PRECISION
Health Primary Care

When it comes to your health, choose Precision.

Shaival Thakore, M.D.
14100 Fivay Road, Suite 100
Hudson, FL 34667
Phone 727-819-2534
Fax 727-819-2687

New Patient Paperwork

Before your first visit

1. Complete the form on your computer and print it, or print it and complete it by hand in blue or black ink.
2. Read our Notice of Privacy Practices and Office Policies handouts before signing. Ask the office if you need copies.
3. Sign the three signed sections by hand and initial where marked. To have us request records from a previous doctor, also complete the separate Records Release Authorization.
4. Bring the completed form to your first appointment, along with your insurance card and a photo ID.
   Questions? Call the office at 727-819-2534.

NEW PATIENT REGISTRATION

First name _____ Last name _____ Date of birth _____

Social Security number _____ Email _____ Cell phone _____ Home phone _____

Street address _____ City _____ State _____ ZIP code _____

Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Primary language: ☐ English ☐ Spanish ☐ Other _____

Ethnicity / race _____ Weight _____ Height _____ Spouse name _____ Spouse phone _____

EMERGENCY CONTACT

Name _____ Relationship _____

Cell phone _____ Home phone _____

Email _____

RESPONSIBLE PARTY

Only if someone other than the patient pays the bill.

Name _____ Relationship to patient _____

Phone _____ Address _____

PRIMARY INSURANCE

Insurance company _____

Group number _____ ID number _____

Policy holder _____ Holder date of birth _____

Relationship to patient _____ Policy holder SSN _____

SECONDARY INSURANCE

Insurance company _____

Group number _____ ID number _____

Policy holder _____ Holder date of birth _____

Relationship to patient _____ Policy holder SSN _____

TREATING PHYSICIANS

Prior primary care physician _____ Date last seen _____

Specialists seen in the last year _____

PREFERRED PHARMACY

Pharmacy name _____ Phone _____

Address (street, city, ZIP) _____

Mail-order pharmacy (if any) _____

Patient name _____ Date of birth _____

ALLERGIES

☐ No known allergies

Allergy (medication, food, latex, other)	Reaction

CURRENT MEDICATIONS

☐ No current medications Need more room? Attach a list.

Medication	Dose	Times per day	Prescribing doctor

Supplements taken

IMMUNIZATIONS

Vaccine	Date of last dose	Vaccine	Date of last dose
Flu		Tetanus (Td/Tdap)	
Pneumonia		COVID-19	
Shingles		Other:	

FAMILY MEDICAL HISTORY

Relative	Condition	Living? Yes	Living? No
Mother		☐	☐
Father		☐	☐
Sibling		☐	☐
Sibling		☐	☐
Children		☐	☐
Grandparents		☐	☐
Other: _____		☐	☐
Other: _____		☐	☐

Patient name _____ Date of birth _____

SURGERIES AND HOSPITAL STAYS

Surgery, or reason for a hospital stay	Date

MEDICAL HISTORY

Check any conditions you have had:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bleeding problems
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Deep vein thrombosis
- ☐ Depression / anxiety
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Heartburn (frequent)
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Irritable bowel
- ☐ Kidney problems
- ☐ Migraines
- ☐ Osteopenia / osteoporosis
- ☐ Other mental health condition
- ☐ Prostate problems
- ☐ Seizure disorder
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Tremors

Cancer: ☐ Yes ☐ No Type: _____

SOCIAL HISTORY

Do you currently consume alcohol? ☐ Yes ☐ No How many drinks per week? _____

Do you currently smoke? ☐ Yes ☐ No If you stopped, how long ago? _____

Do you smoke? ☐ Tobacco ☐ Marijuana ☐ Other _____ Cigarettes per day: _____

Do you drink caffeine? ☐ Yes ☐ No How many cups per day? _____

How often do you exercise? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Have you fallen in the last 12 months? ☐ Yes ☐ No

ADVANCE DIRECTIVES

Do you have a living will? ☐ Yes ☐ No

Do you have a health care surrogate or power of attorney? If yes, please bring a copy to your visit. ☐ Yes ☐ No

Surrogate or power of attorney name _____ Phone _____

TESTING HISTORY

Answer the screening questions that apply to you.

Date of last physical? _____ Date of last lab work? _____ Date of last colonoscopy? _____ Date of last mammogram? _____

Date of last Pap smear? _____ Date of last PSA? _____ Date of last bone density? _____ Date of last eye exam? _____

Eye doctor _____

Patient name _____ Date of birth _____

PATIENT CONSENT

Consent for treatment. The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, which may include but are not limited to laboratory procedures, X-ray examination, medical or surgical treatment or procedures, anesthesia or other services rendered to the patient under the general and special instructions of the patient's physician. Precision Health Primary Care has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Acknowledgment. I have read and understand the Office Policies handout regarding emergency care, after-hours services, and appropriate use of the office. In an emergency, I will call 911 or go to the nearest emergency room.

Initials (by hand) _____

AI-assisted documentation. The Practice may use artificial intelligence (AI) to help document your visit. The AI listens to our conversations and creates a draft of your visit notes. Your provider reviews and approves final documentation before it becomes part of your medical record. Your health information remains protected under HIPAA and all privacy laws. I consent to the use of AI technology.

Initials (by hand) _____

Signature. The undersigned certifies that he/she has read the foregoing, received a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

Signature of patient or authorized person (sign by hand) _____ Printed name _____ Date _____

If signing for the patient, your relationship and authority: _____

HIPAA DISCLOSURES

Use of health information. Precision Health Primary Care (the Practice) uses and shares my health information for treatment, payment, and health care operations as described in its Notice of Privacy Practices. This includes sharing information with providers I am referred to, my insurance company, and others involved in my care or payment, as permitted by law. Some information, such as HIV test results, mental health records, and substance use treatment records, has extra protection under Florida and federal law and will be shared only as those laws allow. Patients with implantable devices consent to the release of their Social Security numbers to the device manufacturer to comply with the Safe Medical Devices Act.

Notice of Privacy Practices. I acknowledge that I received, or was offered, a copy of Precision Health Primary Care's Notice of Privacy Practices effective June 1, 2026. I understand that I may obtain a copy of the current Notice in effect upon request.

People we may speak with. I authorize the Practice to discuss my health information with the people listed below. Check what each person may discuss. This access is granted unless you notify the office of any change.

Name	Relationship	Phone	Medical	Billing
			☐	☐
			☐	☐
			☐	☐

Communication preferences. I consent to receive phone calls and portal messages, regarding appointments, medication refills and test results. Messages left on voicemail, with another person, or at work will be of a non-sensitive nature, such as appointment reminders. Test results and other clinical details will be shared through the patient portal or by phone directly with you.

May we leave a message using the doctor's or practice name:

On your voicemail? ☐ Yes ☐ No With another person? ☐ Yes ☐ No At your work? ☐ Yes ☐ No

Text appointment reminders to your cell? ☐ Yes ☐ No Email about appointments and the portal? ☐ Yes ☐ No

Signature. I have read this section. I agree to the uses and disclosures described above and to the people and communication preferences I selected.

Signature of patient or authorized person (sign by hand) _____ Printed name _____ Date _____

If signing for the patient, your relationship and authority: _____

Office use only. Patient did not sign: reason / good-faith effort _____ Staff initials _____ Date _____

Patient name _____ Date of birth _____

STATEMENT OF FINANCIAL RESPONSIBILITY

Payment and insurance. Payment is due at the time of service. If applicable, Medicare requires a deductible at the beginning of each year. I authorize payment directly to Precision Health Primary Care of any insurance benefits otherwise payable to me, at a rate not to exceed the Practice's regular charges.

Responsibility for payment. I am responsible for payment of this account, including services my insurance carrier or Medicare considers "non-covered."

Out-of-network coverage. The Practice's fees may exceed what my plan considers "usual, customary and reasonable." I agree to pay the Practice's fees in full, even if my insurance reimburses me less.

Bill to / payment instructions

☐ Commercial insurance / third-party payor **Initial** (by hand) _____

☐ Medicare **Initial** (by hand) _____

☐ Medigap* **Initial** (by hand) _____

I hereby authorize Precision Health Primary Care to bill my insurance company and/or Medicare (indicated or initialed above) for services provided to me and request that payments for such services to be made to the Practice on my behalf.

*If Medigap: name of beneficiary	Medigap policy number	Health insurance claim number

Office policies

The full policies are in the Office Policies handout. Please read it and keep it for your records.

Acknowledgment. I understand the referral and authorization policy in the Office Policies handout, including that referral requests need at least 7 business days' notice and that I may be responsible for the full cost of services received without a required authorization. **Initials** (by hand) _____

Acknowledgment. I understand the cancellation and no-show policy in the Office Policies handout: I will give at least 1 business day's notice to cancel, and after my first late cancellation or no-show, each one is charged a $50 fee that insurance does not cover. **Initials** (by hand) _____

Signature. I have read this Statement of Financial Responsibility and agree to its terms.

Signature of patient or authorized person (sign by hand)	Printed name	Date

If signing for the patient, your relationship and authority: _____