



Beth Hanrahan, M.D., J.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.

1831 N. Belcher Road, Suite G1, Clearwater, FL 33765

(727) 724-9656 • Fax (727) 725-8589

New Patient Information

Dr. Beth Hanrahan, M.D.
1831 N. Belcher Road, Suite G1
Clearwater, FL 33765

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
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Asthma	
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> COPD	
<input type="checkbox"/> Atrial Fibrillation		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Cholesterol Problem		<input type="checkbox"/> Positive TB Skin Test	
<input type="checkbox"/> Blood Clots		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Thyroid Problem	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Stroke		<input type="checkbox"/> Kidney Problems	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Colitis		<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Peptic Ulcer		<input type="checkbox"/> Dementia	
<input type="checkbox"/> Osteoporosis		<input type="checkbox"/> 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
<input type="checkbox"/> Eyes		<input type="checkbox"/> Hernia		<input type="checkbox"/> Plastic Surgery	
<input type="checkbox"/> Ears		<input type="checkbox"/> Hemorrhoids		<input type="checkbox"/> Fractures	
<input type="checkbox"/> Nose		<input type="checkbox"/> Stomach		Where?	
<input type="checkbox"/> Throat		<input type="checkbox"/> Colon			
<input type="checkbox"/> Thyroid		<input type="checkbox"/> Rectum		<input type="checkbox"/> Other Operations	
<input type="checkbox"/> Tonsils		<input type="checkbox"/> Prostate			
<input type="checkbox"/> Skin		<input type="checkbox"/> Uterus			
<input type="checkbox"/> Hip		<input type="checkbox"/> Ovary			
<input type="checkbox"/> Breast		<input type="checkbox"/> Appendectomy			
<input type="checkbox"/> Varicose Veins		<input type="checkbox"/> Gallbladder			
<input type="checkbox"/> Chest		<input type="checkbox"/> Spine			
<input type="checkbox"/> Heart		<input type="checkbox"/> Bladder Repair			
<input type="checkbox"/> Kidney		<input type="checkbox"/> 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
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Heart Trouble		<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Strokes		<input type="checkbox"/> Bleeding Disorder	
<input type="checkbox"/> COPD		<input type="checkbox"/> Cancer (Type)	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> 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
<input type="checkbox"/> Fevers, chills, or sweats	<input type="checkbox"/> Unusual vaginal discharge
<input type="checkbox"/> Recent loss of appetite	<input type="checkbox"/> Loss of control of your urine
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Painful urination
<input type="checkbox"/> Recent unexpected weight loss	<input type="checkbox"/> Blood in urine
Eyes	<input type="checkbox"/> Increased frequency of urination
<input type="checkbox"/> Blurred or double vision	<input type="checkbox"/> Stopped periods
<input type="checkbox"/> Eye pain or irritation	<input type="checkbox"/> Nipple discharge
<input type="checkbox"/> Eye discharge	<input type="checkbox"/> Breast mass or tenderness
Ears, Nose, Throat	Men
<input type="checkbox"/> Earache	<input type="checkbox"/> Painful urination
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Decreased hearing	<input type="checkbox"/> Increased frequency of urination
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Urination more than twice a night
<input type="checkbox"/> Frequent nose bleeds	<input type="checkbox"/> Loss of control of your urine
<input type="checkbox"/> Prolonged hoarseness	<input type="checkbox"/> Difficulty getting or maintaining an erection
<input type="checkbox"/> Sinus trouble or congestion	Musculoskeletal
Cardiovascular	<input type="checkbox"/> Back pain
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Swelling in joints
<input type="checkbox"/> Palpitation	Skin
<input type="checkbox"/> Shortness of breath with exertion	<input type="checkbox"/> Skin rashes
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Itching
Respiratory	<input type="checkbox"/> Suspicious moles or other skin abnormalities
<input type="checkbox"/> Chronic cough	Neurologic
<input type="checkbox"/> Chronic wheezing	<input type="checkbox"/> Headache
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Numbness/tingling sensations
Gastrointestinal	<input type="checkbox"/> Seizures/convulsions
<input type="checkbox"/> Persistent nausea/vomiting	<input type="checkbox"/> Fainting spells
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Tremor/hand shaking
<input type="checkbox"/> Constipation	<input type="checkbox"/> Dizziness/vertigo
<input type="checkbox"/> Change in appearance of stool	Psychological
<input type="checkbox"/> Chronic abdominal pain	<input type="checkbox"/> Feeling depressed or sad
<input type="checkbox"/> Bloody or very black stool	<input type="checkbox"/> Memory loss
<input type="checkbox"/> Jaundice (yellow skin)	Endocrine
	<input type="checkbox"/> Cold or heat intolerance
	<input type="checkbox"/> Significant weight change
	Heme and Lymphatic
	<input type="checkbox"/> Excessive bruising or bleeding
	<input type="checkbox"/> Swollen glands in neck, armpits, or groin

Insurance Information

<p>Primary Insurance: Insurance Company Name: _____</p> <p>Insurance Company Address: _____</p> <p>Policy Holder Name: (Primary Card Holder) _____</p> <p style="text-align: center;">Last First Middle</p> <p>Relationship to Patient:(please circle) Self Spouse Dependent Child Other</p> <p>ID# or Policy #: _____</p> <p>Group #: _____ Plan #: _____</p>	<p>Secondary Insurance: Insurance Company Name: _____</p> <p>Insurance Company Address: _____</p> <p>Policy Holder Name: (Primary Card Holder) _____</p> <p style="text-align: center;">Last First Middle</p> <p>Relationship to Patient: (please circle) Self Spouse Dependent Child Other</p> <p>ID# or Policy #: _____</p> <p>Group #: _____ Plan #: _____</p>
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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 individuals 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

Important Information For New Patients
Please Read and Sign Below

Please be aware of the following office policies and procedures.

The first visit will be to obtain your medical history and to discuss your active medical problems.

A very brief exam will be conducted on your first visit and we will then send for your old medical records and order any tests, labs, etc that are needed.

The next visit will be your yearly physical if it is time to do this exam. We do not do yearly physical exams on the first visit because we don't know your medical history and can't order or conduct appropriate testing without this knowledge.

When you come for your yearly physical (wellness visit) we will likely address other concerns that you have and/or identify new issues that need to be managed. We will also review your chronic medical problems and change management if needed. When we do this, we combine a problem visit with a wellness visit so that you don't need to come in for another appointment. This requires that a co-payment be charged according to the contract that both the patient and provider have with the insurer. Very rarely is this visit just "wellness".

Please note: failure to cancel your annual appointment with us less than 24 hours in advance may result in a \$25 charge being added to your account.

I understand and agree to abide by these office policies and procedures.

Patient Signature