Beth Hanrahan, M.D., L.L.C.

Diplomate
American Board of Internal Medicine

Thank you for choosing Beth Hanrahan, MD as your Primary Care Provider. My staff and I look forward to meeting you and providing you with the highest quality care that will allow you to lead an enjoyable, active lifestyle. We do our very best to provide friendly, expedient, knowledgeable care with an emphasis on communication and education. Understanding your health and your healthcare needs provides empowerment and comfort.

In order to best meet your healthcare needs, it's important that we receive as much information about your previous and current medical background as possible. This will enable Dr. Hanrahan to tailor an optimal healthcare plan with you in order to keep you at your very best. Please feel free to use the checklist below to help prepare for your initial visit:

	Fill out New Patient packet. Please include your email address located on the last page		Insurance cards
	Contact information for previous Primary Care physician		List of specialists and their contact info, ie: eye, heart, foot, skin, GI doctors, etc
	Record request form signed		Mail order and/or local pharmacy information
	List of current medications or prescription bottles		Advanced Directive, Living Will, and/or Power of Attorney paperwork

Please keep in mind that many of our patients have allergies to perfumes and lotions. We kindly ask that you refrain from wearing lotions, creams, perfumes, and body sprays when coming to our office. We greatly appreciate your understanding as we strive to provide a comfortable environment for all of our valued patients.

If you have any questions, do not hesitate to call us at any time. Thank you again for choosing Dr. Hanrahan. We greatly appreciate your trust and confidence in our practice.

2495 Enterprise Rd Unit 102•Clearwater, FL 33763
(727) 724-9656•Fax (727) 725-8589

New Patient Information

Beth A. Hanrahan, MD
2495 Enterprise Rd, Unit 102
Clearwater, FL 33763

Please Provide Insurance Card(s) to Receptionist for Copying
Patient Information - Please Print Clearly

Patient Name: ___________________ ___________________ _______________
Last First Middle

Local Address: ____
Street Apartment Number

__________________________ _______________ ____________
City State Zip

Home Address (if different from above):

___________________________________ ___________________ __________ _________
Street City State Zip

Patient Employer: _____________________________ Your Occupation: ______________

Employer Address: ____
Street City State Zip

Home Phone # ( ) ______-___________ Work Phone # ( ) _____-____________ Ext. ___

Patient's Date of Birth: ____ /___ / _______ Social Security # _____ - ____ - __________

Medicare # ____

Marital Status: (please circle) Single Married Divorced Widowed

Please fill out spouse's information even if widowed or divorced

Spouse's (if married) or Legal Guardian's (if child) Name: ________________________________

Spouse's or Guardian's Date of Birth: ___ /____ /_______ *SS #* _____ - ____ - __________

Spouse's or Guardian's Employer: ____

Spouse's or Guardian's Work # ( ) ____-______ Spouse's Occupation: ___________________

You were referred by: ____

Emergency Information

Nearest Relative/Friend Not Living With You: __________________ Relationship: _________

Address: ____ Phone: ( ) ____-______
Street City State Zip

Health Questionnaire

Name: ______________________________ Date: ____________________

Present Complaint: ____
____

Present Medications (including vitamins)
Please list milligrams : ____
____

Check any of the below conditions if you have or have ever had them:

	Date Onset		Date Onset
☐ High Blood Pressure		☐ Asthma	
☐ Heart Disease		☐ COPD	
☐ Atrial Fibrillation		☐ Tuberculosis	
☐ Cholesterol Problem		☐ Positive TB Skin Test	
☐ Blood Clots		☐ Diabetes	
☐ Rheumatic Fever		☐ Thyroid Problem	
☐ Anemia		☐ Arthritis	
☐ Stroke		☐ Kidney Problems	
☐ Cancer		☐ Hepatitis	
☐ Colitis		☐ Epilepsy	
☐ Peptic Ulcer		☐ Dementia	
☐ Osteoporosis		☐ Other	

List any allergies to medications and the reaction:

____

PLEASE provide the date of last:

Complete history and physical exam		Pap Smear	
Blood Test		Tetanus Shot	
Chest X-Ray		Pneumonia Shot	
Mammogram		Flu Shot	
Bone Density		Colonoscopy	

Surgical History

	Date		Date		Date
☐ Eyes		☐ Hernia		☐ Plastic Surgery	
☐ Ears		☐ Hemorrhoids		☐ Fractures	
☐ Nose		☐ Stomach		Where?	
☐ Throat		☐ Colon			
☐ Thyroid		☐ Rectum		☐ Other Operations	
☐ Tonsils		☐ Prostate			
☐ Skin		☐ Uterus			
☐ Hip		☐ Ovary			
☐ Breast		☐ Appendectomy			
☐ Varicose Veins		☐ Gallbladder			
☐ Chest		☐ Spine			
☐ Heart		☐ Bladder Repair			
☐ Kidney		☐ Exploratory			

Family and Social History

Do you smoke? _________ How Much? _________ Did you quit? When? ____________

Do you consume alcohol? _________ How Much? _________ Did you quit? When? ____________

Do you take illicit drugs? _________ How Much? _________ Did you quit? When? _____________

Do you have any children? _________ Ages? ________________________

	Age	Alive	Deceased	Age at Death	Cause of Death
Mother					
Father					
Brothers and Sisters					

Do any of the following run in the family?

	Relative		Relative
☐ High Blood Pressure		☐ Kidney Disease	
☐ Heart Trouble		☐ Epilepsy	
☐ Strokes		☐ Bleeding Disorder	
☐ COPD		☐ Cancer (Type)	
☐ Diabetes		☐ Tuberculosis	

Review of Systems

Name: ______________________ DOB: ______________________ Date: ______________

Please place a check mark beside any of the following symptoms or problems if you have experienced them recently or have concerns about them.

General	**Women**
☐ Fevers, chills, or sweats	☐ Unusual vaginal discharge
☐ Recent loss of appetite	☐ Loss of control of your urine
☐ Fatigue	☐ Painful urination
☐ Recent unexpected weight loss	☐ Blood in urine
Eyes	☐ Increased frequency of urination
☐ Blurred or double vision	☐ Stopped periods
☐ Eye pain or irritation	☐ Nipple discharge
☐ Eye discharge	☐ Breast mass or tenderness
Ears, Nose, Throat	**Men**
☐ Earache	☐ Painful urination
☐ Ringing in ears	☐ Blood in urine
☐ Decreased hearing	☐ Increased frequency of urination
☐ Difficulty swallowing	☐ Urination more than twice a night
☐ Frequent nose bleeds	☐ Loss of control of your urine
☐ Prolonged hoarseness	☐ Difficulty getting or maintaining an erection
☐ Sinus trouble or congestion	**Musculoskeletal**
Cardiovascular	☐ Back pain
☐ Chest pain	☐ Joint pain
☐ Fainting spells	☐ Swelling in joints
☐ Palpitation	**Skin**
☐ Shortness of breath with exertion	☐ Skin rashes
☐ Swollen ankles	☐ Itching
Respiratory	☐ Suspicious moles or other skin abnormalities
☐ Chronic cough	**Neurologic**
☐ Chronic wheezing	☐ Headache
☐ Coughing up blood	☐ Numbness/tingling sensations
Gastrointestinal	☐ Seizures/convulsions
☐ Persistent nausea/vomiting	☐ Fainting spells
☐ Diarrhea	☐ Tremor/hand shaking
☐ Constipation	☐ Dizziness/vertigo
☐ Change in appearance of stool	**Psychological**
☐ Chronic abdominal pain	☐ Feeling depressed or sad
☐ Bloody or very black stool	☐ Memory loss
☐ Jaundice (yellow skin)	**Endocrine**
	☐ Cold or heat intolerance
	☐ Significant weight change
	Heme and Lymphatic
	☐ Excessive bruising or bleeding
	☐ Swollen glands in neck, armpits, or groin

Insurance Information

Primary Insurance:	Secondary Insurance:
Insurance Company Name: ____	Insurance Company Name: ____
Insurance Company Address: ____	Insurance Company Address: ____
Policy Holder Name: (Primary Card Holder) ____ Last First Middle	Policy Holder Name: (Primary Card Holder) ____ Last First Middle
Relationship to Patient:(please circle) Self Spouse Dependent Child Other	Relationship to Patient: (please circle) Self Spouse Dependent Child Other
ID# or Policy #: ___________________________	ID# or Policy #: ___________________________
Group #: __________________ Plan #: ________	Group #: ____________________ Plan #: ________

CO·PAY AMOUNT WILL BE COLLECTED AT THE TIME OF SERVICE.

Signatures Required

For Medicare Patients: I request that payment of authorized Medicare benefits be made either to me or on my behalf, or to DR. BETH HANRAHAN for any services furnished. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits or these benefits payable for related services. I also request that payments or authorized Medigap benefits be made on my behalf to DR. BETH HANRAHAN for services provided. I authorize any holder of medical information about me to release to the Medigap insurer listed above any information needed to determine these benefits. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim because my signing this authorization will cause Medicare payment information to cross over automatically.

______________________________ ______________________________

Beneficiary Signature Date

For Non-Medicare Patients: I authorize release of any medical information necessary to process this claim and related claims. I authorize release of any medical records to all providers that I am referred to by my Primary Care Physician. I request that payment of authorized benefits be made either to me or on my behalf to the physician for any services furnished to me by that physician.

______________________________ ______________________________

Patient Signature/Parent if child/Legal Guardian Date

All Patients: I agree to pay all charges for myself and members of my family, as applicable, promptly upon presentation thereof. Charges as shown by statements are agreed to be correct unless protested in writing within 30 days. It is agreed that payments will not be delayed or withheld because of an insurance coverage or the pendency of claims thereon. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

______________________________ ______________________________

Patient Signature/Parent if child/Legal Guardian Date

All Patients: I agree that I may be contacted at the email address below. I understand that no personal medical information will be sent to me via the email address provided.

Email Address: ______________________________

______________________________ ______________________________

Patient Signature/Parent if child/Legal Guardian Date

HIPAA AUTHORIZATION FORM

(permission from patient/patient's legal guardian to share personal medical information)

PATIENT NAME:____

DOB: _____/_____/_____

STREET ADDRESS:______________________________________

CITY,STATE,ZIP: ______________________________________

I, ______________________________,hereby authorize Dr. Beth Hanrahan and/or
(name of patient)
Any medical facility to release any and all medical information and test results that pertain to me, to the following individual(s):

Name:________________________PH#_____________Relationship to Pt_______________

Name:________________________PH#_____________Relationship to Pt_______________

Name:________________________PH#_____________Relationship to Pt_______________

I authorize Dr. Beth Hanrahan or the medical facility to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization by notifying Dr. Beth Hanrahan in writing of my intent to revoke authorization or change the name(s) of the indviduals to whom information is to be released.

____ ____________________

Signature of Patient Date

____ ____________________

Signature of Legal Guardian or Personal Rep of Patient's Estate Date

____ ____________________

Name of Witness Date