ALPHA MEDICAL CLINIC

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Internal Medicine/Family Practice

Diplomate of American Board of Internal Medicine

NEW PATIENT INFORMATION

NAME: ____ SEX: ______
last name first name

ADDRESS: ____

____
city state zip code

DATE OF BIRTH: ________________________ AGE: ______ SSN: __________________

PHONE: ______________________________ E-MAIL: ____________________________

EMERGENCY CONTACT: ____

REFERRED BY: ____

INSURANCE INFORMATION

Do you have insurance? [ ] YES [ ] NO

SUBSCRIBER: ____

INSURANCE: ____

MEMBER ID: ________________________________ GROUP: ____________________

I give consent for treatment by Dr. Dhiraj Patel and Dr. Neil Patel. I fully understand that payment/copayment are required at the time of service. Should my insurance be filed, any unpaid balance is my personal responsibility. I further authorize the release of any medical information to my insurance company when necessary. In the event that insurance is filed by the doctors' office, I authorize benefits to be paid directly to Alpha Medical Clinic.

Signature: ____ Date: _____________

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NEW PATIENT HISTORY AND PHYSICAL FORM

Please state in your own words your medical reason(s) for coming to our office:

____

____

____

PAST Medical and Surgical History **(Please fill out completely)**

Do you have any drug **allergies**? (Please circle one) No Known Drug Allergies

Penicillin Sulfa Tetracycline Cipro/Levaquin Erythromycin IV Iodine Macrobid Gentamycin

Other Allergies: ____

____

Have you had any **medical problems** in the past or currently taking medications for:

Diabetes	High Blood Pressure	Coronary Heart Disease	Atrial Fibrillation	Asthma
COPD	Kidney Stones	Hypothyroidism	Hypercholesterolemia	Stroke
Gastric Reflux	Gout	Arthritis	Morbid Obesity	Seizures
Seasonal Allergies	Depression	Cancer (Type ________________)		NONE

PLEASE LIST ANY OTHER MEDICAL PROBLEMS (NOT LISTED ABOVE) THAT YOU HAVE BEEN TREATED FOR IN THE PAST:

____

____

Please list all of your past **surgeries**: □ None

Appendectomy	Tonsillectomy	Hysterectomy (uterus)	Cholecystectomy (gall bladder)
Spine Surgery	Colonoscopy	Hernia Locations ______	Hip Replacement
Knee R L	Shoulder R L	Coronary Stents	Coronary Bypass Graft ___ vessels
C-Section	Tubal Ligation	Gastric Bypass	Peripheral Vascular Bypass

Other: ____

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NEW PATIENT HISTORY AND PHYSICAL FORM (cont'd)

Please detail your **social** history:
Do you smoke? □ Yes □ No How many packs a day? ____ For how many years? ____
Have you quit? □ Yes □ No What year? _______
Do you drink alcohol? □ Yes □ No How many drinks per week? _______
Do you use any illicit drugs (please list): ____

Please detail your **family** history: (any disease that your parents, grandparents, or siblings have/had)
Prostate Cancer ________ Kidney Cancer ________ Bladder Cancer ________ Breast Cancer ________
Kidney Stones _______ High Blood Pressure _______ Diabetes _______ Gout _______ Arthritis _______
Other: ____

PLEASE LIST ANY OTHER FAMILY PROBLEMS (NOT LISTED ABOVE):
____
____

Are you: □ Married □ Single □ Divorced □ Widowed
How many pregnancies (if applicable): __________ How many children do you have: ________
What is your occupation: ____

REVIEW OF SYSTEMS (please check any ***new*** symptoms that you have ***recently*** had):

Genitourinary
Urinary frequency
Urinary urgency
Blood in the urine
Flank pain
Sense of not emptying bladder
Burning/painful urination
Incontinence of urine

Constitutional
Fever
Chills
Headaches

Integumentary
Skin rash
Boils
Persistent itch

Gastrointestinal
Hepatitis
Ulcer/Reflux
Constipation

Musculoskeletal
Back pain/surgery
Muscle disorder
Joint disorder

Sight/Sound
Blurred vision
Glaucoma
Loss of hearing/ringing

Pulmonary
Wheezing
Frequent cough
Shortness of breath

Endocrine
Diabetes
Thyroid disease
Parathyroid disease

Ear/Nose/Throat
Ear infection
Sore throat
Difficulty swallowing

Circulatory
Chest Pain
High blood pressure
Varicose vein

Neurological
Dizziness
Migraine
Multiple Sclerosis

Hematologic/Lymphatic
Lymph node swelling
Bleeding disorder
Immune disorder (HIV)

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ADDITIONAL INFORMATION

If there is additional information regarding your medical history that we should be aware of (such as specialist information or medications), please detail it here:

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PAIN MEDICATION AND PRESCRIPTION REFILL POLICY

1. I agree to allow 48 hours for prescription refills.
2. I understand that prescription refills requested after 4:00pm will not be received until the next business day.
3. I understand that a follow-up visit is required from my physician to obtain a refill.
4. I agree to take all medication exactly as instructed. I am **NOT** allowed to change dosage amounts or alter the time schedule of taking the medication without speaking to my physician.
5. Narcotics and non-narcotic medications will **NOT** be phoned in after hours or on weekends.
6. Patients may be terminated from the practice with 30 days notice for noncompliance in taking of their medications.
7. Alpha Medical Clinic will **NOT** refill prescriptions that have been lost or misplaced.
8. I must keep all appointments as recommended.
9. I will not give, trade, or sell prescriptions.
10. The following are conditions for immediate termination from the practice;
    a. Obtaining narcotics from other physicians while under Alpha Medical Clinic care.
    b. Altering or forging of a prescription. *This is a felony and will be reported*
11. I am aware that most of the manufactures of drugs used to treat chronic pain recommend against the operation of heavy equipment, which includes driving a motor vehicle. Please be aware that if you choose to drive a vehicle you could be charged with a DUI.
12. I will not combine any narcotic medications with the consumption of alcohol.
13. Only one pharmacy may be used for filling prescriptions. My pharmacy and its location:

    ____

    ____

I have read, understand, and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe me pain medications.

Signature: ______________________________________ Date: ______________

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PATIENT CONSENT FORM HIPAA

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

You may refuse to consent to use or disclosure of your personal health information, but this MUST be in writing. Under this law, we have the right to perform this exam should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Office.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Name: ____ Date of Birth: ___________

Signature: ____ Date: ___________________