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

PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)________________(First)________________(MI) __________

Preferred Full Name (if different from above): ________________

Address: ________________

City, State, Zip: ________________

Home Phone Number (landline):________Cell:____________Work: ____________

E-Mail Address:________________Date of Birth: ____________

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed ____________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed ____________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_______

Patient Social Security Number:___-____-_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last)________________(First)________________(MI) __________

Date of birth: MM______/DD______/YYYY_______ Sex: ☐ Female ☐ Male

Responsible Party Social Security Number:_-_______-_____Phone number: __________

Address:________________

City, State:________________ZIP: __________

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)________________ (First) ____________

Phone number:________________ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:________________☐ Guardian

Address________________

City, State:________________ZIP: __________

Home phone:________________Work hone:____________Ext. _______

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:________________Date: ____________

Printed name of patient or personal representative:________________Relationship to patient: ____________

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
Cancer	❑	❑	
Aneurysm	❑	❑	
Bleeding/Clotting Problem	❑	❑	
Other Conditions	❑	❑	

Condition	Yes	No	type/affected relative
Heart Disease	❑	❑	
High Cholesterol	❑	❑	
Hypertension	❑	❑	
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	❑	❑

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 __________