## Internal Medicine & Geriatrics Associates

**Dr. Jahanzeb Chaudhry** **Dr. Sonal Patel**

Patient Name: _____ DOB:_____

Male ◯ Female ◯ Cell Phone: _____ Home:_____

Home Address: _____

Email Address: _____ Would you like email reminders at this address?
SS#_____ Yes ◯ No ◯

**Insurance Information:** Ins company Name: _____

Id# or Policy #: _____ Group :_____

RX BIN#: _____ RX Group#:_____ PCN#:_____

Ins Address: _____

Ins Phone#: _____

Primary Holders Name and DOB if other than yourself:
_____

_____

**Who is the primary insurance holder? (please circle one)**
Self Spouse Parent/Guardian

Secondary Insurance or RX Prescription Card**: _____**

_____

**Pharmacy Name: _____Phone: _____**

**Address: _____**

**Is there anyone we can speak to/call about appointments other than yourself? Yes ◯ No ◯**
Please list their name: _____ Phone #: _____

**I Authorize release of any health information concerning my healthcare, advice and treatment provided for evaluating claims insurance benefits, lab services and or referring doctors or specialists.

**Patient Signature: _____** **Date: _____**

FOR OFFICE USE ONLY: ENTERED IN EMR? YES NO INITIAL: _____

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**EMR INFORMATION:**

ETHNICITY: ☐ Asian ☐ Black or African American ☐ White

☐ Hispanic / Latino ☐ Patient declined to specify ☐ Other

**CIRCLE ONES THAT APPLY:** MARRIED SINGLE DIVORCED WIDOWED SEPERATED

SOCIAL HISTORY: Smoking (how much/ how often)_____

Alcohol (how much/how often) _____

Recreational drug use (what kind/how much/how often) _____

MEDICAL HISTORY: Surgical History: _____

Family Medical History_____

*Allergies (Rx and or Environmental; reaction and level of severity (mild, moderate, severe)-

_____

_____

Please list all current Medications: _____

_____

**Authorized Representative** : please list and persons whom we may speak to about your medical condition and diagnosis including treatment, payment and healthcare operations. They may also pick up medical records, radiology results, prescriptions and may receive phone calls regarding appointments.

NAME_____ RELATIONSHIP_____

NAME_____RELATIONSHIP_____

EMERGENCY CONTACT AND PHONE# _____

* I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY HEALTHCARE, ADVICE AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING CLAIMS INSURANCE BENEFITS. I ALSO HERABY AUTHORIZE PAYMENT OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE DOCTOR.

Signature of Patient X_____ DATE _____

**Internal Medicine & Geriatrics Associates**

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## MEDICAL HISTORY

PATIENT NAME_____ DOB_____

HEIGHT_____ WEIGHT_____ SEX: MALE___ FEMALE___

REASON FOR VISIT_____

IS YOUR INJURY WORK RELATED? (WORKERS COMP) Y__ N__

IS YOUR INJURY FROM AN AUTOMOBILE ACCIDENT? (NO FAULT) Y__N__

***Do you have any of the following illnesses:***

PLEASE CIRCLE ALL ANSWERS –WETHER ***YES*** OR ***NO***

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Disease | No | Yes | Kidney Disease | No | Yes | Epilepsy | No | Yes |
| High Blood Pressure | No | Yes | Liver Disease, Hepatitis | No | Yes | Migraine Headaches | No | Yes |
| Blood clots | No | Yes | Gall Bladder Disease | No | Yes | Arthritis | No | Yes |
| Blood circulation Problems | No | Yes | Stomach Problems, Ulcer | No | Yes | Rheumatoid Arthritis | No | Yes |
| Phlebitis | No | Yes | Enlarged Prostate | No | Yes | Lupus | No | Yes |
| Bleeding tendencies | No | Yes | Diabetes | No | Yes | Lyme Disease | No | Yes |
| Anemia | No | Yes | Hypoglycemia | No | Yes | Glaucoma | No | Yes |
| Asthma | No | Yes | Cancer, Tumor, Masses | No | Yes | Cataracts | No | Yes |
| Bronchitis | No | Yes | HIV/AIDS | No | Yes | Infection | No | Yes |
| Pneumonia | No | Yes | Eczema, Hives, Rashes | No | Yes | Thyroid Disease | No | Yes |
| Tuberculosis | No | Yes | Depression | No | Yes | Other | No | Yes |

# Internal Medicine & Geriatrics Associates

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**Patient Name_____ Date of Birth_____**

Review of systems (do you have or have you had and of the following within the past year)

Please circle whether **YES** or **NO**

| **HEAD & NECK** | | | **CONSITIUTIONAL** | | | |
|---|---|---|---|---|---|---|
| Chronic Headaches | **No** | **Yes** | Recent Weight Change | **No** | **Yes** | |
| Lumps or Swelling | **No** | **Yes** | Recurrent Fevers | **No** | **Yes** | |
| Stiff or Painful Neck | **No** | **Yes** | Fatigue | **No** | **Yes** | |
| **EYES** | | | **MOUTH** | | | |
| Blurred or Double Vision | **No** | **Yes** | Taste Changes | **No** | **Yes** | |
| Watering or Itchiness | **No** | **Yes** | Sore Tongue, Sore or Swollen Gums | **No** | **Yes** | |
| Any Change or Decline in Vision | **No** | **Yes** | Dental Problems | **No** | **Yes** | |
| **EARS** | | | **NOSE/THROAT** | | | |
| Earache(s) | **No** | **Yes** | Frequent Colds or Sneezing | **No** | **Yes** | |
| Drainage Discharge from Ear(s) | **No** | **Yes** | Nose Bleeds | **No** | **Yes** | |
| Ringing/Noise in Ear(s) | **No** | **Yes** | Difficulty Swallowing | **No** | **Yes** | |
| Difficulty Hearing | **No** | **Yes** | Hoarseness of Voice | **No** | **Yes** | |
| **NEUROLOGIC** | | | Broken Nose or Deviated Septum | **No** | **Yes** | |
| Frequent Dizziness | **No** | **Yes** | Snoring | **No** | **Yes** | |
| Numbness/Tingling | **No** | **Yes** | **DIGESTIVE** | | | |
| Fainting | **No** | **Yes** | Nausea or Vomiting | **No** | **Yes** | |
| Convulsions/Seizures | **No** | **Yes** | Heartburn | **No** | **Yes** | |
| Trembling | **No** | **Yes** | Vomiting of Blood | **No** | **Yes** | |
| Memory Difficulties | **No** | **Yes** | Diarrhea | **No** | **Yes** | |
| **MUSCULOSKELETAL** | | | Constipation | **No** | **Yes** | |
| Recurrent Back or Neck Pain | **No** | **Yes** | Pain w/ Stool or Rectum | **No** | **Yes** | |
| Joint Pains or Problems | **No** | **Yes** | Change in Bowel Habits | **No** | **Yes** | |
| Muscle Pains | **No** | **Yes** | Excess gas, Bloating | **No** | **Yes** | |
| **CARDIOVASCULAR/ CIRCULATION** | | | Hemorrhoids | **No** | **Yes** | |
| Chest Pain, Tightness or Pressure | **No** | **Yes** | **GENITOURINARY** | | | |
| Fast or Irregular Heart Rate | **No** | **Yes** | Painful or Burning | **No** | **Yes** | |
| Leg Cramps on Walking or at Night | **No** | **Yes** | Frequent of Nocturnal Urination | **No** | **Yes** | |
| Swelling of Hands, Ankles, or Feet | **No** | **Yes** | Difficulty Starting or Stopping Urination | **No** | **Yes** | |
| High Blood Pressure | **No** | **Yes** | Loss of Control or Dribbling Urine | **No** | **Yes** | |
| Varicose Veins | **No** | **Yes** | Brown or Bloody Urine | **No** | **Yes** | |
| Dizziness or lightheadedness | **No** | **Yes** | Prostate Problems (men only) | **No** | **Yes** | |
| Sleeps on Two or More Pillows | **No** | **Yes** | **WOMEN ONLY: MENSTRUAL** | | | |
| **RESPITORY** | | | Date of last menstrual cycle | | | |
| Chronic or Frequent Cough | **No** | **Yes** | pregnancy | **No** | **Yes** | |
| Coughed up Blood | **No** | **Yes** | **ENDOCRINE** | | | |
| Shortness of Breath | **No** | **Yes** | Excessive Thirst or Urination | **No** | **Yes** | |
| | | | Inability to Tolerate Heat or Cold | **No** | **Yes** | |

**PATIENT INFORMATION CONTINUED:**

REFFERED BY_____

EMPLOYER _____ STUDENT: FT ◯ PT ◯

EMPLOYER ADDRESS_____

WORK PHONE: _____

PRIMARY CARE PHYSICIAN (OTHER THAN OUR OFFICE)_____

ADDRESS_____ PHONE#_____

## EMERGENCY CONTACT INFORMATION:

EMERGENCY CONTACT NAME_____RELATIONSHIP_____

PHONE #_____

EMERGENCY CONTACT NAME_____RELATIONSHIP_____

PHONE #_____

## NOTICE OF PRIVACY PRACTICES

## PATIENT ACKNOWLEDGEMENT OF RECIPT OF NOTICE

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) called for the establishment of standards and requirements for transmitting certain health information to improve the efficiency and effectiveness of the health care system while protecting patient privacy. The Administrative Simplification Regulations have been developed to implement these statutory provisions.

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

**THIS IS TO ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED NOTICE OF PRIVACY PRACTICES. SHOULD I HAVE ANY QUESTIONS REGUARDING THE NOTICE OF PRIVACY PRACTICES, I UNDERSTAND THAT I CAN CONTACT THE PRIVACY OFFICER 631-588-4888.**

**Patient's signature x_____ Date_____**