Beth Hanrahan MD, LLC

Diplomat
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 North Belcher Rd. Ste G1, Clearwater, FL 33765

(727) 724-9656•Fax (727) 725-8589

New Patient Information

Beth A. Hanrahan, MD

1831 North Belcher Rd. Ste. G1, Clearwater, FL 33765

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

BETH HANRAHAN, M.D., LLC

Please list the prescription drugs, over the counter medications, vitamins and supplements you are taking:

Medication name: _____ Dosage: _____ Frequency:_____

Medication name: _____ Dosage: _____ Frequency:_____

Medication name: _____ Dosage: _____ Frequency:_____

Medication name: _____ Dosage: _____ Frequency:_____

Medication name: _____ Dosage: _____ Frequency:_____

Medication name: _____ Dosage: _____ Frequency:_____

Medication name: _____ Dosage: _____ Frequency:_____

Medication name: _____ Dosage: _____ Frequency:_____

Medication name: _____ Dosage: _____ Frequency:_____

Medication name: _____ Dosage: _____ Frequency:_____

Medication name: _____ Dosage: _____ Frequency:_____

Please list any specialists or providers you see:

Specialist's name/Specialty: _____ Phone: _____

Specialist's name/Specialty: _____ Phone: _____

Specialist's name/Specialty: _____ Phone: _____

Specialist's name/Specialty: _____ Phone: _____

Specialist's name/Specialty: _____ Phone: _____

Specialist's name/Specialty: _____ Phone: _____

Name: _____ **Date:** _____

BETH HANRAHAN, M.D., LLC

Our Goal is to provide our patients with timely medical care in a professional manner. Your health care is a partnership between you, the Physician and/or Provider and our Staff. In order to serve you better, we have instituted policies to make your experience with us the best it can be.

Patients arriving late: Every effort will be made to accommodate a patient who is tardy. However, if a patient is more than 15 minutes late for their scheduled appointment, we may need to reschedule that individual if they cannot be accommodated without delaying other patients.

Schedule running behind: On occasion, the provider may be behind schedule due to an emergency or to a patient requiring more than the allotted time. If you would like to reschedule, our Staff will do everything to accommodate you.

Scheduling Appointment: We respectfully request when calling to schedule an appointment that you let the scheduler know what type of problems you are experiencing. This allows him/her to offer you an appointment with the proper time allotment. Your health is important to us. We do not want to rush the evaluation and treatment of any problem.

Patient Messages: We try to call back by the end of the day and usually able to accomplish this. Our staff is knowledgeable and has been trained to answer many of your questions. Depending on your question, it may take longer to gather the information you request. We firmly believe that practicing medicine over the phone is not in your best interest and you may be asked to come to the office for a visit.

Prescription & Renewals: Routine prescription refills will only be handled during regular office hours. Please call 48 hours before needed, with the name of the medication, the strength, and the quantity needed, as well as the phone number of your pharmacy. Please call your pharmacy and have them fax your request to our office at (727) 725-8589. Please allow 48 hours. We attempt to address prescription refills within one working day. No narcotic prescriptions will be called after hours.

Authorizations & Referrals: Please notify us 48-72 hours prior to scheduling specialist visits to facilitate authorizations from your insurance company. Please remember that your insurance company must review the request, approve the visit and notify our office. Once this is done, we will notify the specialist that your visit has been approved. Please provide the name of the specialist, his/her phone number, fax number and procedure codes required by the insurance company for consideration.

After Hours & Emergencies: In an emergency, if the situation is life threatening, CALL 911. If the situation is urgent but less critical, call our regular office number and you will be provided with a doctor on call through our answering service. If you are experiencing chest pain, please report to the nearest hospital Emergency room or CALL 911. Please be advised that the answering providers will not have access to your medical chart and will only be able to give medical advice.

Fees For Forms Filled Out: There are $10-$40 fees expected from the patient if our office has to complete any forms. The fee is per form. We will not bill any insurance companies for these fees, it is the patient's responsibility.

Medical Insurance: Payment for services is due at the time of visit. This includes co-payments, co-insurance, deductibles and any non-covered services. We accept cash, local checks, Visa and MasterCard.

No-Show/Late cancellation: There will be a charge to the patient of $25 if you are a no-show or fail to cancel your apt within 24 hours.

***Annual Physical**: The doctor will see you and will then submit the charges to your insurance company as provided by your provider. Annual Physicals are considered "Well Visits" and are directed at your health maintenance. Any problems or other health complaints such as a cough, uti, leg pain, etc., discussed are eligible to be billed as an additional office visit and may be subject to co-insurance or deductible payments from the patient. If you do not wish to have an additional charge billed for this date of service we request you speak to the front desk to schedule a separate office visit for a future date.

Your medical insurance is a contract between you and your insurance company. Certain tests and procedures such as labs, EKG's, etc., may not be fully covered. It is important to follow the rules of your plan. Our office is NOT responsible for determination of whether or not tests and procedures are covered by your plan.

Signature_____ Date_____

Print Name_____ Date of Birth _____