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice. THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING - note that signature is required in two places.\*

Signature of Individual\*
(The person about whom the information relates)
OR, if applicable -

Date of Individual's Signature

Signature of Guardian\* or
Personal Representative of Patient's Estate

Date of Guardian's/Personal
Representative's Signature

A copy of this completed, signed and dated form must be given to the Individual or other signator.



Lake America Family Physicians
HIPAA AUTHORIZATION FORM

Patient's Full Name

Patient's Social Security Number/Medical Record Number

Address

Patient's Date of Birth

City, State Zip Code

Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

- 1. The following specific person/class of person is authorized to use or disclose information about me:

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(T): 352-432-3939 (F): 352-432-3908

- 2. The following person (or class of persons) may receive disclosure of protected health information about me:

- Five empty checkboxes with horizontal lines for names.

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Signature of Individual\*
(The person about whom the information relates)
OR, if applicable -

Date of Individual's Signature

Signature of Guardian\* or
Personal Representative of Patient's Estate

Date of Guardian's/Personal
Representative's Signature

A copy of this completed, signed and dated form must be given to the Individual or other signator.





**POLICY & PROCEDURES AMENDMENT**

**PATIENT NAME:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**CONTACT INFORMATION**

Please provide your best reachable phone numbers where we can call you e.g. abnormal labs, emergent situations etc.

BEST REACHABLE CELL PHONE: ..... .Relation/Name.....

Alternative phone number: .....Relation/Name .....

A communication tool is available to help remind appointments or sending important health information. Please provide:

Cell Phone(where you can receive texts): same as above .....

Email address: .....

**NO-SHOW/CANCELLATION POLICY**

You will be contacted via text/email or phone call to confirm any scheduled appointments. If you can't be reached, it will be considered a confirmed appointment. If you are a NO-SHOW (if you don't show up for your appointment within one hour), you will be charged a \$25 penalty. If you cancel your appointment less than 24 hours, you will be charged a \$25 penalty. If you can't make it to your appointment due to any reason, please call or text us to reschedule appointment ASAP to avoid any penalties.

**REFILLS**

In regards to prescription refills, this is to notify you that it may take up to 3 business days to send in refills once a request is submitted to us. Please do not wait until the last minute to call us about medications refills.

I have read the above and I approve the above-mentioned information to be used for any purpose to contact me by Lake America Family Physicians.

.....

Signature of patient

*Please note that all the information received is HIPAA compliant and kept protected. Contact info will only be used for patient care purposes.*

Phone: (352) 432-3939 Fax: (352) 432-3908

www.lakeamerica.com (UPDATED 8/20/19)