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

LAKE AMERICA
FAMILY PHYSICIANS

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:** | | | | | | | | | |

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)

865 Oakley Seaver Drive, Clermont FL 34711
Phone: (352) 432-3939 Fax: (352) 432-3908
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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:** | | | | | | | | | |

Address: _____

City: _____ **State:** _____ **Zip:** _____

Best Phone #: _____

Demographic Information

Ethnicity:	**Race:**
☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to Specify	☐ American Indian or Alaska Native ☐ Asian ☐ Black of African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Decline to Specify

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**?

- o None
- o 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.

- ☐ Tetanus _____
- ☐ Pneumonia _____
- ☐ Shingles _____
- ☐ Influenza _____

FAMILY MEDICAL

	Father	Mother	Child	Sibling	Grandparent	Other
Alcoholism	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer: type _____	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

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:

- ☐ Single
- ☐ Married
- ☐ Partnered
- ☐ Separated
- ☐ Divorced
- ☐ 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: _____

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LAKE AMERICA
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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 it's 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

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LAKE AMERICA
FAMILY PHYSICIANS

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):

_____

_____

_____

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* **Date of Individual's Signature**
(The person about whom the information relates)

OR, if applicable –

_____ _____
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.

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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:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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

Signature of Individual* (The person about whom the information relates) | **Date of Individual's Signature**

OR, if applicable –

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

KE AMERICA

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 POLICY

If you any scheduled appointment, you will be contacted to confirm the appointment. If you can't be reached, it will be considered confirmed appointment. If you are NO-SHOW (if you don't show up for your appointment within one hour), you will be charged $25 penalty. If you can't make it to your appointment due to any reason, please call 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 HfPAA compliant and kept protected. Contact info will only be used for patient care purposes.

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