BAYSIDE LAKES FAMILY CARE

VIKASH PRIYADARSHI, M.D.
336 COGAN DRIVE SE
PALM BAY, FL 32909
Phone: 321-462-4001 Fax: 321-622-6400

Patient Information

Patient's Name: _____

Date of Birth: _____ **Age:** _____ [ ] Male [ ] Female

Local Address:
_____
_____

Billing/Second Address:
_____
_____

Year-Round Residence? [ ] Yes [ ] No **Email:** _____

Cell Phone: _____ **Home Phone:** _____

Preferred Pharmacy: (name and location) _____

Preferred Laboratory: (for blood draws or imaging) _____

Preferred Language: _____

Race: [ ] Black or African American [ ] Asian [ ] Native American
[ ] White [ ] Pacific Islander [ ] Prefer not to answer

Ethnicity: [ ] Hispanic/Latino [ ] Non-Hispanic/Latino [ ] Prefer not to answer

Insurance Information

Primary Insurance: _____

Policy Number: _____

Policy Holder Information (if not the same as patient)

Name _____ **DOB:** _____

Secondary Insurance: _____

Policy Number: _____

Policy Holder Information (if not the same as patient)

Name _____ **DOB:** _____

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HIPPA Release

Patient's Name: _____

I hereby authorize the Medical Associates of Brevard LLC to discuss my Healthcare information with the below named individuals.

Emergency Contact Name: _____

Relationship: _____

Primary Phone: _____ **Secondary Phone**: _____

Other Contact: _____

Relationship: _____

Primary Phone: _____ **Secondary Phone**: _____

Other Contact: _____

Relationship: _____

Primary Phone: _____ **Secondary Phone**: _____

Preferred appointment reminder notification:
[ ] Home Phone [ ] Cell Phone [ ] Text Messaging

I authorize Medical Associates of Brevard to utilize the following methods of communication for appointment reminders, information sharing or other reminders. This communication may contain personal health information.

[ ] Home Phone [ ] Cell Phone [ ] Voicemail [ ] Text Messaging [ ] Email

Your HIPPA contract will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.

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Release of Medical Records

Patient's Name: _____

Date of Birth: _____

I give my authorization for Medical Associates of Brevard to [ ] Request/Obtain [ ] Release

The following protected health information.

Please check all information that applies:

[ ] Complete Medical Records	[ ] Laboratory Reports
[ ] History and Physical	[ ] Immunization Records
[ ] Progress Notes	[ ] MRI reports
[ ] Consultation Notes	[ ] X-ray reports
[ ] Hospital Records	[ ] CT scan reports

[ ] Other (please specify): _____

From or to the below named individual or organization:

Name: _____
Address: _____
Fax #: _____

Select one of the following if applicable:
[ ] This authorization will end on the following date: _____
[ ] This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use/or disclosure. Describe the event below:
_____
_____

_____ _____ _____
Patient Name Date of Birth Date

_____ _____
Patient Signature or Parent/Guardian if minor Relationship to Patient

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No-Show/Missed Appointment Policy

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one business day prior to your scheduled appointment. It is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel/reschedule your appointment with at least a **24 hours' notice**.

2. If less than a 24-hour cancellation is given, this will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, or if you are more than **fifteen minutes late** for your appointment without communicating with our office prior, this will be documented as a "No-Show" appointment.

4. After the first "No-Show/Missed" appointment, you will be assessed a $25.00 no show fee. This fee must be paid before you can be seen at the office again.

5. If you have subsequent "No-Show/Missed" appointments, you will receive another $25 no show fee assessment. After 3 instances, dismissal from the practice will be considered, and you will be notified by letter if the dismissal was approved.

6. New Patients who schedule, confirm, and then no-show or late cancel their appointment will not be scheduled at our office again.

I have read and understand Bayside Lakes Family Care No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify the office appropriately if I have difficulty keeping my scheduled appointments.

_____ _____ _____

Patient Name Date of Birth Date

_____ _____

Patient Signature or Parent/Guardian if minor Relationship to Patient

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Health History Questionnaire

All questions are strictly confidential and will become part of your medical record.

Patient's Name: _____

Date of Birth: _____ **Age:** _____ [ ] Male [ ] Female

Previous Primary Care Provider or Referring Doctor: _____

When was your last complete Physical? _____

Medical History (any previously diagnosed medical problems)

_____
_____
_____
_____
_____
_____
_____

Surgical History (please include description, date/year and location/hospital performed)

_____
_____
_____
_____
_____
_____
_____
_____

Non-Surgical Hospitalizations (please include reason, date/year and location/hospital)

_____
_____
_____
_____
_____
_____
_____
_____

Medications (list all prescribed and over-the-counter drugs you take, including vitamins)

Drug Name	Dose/Strength	Frequency

Allergies (please list any allergies to medications or food)

Drug or Food Name	Reaction You Had

Immunizations (check any received and include date/year)

[ ] Influenza	_____	[ ] COVID-19	_____
[ ] Pneumococcal	_____	[ ] Shingrix/RZV	_____
[ ] Tetanus/Td/Tdap	_____	[ ] Hepatitis B	_____

Screenings (check any that have been done and include date/year/location/performing Dr.)

[ ] Eye Exam	_____
[ ] Colonoscopy	_____
[ ] Mammogram	_____
[ ] Pap Smear	_____
[ ] Bone Density Scan or Ultrasound	_____

Family Health History (list any significant health issues)

Father _____
Mother _____
Sibling(s) _____
Children _____

Occupation/Work status: _____

Marital status: Single Partnered Married Separated Divorced Widowed

Sexual activity: Men Women Both Neither

Do you drink alcohol? Yes No
If Yes, how many drinks per week? _____

Do you smoke or use tobacco? Never Smoker Current Smoker Former Smoker

If Current Smoker, how many cigarettes or packs per day? _____
For how many years? _____
OR
If Former Smoker, how long ago did you quit? _____

Describe, if any, other tobacco use (cigars, chew, e-cigarettes) and amount per day
_____

Do you currently use any recreational or street drugs? Yes No
If Yes, describe _____

How often do you exercise?
[ ] Sedentary (No exercise)
[ ] Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
[ ] Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
[ ] Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Are you following a specific diet plan? Yes No
If Yes, describe _____

Have you fallen in the past 6 months? Yes No
If Yes, describe _____

Do you have an Advance Directive or Living Will? Yes No

Would you like information on the preparation of these? Yes No

Current Code Status Full Code Do not resuscitate (DNR) Do not intubate (DNI)

Physical and/or mental abuse have become major public health issue. This can take the form of verbally threatening behavior, or actual physical or sexual abuse.
Would you like to discuss this issue with your physician? Yes No

Mental health issues have also become a major public health threat. This can take the form of feelings of intense sadness or stress, changes in energy level, sleep, or a loss of interest in things that once gave pleasure.
Would you like to discuss this issue with your physician? Yes No

Do you have, or have you had, any symptoms in the following areas?
(check any that apply and describe)

[ ] Skin _____
[ ] Head/Neck _____
[ ] Eyes _____
[ ] Ears _____
[ ] Nose _____
[ ] Throat _____
[ ] Chest/Heart _____
[ ] Breathing _____
[ ] Joints/Muscles _____
[ ] Back _____
[ ] Abdominal _____
[ ] Bladder _____
[ ] Bowel _____
[ ] Weight changes _____
[ ] Energy level _____
[ ] Ability to sleep _____

Other:
_____
_____
_____
_____
_____