Sunshine Medicine Associates
Advancing Medicine. Touching lives.

Nauman Salim, MD
Board Certified Allergist & Immunologist for Adults & Pediatrics

Samia Malik, MD
Board Certified Neurologist

MEDICAL HISTORY AND ALLERGY SURVEY

Please complete this form. It is important to know the details about your medical history and allergy symptoms.

NAME/NOMBRE: ____DATE/FECHA: _________________

D.O.B/FECHA DE NACIMIENTO: ___________________

EMAIL/CORREO ELECTRONICO: ____________________________________

Health Insurance name/Nombre de Seguro medico: __________________________________

Health Insurance ID number/Numbero de poliza: _______________________

Primary Care Provider name and phone number/nombre de doctor primario y numero de telefono: _______________________

____

Preferred pharmacy/ Farmacia preferida:

____

Pharmacy Address/Direccion de farmacia:

____

____

Circle all that apply/circule todos las que apliquen.

Fever/fiebre	Insect allergy/allergia de insectos	Asthma/asma
Eczema/eczema	Headache/ dolor de cabeza	Food allergies/allergias comida
Drug allergy/allergia de medicamento	Hives/roncha	Bronchitis/bronchitis

Clinical History: Describe your major allergy symptoms. What makes your symptoms worse or better? /describe tus sintmas mayores de allergias. Que hace que sus sintomas mejoren empeoren?

____

____

____

____

What are your expectations from this allergy consultation? Que esperas de esta consulta?

____

____

____

____

____

Height/Estatura: _______ Weight/Peso: ________ Blood pressure/presion de sangre: ___________

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Check all that apply:

SYMPTOMS	EYES/OJOS	EARS/OIDOS	NOSE/NARIZ	THROAT/GARGANTA
Itching/picor				
Swelling/inflamacion				
Burning/ardor				
Sneezing/ Estornudando				
Discharge/descarga				
Pain/dolor				
Tearing/lagrima				
Runny nose/goteo postnasal				

Check all that apply:

SKIN/PIEL:

DERMATITIS____ HIVES/RONCHAS____ RASHES/IRRITACION___

ECZEMA____ SWELLNG/INFLAMACION____

ASTHMA:
COUGH/TOS____ CHEST TIGHTNES/PRESION DE PECHO___ OTHER/OTRAS: ______________

WHEEZING/JADEAR___ SHORTNESS OF BREATH/FALTA DE RESPIRACION___

What time of the year are your allergies worst? En que epoca del año se empeoran sus alergias?
____

What time of day or night is the worst time according to you? A que hora del dia o de noche son peores sus alergias?

____

Does any particular exposure (cat, dust, smoke) make you much worst? Alguna exposicion (gatos, humo) empeora sus sintomas?

____
____

List all food allergies/ Lista todas sus alergias de comidas
____
____
____

Have you had a life-threatening allergic reaction to an insect? Alguna vez has tenido una reaccion alergica potencialmente mortal a una picadura de insecto?

____
____

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HAVE YOU HAD A PREVIOUS ALLERGIST? / HAS TENIDO OTRO ALERGISTA?

Name of doctor/nombre del doctor____

ALLERGY MEDICATIONS/MEDICAMENTOS PARA LAS ALERGIAS

Benadryl	Zyrtec	Claritin-D
Trinalin	Claritin	Semprex-D
Allegra	Allegra-D	

Others/Otras: ____

How often do you use these medications? /Con que frequencia usas estos medicamentos? ______________

Have they improved your symptoms? /Han mejorado sus sinptomas? ______________________

Adverse reactions/reacciones: ____

ASTHMA MEDICATIONS:

Inhalers: Ventolin or Proventil (albuterol)___ Vanceril or Beclovent (beclomethasone)___

Others/otras: ____

How often do you use these medications? /Con que frequencia usas estos medicamentos? ______________

Have they improved your symptoms? /Han mejorado sus sinptomas?______________________

Adverse reactions/ reacciones: ______________________________

CURRENT MEDICATION/MEDICAMENTOS UTILIZADOS

MEDICATION NAME/NOMBRE DE MEDICAMENTO	DOSAGE AND FREQUENCY/DOSIS Y FREQUENCIA

MEDICATION ALLERGIES/ALLERGIAS A MEDICAMENTOS

MEDICATION NAME/NOMBRE DE MEDICAMENTO	REACTION/REACCION

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PAST MEDICAL HISTORY/HISTORIA MEDICO

Have you been hospitalized for asthma? When? /Has sido hospitalizado por asthma? Cuando? ______________________________
____

ENVIORNMENTAL HISTORY/ HISTORIA AMBIENTAL

Do your symptoms occur around any specific environment? /Sus sintomas occurren en un ambiente espesifico?
____
____

Do you suspect that anything causes your symptoms? / Sospechas que algo causa sus sintomas?
____
____

What type of home do you have? (apartment, mobile home, etc.) Que tipo de hogar tienes? (apartamento, casa mobil, etc.)
____

Do you have indoor animals? /Tienes animales en el hogar? ____

Do you have central air conditioning? / Tienes aire acondicionado central? ____

Does air conditioning help with your symptoms? El aire acondicionado ayuda mejorar sus sintomas? _______________________

PERSONAL AND SOCIAL HISTORY

Do you currently smoke? /Fumas? ____________How frequent? /Que tan frequente? ____________________________________

Have you ever smoked? /Has fumado en el pasado? ____When did you quit smoking? /Cuando dejaste de fumar? _____________
____

What is your occupation? /Que es su ocupacion? ____

What are your daily activities? / Actividades diarias?____
____

How long have you lived in Florida? Por cuanto tiempo has vivido en Florida? ____

Where have you lived previously? /Donde has vivido anteriormente? ____

Signature/Firma____Date/Fecha: ____

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME / NOMBRE DE PACIENTE:
____
____

DATE OF BIRTH/ FECHA DE NACIMIENTO:

____
____

ADDRESS/DIRECCION:

____
____

I, ______________________________ hereby authorize and request you to release the following protected health information to Sunshine Medicine Associates the office of Nauman Salim M.D. and Samia Malik M.D.

The patient information being requested may not be further disclosed to any party under any circumstances except with the patients express written consent or as otherwise permitted by law. The information may not be used except for the need specified above.

Yo, _________________________________ autorizo y solocito que divulgue la siguiente informacion medica protegida a Sunshine Medicine Associate la oficina de Nauman Salim M.D. y Samia Malik M.D.

La informacion del paciente que se solicita no puede ser divulgada a ninguna parte bajo ninguna circunstancia excepto con el consentimiento por escrito del paciente o lo permita la ley. La informacion no se puede utilizar excepto para la necesidad especificada.

Signature/Firma____Date/Fecha: ___________________________________

Westchase: 13692 W. Hillsborough Ave Tampa, FL. 33635 **Carrollwood:** 16598 N Dale Mabry Hwy Tampa, FL. 33618
Trinity: 2445 Country Place Blvd Suite #102 New port Richey FL. 34655
Phone: 813-252-2375 **Fax:** 813-324-5680 **E-mail:** sunshineallergyasthma@gmail.com

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Patient Financial Responsibility Form

Thank you for choosing Sunshine Medicine Associates, as your health care provider. We are honored that you selected us, we are committed to providing you with the highest quality healthcare. We do ask that you read and thoroughly understand before signing the following acknowledgment of our patient financial responsibility:

- Patient is ultimately responsible for the payment of his/her treatment and care by our facility.
- Patient is responsible for any costs associated with collection of patient balances.
- Patient is responsible for all copayments and coinsurance of patients' balances
- Patient is made fully aware that failure to pay for his/her treatment and care will result in collection actions being taken to settle the debt
- Medical records: $1 per page for the first 25 pages and $0.25 per page for each additional page

Do you have an HSA account? Yes _________ No__________

Do you currently have your HSA card with you? Yes __________ No__________

Patient Authorizations:

- My signature shows that, I hereby authorization assignment of financial benefits directly to Sunshine Medicine Associates and all associated healthcare entities for services rendered as allowed under third party contracts. I understand and take full financial responsibility for my patient account, all associated fees and balances my care may accrue and give my consent.

I have read, understand, authorization and agree to all the provisions of this patient financial responsibility form.

Print patient name: ____

Patient or guardian signature: ____

Address: ____

Phone number: ____

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Florida law, and not by a lawsuit or resort to court process except as Florida law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
Article 2: **All claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.
All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect the assertion of any claim, against the physician, any fee dispute, whether the subject of any existing court action, shall also be resolved by arbitration.
Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.
Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in the arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that provision of Florida law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.
Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Florida statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the Florida Code of Civil Procedure provisions relating to arbitration.
Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.
Article 6: **Retroactive Effect:** If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services. ______________________________
Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.
I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_________________________ _________________ ________________________________ ______________
Physician's Authorized Representative's Signature | Date | Patient's or Patient's Representative's Signature | Date

____
Print Patient's Name
(If representative, print Name and Relationship to Patient)