Pinnacle
MEDICAL GROUP

Dear Patient:

Welcome to the department of General Surgery at Pinnacle Medical Group. Please take the time to complete the attached forms as Dr. Sharla Sundberg requires as much information as possible to ensure the best possible care.

To allow Dr. Sundberg to develop a safe and effective treatment plan for your condition we would appreciate you having the following items with you on the day of your visit:

-CDs or films from any relevant X-Ray, US, or CT Scan
-Operative reports from any prior surgery performed by another surgeon
-Any relevant endoscopy reports (such as an EGD, or colonoscopy)

Note – if you had any of the above services performed at Pinnacle Medical Group or Blake Medical Center please inform our staff upon arrival for your appointment.

Thank you for visiting our offices and allowing us to become partners in your health care.

Sincerely,

Pinnacle Medical Group
General Surgery Department
A Division of West Florida Physician Network, LLC

315 75th Street West, Bradenton, FL 34209
P: 941-795-3600

Pinnacle Medical Group Patient Registration Form

PATIENT INFORMATION

(Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last)_____ (First)_____ (MI) _____

Previous Name (Last) _____ (First) _____

Address_____City_____ State_____ Zip _____

Home Phone_____ Cell_____ Work_____ Ext. _____

Primary Care Provider (PCP)_____ Referring Provider _____

Email Address _____

Date of Birth _____/_____/_____ ☐ Female ☐ Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Island ☐ Black or African American ☐ White ☐ Decline

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Japanese ☐ Chinese ☐ French ☐ German ☐ Russian ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security No. _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full Time ☐ 2 - Part Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full Time Student ☐ P - Part Time Student ☐ N - Not a Student Do you have a living will? ☐ Yes ☐ No

Emergency Contact Name_____ Phone Number _____

Emergency Contact Relationship to Patient _____ ☐ Guardian

Home Phone_____ Cell_____ Work_____ Ext. _____

Pharmacy Name_____ Location _____

RESPONSIBLE PARTY INFORMATION

(Information used for patient balance statements)

Responsible Party ☐ Guarantor ☐ Self

Responsible Party Name (Last)_____ (First)_____ (MI) _____

Also Known As Name (Last) _____ (First) _____

Date of Birth _____/_____/_____ ☐ Female ☐ Male Social Security No. _____-_____-_____

Home Phone_____ Cell_____ Work_____ Ext. _____

Address_____City_____ State_____ Zip _____

Employer_____ Employer Phone _____

PRIMARY INSURANCE INFORMATION

(Provide your insurance card to the front desk at check-in)

Insurance Company _____ Insurance Company Phone _____

Name of Insured_____ Patient Relationship to Insured _____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____/_____/_____ Termination Date_____/_____/_____ Date of Birth _____/_____/_____

SECONDARY INSURANCE INFORMATION

(Provide your insurance card to the front desk at check-in)

Insurance Company _____ Insurance Company Phone _____

Name of Insured_____ Patient Relationship to Insured _____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____/_____/_____ Termination Date_____/_____/_____ Date of Birth _____/_____/_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ **Date**_____/_____/_____

PINNACLE MEDICAL GROUP
General Surgery
315 75th Street West, Bradenton, FL 34209 • Phone 941-795-3600 • Fax 855-521-2857

New Patient Intake Form

Date: _____

Patient Name:_____ DOB: _____

CARE INFORMATION – *please list complete name and address of physicians* (VERY IMPORTANT)

Primary Care Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Referring Physician (if different from PCP): _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Other Physicians (if different from above): _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Pharmacy: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PRIOR STUDIES

Have you had any prior studies? Please write the most recent dates for each:

STUDY:	DATE(s):	BODY PART STUDIED:	RESULTS:
XRAY	_____	_____	_____
	_____	_____	_____
US	_____	_____	_____
	_____	_____	_____
CT SCAN	_____	_____	_____
	_____	_____	_____
Other:	_____	_____	_____
	_____	_____	_____

PAIN ASSESSMENT

Are you experiencing pain or discomfort? ☐ Yes ☐ No

If yes, please describe the location(s), onset, duration, and characteristics of your pain:

_____

_____

_____

If yes, on a scale of 1 to 10 (0 = no pain, 10 = the worst pain), how would you rate your pain? _____

MEDICAL HISTORY Please list all active conditions:

_____

_____

_____

_____

_____

SURGICAL HISTORY Please list all operations you have had: Date:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

HANDEDNESS ❑ Right Handed ❑ Left Handed

MEDICATIONS Please list all medications you take routinely, prescribed or over-the-counter, along with the dosages.

Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you **ALLERGIC** to any medicines, latex, X-Ray dye, or iodine? ❑ Yes ❑ No

If yes, please explain: _____

Are you taking any "blood thinning" medications? ❑ Yes, indicate below ❑ No

❑ Aspirin or aspirin-containing medication ❑ Anti-flammatory medication ❑ Plavix

❑ Coumadin ❑ Fish Oil ❑ Other: _____

SOCIAL HISTORY

Occupation:_____ Marital Status:_____ Number of Children: _____

Do you exercise regularly? ❑ Yes ❑ No How frequently?_____

Do you smoke cigarettes? ❑ Yes ❑ No If so, how many packs a day? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much daily? _____

Do you or have you used recreational drugs? ❑ Yes ❑ No If yes, type? _____

Females: Are you, or could you be pregnant? ❑ Yes ❑ No Ever used Oral Contraceptives? ❑ Yes ❑ No

Ever used Hormone Replacement Therapy? ❑ Yes ❑ No

FAMILY HISTORY

Do you have a family member affected with:

Condition	Yes	No	type/affected relative	Condition	Yes	No	type/affected relative
Cancer	❑	❑	_____	Heart Disease	❑	❑	_____
Aneurysm	❑	❑	_____	High Cholesterol	❑	❑	_____
Bleeding/Clotting Problem	❑	❑	_____	Hypertension	❑	❑	_____
Other Conditions	❑	❑	_____	Diabetes	❑	❑	_____

Explain Other Conditions: _____

_____

REVIEW OF SYMPTOMS Do you currently, or have you had a problem with:

Musculoskeletal:	**Yes**	**No**
Broken bones	☐	☐
Arm or leg weakness	☐	☐
Arm or leg pain	☐	☐
Joint pain or swelling	☐	☐
Arthritis	☐	☐

Neurological:	**Yes**	**No**
Fainting spells or "black outs"	☐	☐
Seizures	☐	☐
Problems with memory	☐	☐
Disorientation	☐	☐
Difficulty with speech	☐	☐
Inability to concentrate	☐	☐
Double or blurred vision	☐	☐
Weakness in arms and/or legs	☐	☐
Loss of sensation	☐	☐
Difficulty with balance	☐	☐

Psychiatric:	**Yes**	**No**
Anxiety	☐	☐
Depression	☐	☐

Constitutional:	**Yes**	**No**
Fever	☐	☐
Weight loss	☐	☐
Excessive fatigue	☐	☐
History of Falls	☐	☐

Cardiovascular:	**Yes**	**No**
Chest pain or angina	☐	☐
High blood pressure	☐	☐
Irregular pulse	☐	☐
Heart murmur	☐	☐
High cholesterol	☐	☐
Swelling in hands or feet	☐	☐
Leg pain while walking	☐	☐

Respiratory:	**Yes**	**No**
Asthma	☐	☐
Emphysema	☐	☐
Shortness of breath	☐	☐
Pneumonia	☐	☐
Bloody sputum	☐	☐

Allergic/Immunologic:	**Yes**	**No**
Food, Inhalant (nasal) allergies	☐	☐
Autoimmune disease (i.e., lupus)	☐	☐

Gastrointestinal:	**Yes**	**No**
Nausea	☐	☐
Heartburn	☐	☐
Vomiting	☐	☐
Blood in your vomit	☐	☐
Liver disease	☐	☐
Jaundice	☐	☐
Abdominal pain	☐	☐
Change in bowel habits	☐	☐
Ulcers or gastritis	☐	☐

Hematologic/Lymphatic:	**Yes**	**No**
Anemia	☐	☐
Hemophilia	☐	☐
Bleeding tendencies	☐	☐
Blood transfusion	☐	☐
Persistent swollen glands/lymph nodes	☐	☐
HIV	☐	☐

Eyes:	**Yes**	**No**
Wear glasses	☐	☐
Infections	☐	☐
Injuries	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐

Ear, Nose, Throat & Mouth:	**Yes**	**No**
Wear hearing aid(s)	☐	☐
Hearing loss	☐	☐
Ear pain/infections	☐	☐
Ringing in ear	☐	☐
Nose bleeds	☐	☐
Nasal congestion/drainage	☐	☐
Inability to smell	☐	☐
Sinus problems	☐	☐
Balance (vertigo, spinning, etc.)	☐	☐

Endocrine:	**Yes**	**No**
Diabetes	☐	☐
Thyroid disease	☐	☐
Excessive thirst/urination	☐	☐

Genitourinary:	**Yes**	**No**
Urinary tract infections	☐	☐
Painful urination	☐	☐
Blood in your urine	☐	☐
Difficult starting/stopping stream	☐	☐
Incontinence	☐	☐
Kidney stones	☐	☐

Pinnacle
MEDICAL GROUP

Authorization for Release of Protected Health Information (PHI)

Patient Name: _____ Patient's Address: _____ _____	Birth Date:	Phone Number:
	Requestor's Name/Phone Number (if patient is not the requestor):	

PHI Recipient Name: Dr. Sharla Sundberg Address: 315 75th Street West City/State/Zip: Bradenton, FL 34209 Phone Number: (941) 795-3600 Fax Number: (855) 521-2857	PHI Sender Name: _____ Address: _____ City/State/Zip: _____ Phone Number: (_____) _____ Fax Number: (_____) _____

Purpose of Disclosure: _____

_____

_____

_____

Description	Date(s)	Description	Date(s)	Description	Date(s)
☐ All PHI in	_____	☐ Physician	_____	☐ Demographics	_____
☐ History and	_____	☐ Laboratory	_____	☐ Rehabilitation Svcs	_____
☐ Consult Report	_____	☐ Imaging/Radiology	_____	☐ Special Test	_____
☐ Operative	_____	☐ Nursing Notes	_____	☐ Therapy	_____
☐ Progress	_____	☐ Medication	_____	☐ Itemized	_____
				☐ Other:_____	_____

1. I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ **(initial).**
2. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization(except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings.)
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy the information described on this form, for reasonable copy fee, if I ask for it.
6. I will receive a copy of this form after I sign It.

Signatures (Initial above and sign here)
I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative: _____ Date: _____

Print Name of Patient's Representative: _____ Relationship to Patient _____