PATIENT INFORMATION

Patient's Name _____
LAST FIRST MIDDLE

Street Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Birth Date _____ Age _____ Sex _____

Other Phone (_____) _____

Driver's License No. _____ Social Security No. _____

Patient's Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed

Name of Employer _____

Employer's Address _____

City _____ State _____ Zip _____

Work Phone (_____) _____

Spouse's Name _____ Birth Date _____ Social Security No. _____

Spouse's Employer's Name _____

Spouse's Employer's Address _____

City _____ State _____ Zip _____

Work Phone (_____) _____

Emergency Contact _____ Phone (_____) _____

Financially responsible party if patient is a dependent _____

Phone No. (_____) _____

Address of responsible party _____

City _____ State _____ Zip _____

will be paying by: ☐ Insurance ☐ Cash ☐ Check ☑ Credit Card

nsurance Company Name _____

Medicare No. _____ Medi-Cal No. _____

EFAULT PROVISION: SHOULD PATIENT OR RESPONSIBLE PARTY FAIL TO PAY FOR SERVICES RENDERED, RESPONSIBLE PARTY AGREES O PAY FOR ATTORNEY'S FEES, COLLECTION FEES EQUAL TO ONE-HALF THE PRINCIPLE BALANCE, AND COURT COSTS TO ENFORCE AYMENT OF SERVICES RENDERED.

ELEASE AND ASSIGNMENT: I HEREBY AUTHORIZE RELEASE OF INFORMATION BY DR. ANKUR GUPTA , M.D.
O MY INSURANCE COMPANY TO FACILITATE PROCESSING OF CLAIMS AND FURTHER AUTHORIZE PAYMENT DIRECTLY TO HIM FOR REATMENT OF SERVICES RENDERED.

ATE _____ SIGNATURE OF RESPONSIBLE PARTY _____

eferring Physician:

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

MEDICAL HISTORY

(If additional space is needed please continue on back)

Name _____ Today's Date _____

Date of Birth _____ Age ____

Why were you referred to this office/complaint:

_____

_____

Social History:

Do you smoke? __Yes __No If yes, how many cigarettes a day? _____

Do you drink alcohol? __Yes __No If yes, how much do you drink? _____

Do you have any medical problems?

__Heart Condition __High blood pressure __Stroke __Ulcers __Gastritis __Diabetes __Hepatitis __Kidney problems

__Cancer (what kind) _____

__Any other medical problems (please describe) _____

_____

Please list any surgery you have had and approximately when it was performed:

PROCEDURE	YEAR
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you experienced any complications of surgery (bleeding, infection, etc.)? __No __Yes

If yes please explain _____

_____

Please list all current medications and their dosages

_____ _____

_____ _____

_____ _____

_____ _____

Do you have any allergies to any medications? __No __Yes

What was the reaction? _____

Do you take any aspirin, Advil, Nuprin, Motrin, etc.? __No __Yes

MEDICAL HISTORY

(If additional space is needed please continue on back)

Name_____ Today's Date_____

Family History: Please give the age and any health problems of the following relatives (give age at death and cause, if deceased):

Father _____ Sister _____

Mother _____ Sister _____

Brother _____

Brother _____

Review of Systems: (Check symptoms you currently have or have had in the past year)

General
- __ Fever
- __ Persistent headaches
- __ Weight loss
- __ Sweats

Cardiovascular
- __ Chest pain
- __ Shortness of breath on exertion
- __ Shortness of breath when lying flat
- __ Swelling of ankles
- __ Irregular / rapid heart beat

Gastrointestinal
- __ Abdominal pain
- __ Indigestion
- __ Excessive thirst
- __ Nausea
- __ Vomiting
- __ Vomiting blood
- __ Problems swallowing
- __ Diarrhea
- __ Constipation
- __ Rectal bleeding
- __ Fresh blood in bowel movements
- __ Black colored stools

Men only
- __ Breast / chest lump
- __ Lump in testicles
- __ Penis discharge
- __ Sore on penis

Skin
- __ Bruise easily
- __ Sore that won't heal

Respiratory
- __ Cough
- __ Coughing up phlem
- __ Coughing up blood
- __ Pain in chest with deep breaths

Genitourinary
- __ Frequency of urination
- __ Burning on urination
- __ Blood in your urine
- __ Lack of bladder control

Women only
- __ Breast lump
- __ Nipple discharge
- __ Bleeding between periods