Robert Sadaty, M.D.
9400 Fountain Medical Court
Suite 100
Bonita Springs, FL 34135
Phone: 239-494-6244
Fax: 239-992-4121
Email: info@robertsadaty.com

FIRST VISIT CHECKLIST:

1. Forms Completed with Precise Medication Dosages.
2. Bring Insurance Cards.
3. Make Copies of Medical Records for us to keep.
4. Co-pay's are to be paid with personal check or credit card. No cash.
5. Please arrive 15 minutes early.

PLEASE REMEMBER TO BRING ALL PAPERWORK WITH YOU TO YOUR FIRST APPOINTMENT – WE PREFER THAT YOU DO NO MAIL IT TO THE OFFICE.

THANK YOU.

Robert Sadaty, M.D.
9400 Fountain Medical Court, Suite 100
Bonita Springs, FL 34135

Name: ____

Date of Birth: ____

Referral: ____

Your Address: ____

City: _______________ **State**: _____________ **Zip Code**: _______________

Social Security # (required to process bill through Medicare and Private Insurances):

_______ - _______ - _________

Home Phone: __________________________ **Work Phone**: ______________________________

Cell Phone: _______________________ **Email Address**: __________________________________

PHARMACY: NAME _______________________________ PHONE/FAX

____

Occupation (if retired, former occupation): ____

Spouse's Name: ____

Emergency Contact Name/Phone: ____

Out of State Address (if you are seasonal): ____

City: ____________________________ State: ___________________ Zip Code: ______________

Seasonal Phone Number: ____

The above information is true to the best of my knowledge. I authorized my insurance benefits to be paid directly to the physician, Dr. Robert Sadaty, MDPA. I understand that I am financially responsible for any balance.

***Signature**: ________________________________ **Date**: ________________

Permission for Treatment: I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment by Dr. Robert Sadaty, M.D., deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

***Signature:** ________________________________ **Date:** ________________

Privacy Notice: I have received a copy of Dr. Sadaty's privacy notice as required by HIPAA and understand my privacy rights as outlined.

***Signature:** ________________________________ **Date:** ________________

Robert Sadaty, M.D.
9400 Fountain Medical Court, Suite 100
Bonita Springs, FL 34135

PRIVACY NOTICE

The following notice describes how your medical information may be used and disclosed, and how you can get access to this information. Please review the information carefully.

Please be advised that your confidential health care information may be released under the following conditions:

1. To other health-care professionals within the organization for the purpose of providing you with quality health care and treatment.

2. To your health insurance provider for the purpose of receiving payment in the course of providing you with health-care services and treatment.

3. To public or law enforcement officials in the event that investigation in which you are a victim of abuse, a crime, or domestic violence.

4. To other health-care providers in the even that you need emergency care.

5. To a public and federal organization in the even t of a communicable disease or to report a defective device or untoward even to a biological product such as food of medication.

6. For any other purpose than that which is identified in this notice.

Your confidential health care information may be released only after receiving written authorization from you. You may revoke authorization to release confidential health care information at any time in writing.

You have the right to:

* Restrict the use of your confidential health care information. However, the organization may deny this restriction if it is a conflict of providing you with quality health care or in the event of an emergency situation.
* Receive confidential communication about your healthcare status.
* Review and ask for copies of any or all portions of your healthcare information and for what purpose.
* Make changes to your healthcare information.
* Be informed of who has accessed your confidential information and for what purpose.
* Have a copy of this privacy notice upon request. This copy can be in the form of an electronic transmission or hard copy.

Robert Sadaty is required by law to protect the privacy of his patients. In doing so, will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices securing confidential health care information.

Furthermore, Dr. Robert Sadaty, M.D. will abide by the terms of this notice and will reserve the right to make changes to this notice, while continuing to maintain the confidentiality of all healthcare information. Patients will receive a copy of any changes to this notice within 60 days of making the changes via electronic transmission or hard copy.

You have the right to file a complaint with Dr. Robert Sadaty if you believe your rights have been violated. All complaints could be mailed to:

Dr. Robert Sadaty, MDPA 9400 Fountain Medical Court, Suite 100, Bonita Springs, FL 34135

All complaints will be investigated and no personal issue will be raised if a complaint is filed with Dr. Robert Sadaty.

This privacy notice is effective August 1, 2005.

Pre-Surgical Questions

1. What type of surgery is being planned?

2. When is your surgery date?

3. Are you able to walk one block without experiencing chest pain or shortness of breath?

4. Do you have Rheumatoid Arthritis?

5. Have you ever had a blood clot in the leg or lung?

6. Do you ever experience chest pain or shortness of breath?

7. Have you ever had trouble with anesthesia?

8. When was your last EKG?

9. Have you ever had a stress test?

10. Have you ever recieved a blood transfusion? If yes, did you have an adverse reaction?

Patient Name:
____

REVIEW OF SYSTEMS

Please circle any of the following symptoms that you have been experiencing lately:

GENERAL: Weight changes, appetite changes, unusual weakness, fevers, chills, fatigue, night sweats, vision/hearing changes, nosebleeds, unusual sneezing, sore throat, trouble swallowing, ear pain, hoarse voice.

NECK: Neck pain, swelling, stiffness.

LUNGS: Cough, shortness of breath, coughing up blood.

HEART: Palpations, chest pain.

GASTROINTESTINAL: Abdominal pains, nausea, vomiting, vomiting blood, diarrhea, constipation, bloody/black stools, abnormal amount of passing gas, abnormally thin stools.

URINATION: Painful urination, frequently urinating, slow urine flow, incontinent of urine, blood in the urine.

GYNECOLOGIC (sees for woman only): Vaginal discharge, vaginal bleeding, not flashes.

BONE/JOINTS: Joint pain, joint stiffness, back pain, muscle cramps, muscle pain.

SKIN: Rashes, lesions, abnormal amount of itching.

NEUROLOGICAL: Memory Loss, disorientation, passing out, seeing double, dizziness, vertigo “room spinning”, abnormal clumsiness, numbness, tingling, headache.

PAST MEDICAL HISTORY

NAME: ____

PLEASE LIST ALL OF YOUR ONGOING MEDICAL PROBLEMS (for example, Hypertension, Coronary Artery Disease, etc.)

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

7. ____

8. ____

9. ____

10. ____

11. ____

12. ____

PLEASE LIST ANY SURGERIES THAT YOU HAVE HAD (for example, appendectomy, coronary bypass surgery, pacemaker placed):

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

MEDICATION LIST

Patient Name:

____

***PLEASE INCLUDE ALL MEDICATIONS THAT YOU TAKE INCLUDEING VITAMINS, SUPPLEMENTS, AND PAIN MEDICATIONS. BE AS ACCURATE AS YOU CAN WITH THE NAME, DOSE, AND FREQUENCY (*for example: Ibuprofen 200 mg tablets, one tablet twice per day*).**

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

7. ____

8. ____

9. ____

10. ____

11. ____

List any drug allergies that you have.

1. ____

2. ____

3. ____

4. ____

5. ____