Dear Valued Patient,

Thank you for choosing Best Coast Internal Medicine, where we strive to offer the best possible medical care. It is our pleasure to welcome you as a patient. This letter is designed to provide you with some important information about our services and office operation.

Emergency/ After Hours: If the office is closed and you have a medical emergency, please call 911 or proceed to the closest emergency room. For non-life threatening emergencies you may leave a message with our answering service and we will return your call as soon as possible. If you'd like to leave a message for the office staff to return your call the next business day, you may call the office number and leave a voicemail. Prescription refills will NOT be handled after hours, please call during normal business hours. Please refer to our prescription refill policy below.

Prescription Refills: Please call your pharmacy regarding refills on medications at least 72 hours in advance to allow sufficient time for the pharmacy and your provider to receive and respond to your request before you run out of your medication. For maintenance medications, your health care provider will prescribe enough refills to last you until your next office visit. If you are out of refills, this is an indication of the need to schedule a follow up appointment with your provider. ****We do NOT manage chronic pain for the long term, as chronic pain patients should be cared for by pain management specialists.** **

Your opinion matters: If you had a positive experience with your Physician, please leave a review on Google. If you have feedback that can help us improve, please call us immediately so we can change for the better.

Payment/ Billing Options: Payment will be required at the time services are rendered. We will collect all outstanding balances for services performed at the time of service. Please note that your insurance company may process the claim with a higher patient responsibility. You may receive an invoice for any balance from billing. Method of payment includes Cash, Check, MasterCard, Visa, Discover and American Express. If you have a question regarding your statement you may contact the office directly or our billing office at 727-312-4222.

Forms: Some forms are extensive and will require a fee of $25 at the time of request. There are forms that may require an appointment prior to completion of the requested documents.

Identification: The protection of your identity is important to us. You will be required to produce a government issued photo identification card, along with your insurance card(s) at every visit. We will also scan a copy into your electronic health records.

Sean Nonnemaker D.O./ Leslie Gomez D.O./
Waguih El Masry M.D./ Jorge Hernandez M.D.
250 2nd Street East, Suite 3B
Bradenton, FL 34208
Phone: 914-746-4151

Lisa Shannon D.O./ Juliana Dale D.O.
2901 US 301
Ellenton, FL. 34222
Phone: 941-253-0030
Fax: 941-253-003

Choose Your Physician

- ☐ Dr. Jorge Hernandez, MD
- ☐ Dr. Waguih El Masry, MD
- ☐ Dr. Leslie Gomez, DO, FACOI
- ☐ Dr. Sean Nonnemaker, DO, FACOI
- ☐ Dr. Lisa Shannon, DO
- ☐ Dr. Juliana Dale, DO

Name: ______________________________ DOB: ______________

Reason for Visit: ____

Preferred Pharmacy (Name/Location): ______________________________

Do you have any allergies?: ____________________________________

List of medications CURRENTLY taking (prescribed, over the counter, and vitamins)

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Medical History (mark ALL that apply)

- ☐ ADD
- ☐ ADHD
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Bladder Cancer
- ☐ Bowel Problems
- ☐ Breast Cancer
- ☐ Breathing Difficulties
- ☐ Cancer (type): ____________________
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Emphysema
- ☐ GERD
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis (A, B, or C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Liver Problems
- ☐ Lung Cancer
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Pancreatic Cancer
- ☐ Parkinson’s
- ☐ Pneumonia
- ☐ Polymyalgia
- ☐ Prostate Cancer
- ☐ Psoriasis
- ☐ Psychiatric Problems
- ☐ Pulmonary Embolism
- ☐ Rectal Cancer
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Seizure Disorder
- ☐ Sickle Cell
- ☐ Sjogren Syndrome
- ☐ Stroke/ CVA
- ☐ Other: ______________________ ______________________

Surgical Procedures (mark ALL that apply)

- ☐ ACL Surgery/ Reconstruction
- ☐ Adenoids Removed
- ☐ Appendix Removal
- ☐ Back Surgery
- ☐ Gallbladder Removed
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Hysterectomy
- ☐ Splenectomy
- ☐ Tonsils Removed
- ☐ Breast Augmentation
- ☐ Cardiac Bypass Surgery
- ☐ Cardiac Catheterization
- ☐ Cataract Surgery
- ☐ Colon resection
- ☐ Lumpectomy
- ☐ Lymph Node Biopsy
- ☐ Mastectomy
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Total Joint Replacement
- ☐ Colostomy/Reversal
- ☐ C-Section
- ☐ D&C (Dilation & Curettage)
- ☐ Defibrillator Implant
- ☐ Pacemaker
- ☐ PTCA (Angioplasty)
- ☐ Shoulder Surgery
- ☐ Other ______________________ ______________________ ______________________

Women's Health

Procedure	Date	Results	
Last Menstrual Period	______________________________	___ Normal	___ Abnormal
Pap/Pelvic Exam	______________________________	___ Normal	___ Abnormal
Last Mammogram	______________________________	___ Normal	___ Abnormal
Bone Density Exam	______________________________	___ Normal	___ Abnormal

Number of Pregnancies: _________ Deliveries: _________ Miscarriages: _________ Abortions: _________

Health Maintenance

Procedure	Date	Results	
Physical Exam/Wellness Visit	______________________________	___ Normal	___ Abnormal
Cholesterol	______________________________	___ Normal	___ Abnormal
Colonoscopy	______________________________	___ Normal	___ Abnormal
EGD	______________________________	___ Normal	___ Abnormal
Prostate/PSA	______________________________	___ Normal	___ Abnormal
Stress Test/Nuclear Stress Test	______________________________	___ Normal	___ Abnormal

Immunizations **Month/Year**

Hepatitis A #1 ___________________ #2 ___________________

Hepatitis B #1 ___________________ #2 ___________________ #3 ___________________

Gardasil (HPV) #1 ___________________ #2 ___________________ #3 ___________________

Influenza ______________________ Pneumonia ______________________

Tetanus ______________________ Shingrix (Shingles) ______________________

TB Skin Test ______________________ Chicken Pox ______________________

COVID **Type:** _____________________ Dates: ______________________________________

Social History

Smoker: ___ Never ___ Formerly ___ Currently

If YES, mark all that apply: ___ Cigarettes ___ Cigars ___ Chewing/Dipping Tobacco ___ E-Cigarettes

How Much Per Day: _________________ How Many Years: __________________ Quit Date: _______________

Alcohol: ___ Never ___ Daily ___ Social Estimated Daily Consumption: ______________________

Are you Sexually Active? ___ Yes ___ No

Are you using a form of birth control? ___ Yes ___ No If YES, what type?: _______________________

Have you ever had an STD ___ Yes ___ No If YES, what type?: _______________________

Street Drug Use: ___ Never ___ Formerly ___ Currently If YES, what type?: _______________________

Do You Feel Safe at Home? ___ Yes ___ No

Do You Have a Living Will? ___ Yes ___ No

Do you have a Durable Power of Attorney for healthcare? ___ Yes ___ No

---

Family History ___ Adopted ___ Unknown

Mother Living? ___ Yes ___ No Age of Death: ____________ Cause of Death: ___________________

Father Living? ___ Yes ___ No Age of Death: ____________ Cause of Death: ___________________

(Please list any serious medical history that runs in your family)

Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent

---

Provider List (Physician/Practice Name)

Cardiologist ____________________

Gastroenterologist ____________________

General Surgeon ____________________

Neurologist ____________________

OBGYN ____________________

Primary Care ____________________

Urologist ____________________

Other ____________________

Hospital Admission(s) / ER Visit(s)	**Year**	**Diagnosis**

NOTICE OF PRIVACY PRACTICES

A copy of Facility's HIPAA Notice of Privacy Practices is posted in the main lobby and available for me to read in its entirety. The HIPAA Notice of Privacy Practices contains information on the uses and disclosures of my protected health information (PHI).

DISCLOSURE OF PROTECTED HEALTH INFORMATION AND EMERGENCY CONTACT

I authorize Facility to communicate with the following individuals about my medical condition, diagnosis, treatment, appointments (past and future), and financial obligation. I understand medical information may be withheld from individuals, including family members, unless I Hst them by name below.

Name: ____ Relationship: ______________________

Name: ____ Relationship: ______________________

I authorize Facility to leave voicemail or answering machine messages regarding test results or other healthcare related concerns at my home or cell phone number. ___ Yes ___ No

Emergency Contact: _______________ Phone Number: _____________ Relationship: _______________

Email Address ____

FINANCIAL POLICY AND AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

Facility strives to make our financial policy, Insurance filing, and billing process for our patlents as simple as possible. It is your responsibility to make sure we have your correct insurance information and also your responsibility to know your co-pay, co-insurance amount and deductible. For Self-Pay patients, payment must be made at the time of service, and a 5O% discount is offered to those patients. Patients will be assessed a $30 fee for checks returned due to Insufficient Funds. Statements are mailed out each month. Please contact our Central Billing Office for questions or concerns regarding your balance. Facility will submit claims to my primary and secondary insurance directly for their services. I authorize payment directly to Facility of any insurance benefits otherwise payable to me. Charges deemed as non-covered by insurance company are the responsibility of the patient except as required by law for State and Federal reimbursement programs. I authorize Facility to release or receive any information necessary to expedite insurance claims.

GENERAL CONSENT FOR EXAMINATION AND TREATMENT

I hereby consent and authorize Facility to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of Facility. Any photographs or other images taken will become part of my medical record. Facility will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that Facility will provide me with information and forms prior to such procedures. I grant Facility consent to submit immunizations administered to State Immunization Registry; and to view and/or import all medication history prescribed within the last two years. I authorize Facility to search for and access my records through a Health Information Exchange (HIE) for purposes of medical treatment. I have the right to opt-out at any time by notifying Facility .

____ ___________________________

Patient's Name (Please Print) Signature

____ ___________________________

Patient Representative (If patient is unable to sign) Signature

PATIENT DEMOGRAPHICS

Patient Information

Last Name: _______________ First Name: _______________ Middle Name: _________ Suffix: ___________

Social Security #: ____________ Gender (check): ___ Male ___ Female Date of Birth: ____________________

Marital Status(check): ___ Divorced ___ Married ___ Separated ___ Single ___ Widowed ___ Other: ______________

Primary Care Physician: ____________________________ Preferred Language (check): ___ English ___ Spanish

Race (check): ___ Asian ___ Black ___ White ___ Other: _______________

Ethnicity (check): ___ Hispanic ___ Not Hispanic ___ Unknown

Mailing Address: ________________________ Apartment/Lot: ________ City/State: _____________ Zip Code: _______

Phone Numbers: Home ______________________ Mobile ______________________ Work _____________________

Email Address: ___________________________________ How did you hear about us? _________________________

Referring Physician: ____

Responsible Party

Check if same as patient: ____

Last Name: _______________ First Name: _______________ Gender (check): ___ Male ___ Female

Date of Birth: ____________________ Relationship to Patient: ____

Mailing Address: ________________________ Apartment/Lot: ________ City/State: _____________ Zip Code: _______

Phone Numbers: Home ______________________ Mobile ______________________ Work _____________________

Employer Information

Employer: ____________________ Address: _________________________ City/State: ________ Zip Code: _______

Emergency Contact

Check if same as Responsible Party: ____

Last Name: _______________ First Name: _______________ Gender (check): ___ Male ___ Female

Date of Birth: ____________________ Relationship to Patient: ____

Mailing Address: ________________________ Apartment/Lot: ________ City/State: _____________ Zip Code: _______

Phone Numbers: Home ______________________ Mobile ______________________ Work _____________________

Guardian Contact

Check if same as: Responsible Party: ____ Emergency Contact: ____

Last Name: _______________ First Name: _______________ Gender (check): ___ Male ___ Female

Date of Birth: ____________________ Relationship to Patient: ____

Mailing Address: ________________________ Apartment/Lot: ________ City/State: _____________ Zip Code: _______

Phone Numbers: Home ______________________ Mobile ______________________ Work _____________________

Insurance Information Check if Self Pay: ____

Check if Same as Responsible Party: ____	Check if Same as Responsible Party: ____
Subscriber Name ______________ Date of Birth ______________	Subscriber Name ______________ Date of Birth ______________
Relationship to Patient ______________ Gender (Check) ___ Male ___ Female	Relationship to Patient ______________ Gender (Check) ___ Male ___ Female
Primary Insurance Company ______________ Begin Date ______________	Secondary Insurance Company ______________ Begin Date ______________
Insurance Mailing Address ______________	Insurance Mailing Address ______________
City/State ______________ Zip Code ______________	City/State ______________ Zip Code ______________
Subscriber# ______________ Group # ______________	Subscriber# ______________ Group # ______________

______________________________ ______________________________

Patient/Guardian Signature Date Patient/Guardian Print

PATIENT NAME: ________________ PATIENT D.O.B. ______________
TODAYS DATE: ________________ PROVIDER NAME:______________

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?
(USE CHECK MARK TO INDICATE YOUR ANSWER)

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1) LITTLE INTEREST OR PLEASURE IN DOING THINGS	0	1	2	3
2) FEELING DOWN,DEPRESSED, OR HOPELESS	0	1	2	3
3) TROUBLE FALLING OR STAYING ASLEEP, OR SLEEPING TO MUCH	0	1	2	3
4) FEELING TIRED OR HAVING LITTLE ENERGY	0	1	2	3
5) POOR APPETITE OR OVEREATING	0	1	2	3
6) FEELING BAD ABOUT YOURSELF-OR THAT YOU ARE A FAILURE OR HAVE LET YOURSELF OR YOUR FAMILY DOWN	0	1	2	3
7) TROUBLE CONCENTRAITING ON THINGS, SUCH AS READING THE NEWSPAPER OR WATCHING TELEVISION	0	1	2	3
8) MOVING OR SPEAKING SO SLOWLY THAT OTHER PEOPLE COULD HAVE NOTICED.OR THE OPPOSITE-BEING SO FRIDGETY OR RESTLESS THAT YOU HAVE BEEN MOVING AROUND A LOT MORE THAN USUAL	0	1	2	3
9)THOUGHTS THAT YOU WOULD BE BETTER OFF DEAD, OR OF HURTING YOURSELF IN SOME WAY	0	1	2	3

ADD COLUMNS_____ ______ ______
TOTAL: _________

10) IF YOU CHECKED OFF ANY PROBLEMS, HOW DIFFICULT HAVE THESE PROBLEMS MADE IT FOR YOU TO DO YOUR WORK, TAKE CARE OF THINGS AT HOME, OR GET ALONG WITH OTHER PEOPLE?

NOT DIFFICULT AT ALL_____
SOMEWHAT DIFFICULT_____
VERY DIFFICULT _____
EXTEMELY DIFFICULT ______

HQ-9 IS ADAPTED FROM **PRIME MD TODAY,** DEVELOPED BY DR'S ROBERT L. SPITZER, JANET B.W. WILLIAMS, KURT KROENKE, AND COLLEAGUES, WITH AN EDUCATIONAL GRANT FROM PFIZER INC. FOR RESEARCH INFORMATION, CONTACT DR. SPITZER AT RLS8@COLUMBIA.EDU. USE OF THE PHQ-9 MAY ONLY BE MADE IN ACCORDANCE WITH THE TERMS OF USE AVAILABLE AT HTTP://WWW.PFIZER.COM. COPYRIGHT 1999 PFIZER INC, ALL RIGHTS RESERVED. **PRIME MD TODAY** IS A TRADEMARK OF PFIZER INC.

CONFIDENTIAL HIPPA INFORMATION

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_______________________________ Birth Date: _______________

Maiden/Prior Names: ___________________________ Current Phone #:_____________

Current Address: ____

I am requesting disclosure of my protected health information for the following purpose:

__________ Continued medical care   ____________ Disability Determination

__________ Legal Investigation   ____________ Other: ________________

I authorize the release of the following:

_____ Provider office note

_____ Lab results

_____ Diagnostic reports

_____ Other

Items below will not be included unless checked:

_____ Psychological Evaluation

_____ Alcohol and Drug Abuse Treatment Records

_____ HIV Test Results and AIDS Treatment Records

Obtain my health information from:

Facility/Provider's Name	Phone	Fax	Address

Release my health information to:

Facility/Provider's Name	Phone	Fax	Address

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to re-disclosure by the recipient any may no longer be protected by federal regulations. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

This form must be completed in full before signing:

______________________   ______________________   ______________

Patient signature (required for ages 12 +)   Parent/Legal Guardian signature (if applicable)   Relationship to patient

______________________   ______________________

Witness signature   Date Signed