



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

## PATIENT REGISTRATION FORM (eCW)

(Please print)

### PATIENT INFORMATION

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-inflammatory 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	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding/Clotting Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Conditions	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____

Explain Other Conditions: \_\_\_\_\_  
\_\_\_\_\_

**REVIEW OF SYMPTOMS**

Do you currently, or have you had a problem with:

**Musculoskeletal:**

	Yes	No
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>
Arm or leg weakness	<input type="checkbox"/>	<input type="checkbox"/>
Arm or leg pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain or swelling	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>

**Neurological:**

	Yes	No
Fainting spells or "black outs"	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Problems with memory	<input type="checkbox"/>	<input type="checkbox"/>
Disorientation	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with speech	<input type="checkbox"/>	<input type="checkbox"/>
Inability to concentrate	<input type="checkbox"/>	<input type="checkbox"/>
Double or blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Weakness in arms and/or legs	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sensation	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with balance	<input type="checkbox"/>	<input type="checkbox"/>

**Psychiatric:**

	Yes	No
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>

**Constitutional:**

	Yes	No
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Excessive fatigue	<input type="checkbox"/>	<input type="checkbox"/>
History of Falls	<input type="checkbox"/>	<input type="checkbox"/>

**Cardiovascular:**

	Yes	No
Chest pain or angina	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Irregular pulse	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in hands or feet	<input type="checkbox"/>	<input type="checkbox"/>
Leg pain while walking	<input type="checkbox"/>	<input type="checkbox"/>

**Respiratory:**

	Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Bloody sputum	<input type="checkbox"/>	<input type="checkbox"/>

**Allergic/Immunologic:**

	Yes	No
Food, Inhalant (nasal) allergies	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease (i.e., lupus)	<input type="checkbox"/>	<input type="checkbox"/>

**Gastrointestinal:**

	Yes	No
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Blood in your vomit	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers or gastritis	<input type="checkbox"/>	<input type="checkbox"/>

**Hematologic/Lymphatic:**

	Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Persistent swollen glands/lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>

**Eyes:**

	Yes	No
Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>
Infections	<input type="checkbox"/>	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>

**Ear, Nose, Throat & Mouth:**

	Yes	No
Wear hearing aid(s)	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain/infections	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ear	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Nasal congestion/drainage	<input type="checkbox"/>	<input type="checkbox"/>
Inability to smell	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Balance (vertigo, spinning, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

**Endocrine:**

	Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst/urination	<input type="checkbox"/>	<input type="checkbox"/>

**Genitourinary:**

	Yes	No
Urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Blood in your urine	<input type="checkbox"/>	<input type="checkbox"/>
Difficult starting/stopping stream	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>



## Authorization for Release of Protected Health Information (PHI)

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

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

Purpose of Disclosure: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Description	Date(s)	Description	Date(s)	Description	Date(s)
<input type="checkbox"/> All PHI in	_____	<input type="checkbox"/> Physician	_____	<input type="checkbox"/> Demographics	_____
<input type="checkbox"/> History and	_____	<input type="checkbox"/> Laboratory	_____	<input type="checkbox"/> Rehabilitation Svcs	_____
<input type="checkbox"/> Consult Report	_____	<input type="checkbox"/> Imaging/Radiology	_____	<input type="checkbox"/> Special Test	_____
<input type="checkbox"/> Operative	_____	<input type="checkbox"/> Nursing Notes	_____	<input type="checkbox"/> Therapy	_____
<input type="checkbox"/> Progress	_____	<input type="checkbox"/> Medication	_____	<input type="checkbox"/> Itemized	_____
				<input type="checkbox"/> 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 \_\_\_\_\_