Sunshine Walk-In Clinic

3300 Lake Mary Blvd., Suite 220, Lake Mary Florida 32746
Phone # 407-321-7111 Fax # 407-321-7444
www.sunshinewalkinclinic.com

Patient Information

Print Name: Age: Date of Birth Today's Date

Address City State Zip

Email address (please print clearly)

Home Phone Cellular Phone

Work phone Alternate Phone

Patient's SSN Sex/Gender (circle) Female Male

Patient's Employer Phone Ext.

Patient's Work Address

Medical Information

Patient's Primary Care Physician Phone

office location/address City/State/Zip

Patient's Dentist Phone

office location/address City/State/Zip

Patient's preferred Pharmacy Phone

location/address City/State/Zip

Primary Insurance Information

Insurance company name

Group Number Policy Number Effective date

Is Patient the Primary Insured? (circle) Yes NO Member ID

Relationship to Primary Insured

If 'NO' please complete the following information below:

Primary Insured's Name - First Last Middle

Primary Insured's Employer Primary Insured SSN - -

Primary Insured's Date of Birth Home Phone Cellular Phone

Primary Insured's email address

Secondary Insurance Information

Insurance company name

Group Number Policy Number Effective date

Is Patient the Primary Insured? (circle) Yes NO Member ID

Relationship to Primary Insured

If 'NO' please complete the following information below:

Primary Insured's Name - First Last Middle

Primary Insured's Employer Primary Insured SSN - -

Primary Insured's Date of Birth Home Phone Cellular Phone

Primary Insured's email address

Guarantor – person or party responsible for receiving financial status and patient billing correspondences on the above named patient

Guarantor Name - First Last Middle

Address City State Zip

Email address (please print clearly)

Home Phone Cellular Phone

Work phone Alternate Phone

Guarantor SSN - - Sex/Gender (circle) Female Male Date of Birth

Guarantor work address

Suite/Bldg. # City State Zip

Please describe the reason for your visit:

If due to an injury, please provide the following information: Body Part Left ☐ Right ☐

Date of injury Where did the injury occur? Home ☐ Work ☐ Car accident ☐ Other ☐ explain:

Details of the event:

How did you hear about us? Internet Search ☐ Yellow Pages ☐ Mail ☐ Sign ☐ Newspaper Ad ☐ Other:

Referred by Doctor (name) Friend

I authorize the release of all medical information necessary to process this claim that is pertinent to my medical care. I assign all medical and/or surgical benefits to Sunshine Walk-in Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as the original. I agree to be financially responsible for all charges. My signature acknowledges that this information is correct and that I have read and understand the information provided on this document.

Signature Date

If signing for a minor/POA – Please Print Your Name here

Sunshine Walk In Clinic
3300 W. Lake Mary Blvd Ste 220
Lake Mary, Fl. 32746
Phone (407) 321-7111 Fax (407)321-7446

I authorize Sunshine Walk In Clinic, Dr. Anita Gupta, to send confidential information, as selected below, to the email listed. I am aware that this may not be a secure email because it is being sent as an attachment. If at any time you wish to revoke this authorization, please notify us in writing.

Please select which correspondence you would like to authorize:

_____Billing/invoices

_____Medical Records i.e. results (at doctor's discretion after reviewed)

_____Appointment reminders

Name_____

Email_____

Signature_____ Date_____

Anita Gupta, M.D.

Sunshine Walk-In Clinic

Patient Name:
(Print) _____

Date of Birth: _____ Sex: _____ Race: _____

Have you ever had a problem with the following?

	Yes	No
Heart		
Lungs		
Stomach		
Liver		
Kidney		
Anemia		
Diabetes		
Marital Illness		
Cancer		
Bleeding Disorder		
Other		

Explain all Yes Answers

Current Medications (dosage/frequency)

Surgical History

Allergies to Medications

Family History

	Yes	No
Heart		
Blood Pressure		
Diabetes		
Bleeding Disorder		
Cancer		
Other		

Explain all Yes Answers

Social History

Occupation: _____

Smoking History: ☐ Never ☐ Previous ☐ Current ☐ Chew only

If Current, How much? _____ per day

If Previous, Year quit? _____

Alcohol History: ☐ None ☐ Rarely ☐ Moderate ☐ Heavy

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

Number of Children? _____

Height _____ Weight _____

General	Yes	No
Change in Appetite		
Change in weight		
Chills, fever, sweat		

Head	Yes	No
Frequent headaches		
Recent trauma		

Vision	Yes	No
Double Vision		
Reading Glasses		
Change in vision		

Ear Nose and Throat	Yes	No
Loss of hearing		
Ringing in ears		
Gum Problems		
Bleeding		
Nose Bleed		
Hoarseness		
Difficulty Swallowing		
Morning cough		
Toothache		

Respiratory	Yes	No
Difficulty Breathing		
Cough		
Shortness of breath		
Coughing up blood		

Heart	Yes	No
Chest Pain		
Heart beating fast		
Difficulty breathing during activities		

Digestive System	Yes	No
Abdominal pain		
Nausea		
Vomiting		
Bloating		
Diarrhea		
Constipation		
Blood in stool		
Frequent belching		

Urinary System - Men	Yes	No
Penile discharge		
Difficulty urinating		
Blood in urine		

Allergies	Yes	No
None/Normal		
Hay Fever		
Other (explain)		

Urinary System - Women	Yes	No
Regular Periods		
Menopausal		
Hysterectomy		
Vaginal discharge		
Difficulty urinating		
Blood in urine		

Muscles and Bones	Yes	No
Pain		
Weakness		
Joint Swelling		
Backache		
Degenerative disease		

Nervous System	Yes	No
Dizziness		
Loss of consciousness		
Seizures		
Blackouts		
Nervous exhaustion		
Numbness and Tingling		

Emotional Status	Yes	No
Nervous		
Mood changes		
Depression		
Insomnia		

Skin	Yes	No
Normal		
Rash		
Non-healing lesion		

Endocrine and Glands	Yes	No
Thyroid		
Heat Intolerance		
Cold Intolerance		
Diabetes		
Excessive thirst		
Excessive hunger		
Excessive urination		

Blood and Lymph System	Yes	No
Anemia		
Easy Bruising		
Easy Bleeding		
Swollen Glands		

Other (Explain)

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Initial here		I agree that I have read and understood the **HIPAA Policy and Privacy Practices Notice** for this medical facility. I understand my rights as described in the notice.
Initial here		I agree that I have read and understood that **payment is due at the time of service.**
Initial here		I agree that I have read and understand that it **is my responsibility for any DEDUCTIBLES, Co-PAYMENTS, Co-INSURANCE PAYMENTS and or other fees not otherwise covered** by my insurance carrier and the remaining will be filed to my primary insurance.
Initial here		I agree that I have read and understand if my insurance carrier has not paid my account in full within 45 days, **the balance on my account will automatically be billed to me/patient/guardian/guarantor.**
Initial here		I agree that I have read and understand **the reimbursement process** of this medical facility, in the event a credit balance is presented on the patient account.
Initial here		I agree that I have read and understood that I am responsible for the full payment balance of my visit if my insurance carrier has my benefits/eligibility listed as a **"GRACE PERIOD"** during any office visit with this healthcare provider/facility.
Initial here		I agree that I have read and understood that any **past due amounts are subject to interest rates, collection fees and/or court costs.**
Initial here		I agree that I have read and understood the **CLINICAL POLICIES** of this medical facility and during my care with this medical facility follow them accordingly.
Initial here		I agree that I have read and understood that I shall not discuss finances with the Physician, Physician Assistant, Nurse Practitioner, Nurse, Medical Assistant or other medical associate handling my care, but I may direct all questions and concerns to the Billing Specialist/Office Manager.

I agree that I have read and understood all responsibilities regarding the Office and Financial Policies.
My signature acknowledges my agreement to this medical provider and facility for my responsibilities to this office.

Print name _____ DOB _____

Signature _____ Date _____