RAKESH PATEL INTERNAL MEDICINE

3350 SIX FORKS ROAD
RALEIGH, NC 27609
PH- 919-782-5288, Email:apptdrpatel@gmail.com

DATE:____________________________

PATIENT NAME:____

DATE OF BIRTH:____________________________AGE:____________ SOCIAL SECURITY #:__________________________________

GENDER: ☐ MALE ☐ FEMALE **MARITAL STATUS:** ☐ SINGLE ☐ MARRIED ☐ WIDOW ☐ DIVORCED ☐ SEPARATED

PHONE #:____ SECONDARY PHONE #:__________________________________

STREET ADDRESS:____

CITY:______________________________________ STATE:______________________________ ZIP CODE:____________________

E-MAIL:____ OCCUPATION:_________________________

EMPLOYER:____ EMPLOYER PHONE:__________________________________

EMERGENCY CONTACT:____ RELATIONSHIP:_______________________

EMERGENCY CONTACT NUMBER:______________________________________

WHOM MAY WE THANK FOR REFERRING YOU TO US?:____

INSURANCE COMPANY:____

SUBSCRIBER ID:____ GROUP:__________________________________

IF SUBSCRIBER IS NOT THE PATIENT, PLEASE TELL US ABOUT THE POLICY HOLDER

POLICY HOLDER'S NAME:____ POLICY HOLDER'S DATE OF BIRTH:______________

POLICY HOLDER'S PHONE #:____________________________________RELATIONSHIP TO PATIENT:_____________________

POLICY HOLDER'S EMPLOYER:___________________________________EMPLOYER PHONE #:__________________________

STREET ADDRESS OF POLICY HOLDER:____

CITY:______________________________________ STATE:______________________________ ZIP CODE:____________________

REASON FOR VISIT:____

PLEASE LIST ANY ALLERGIES TO MEDICATION, X-RAY DYES OR FOOD:_____________________________________

THE INFORMATION ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. I/WE UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT PAID BY INSURANCE. IN THE EVENT OF DEFAULT, I/WE AGREE TO PAY ALL COST OF COLLECTION, INCLUDING ATTORNEY FEES.

X____

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE PREPARATION OF INSURANCE CLAIMS ON MYSELF. I AUTHORIZE THE INSURANCE TO MAKE PAYMENT DIRECTLY TO THE PHYSICIAN. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURACNE CLAIMS, INCLUDING ELECTRONIC SUBMISSIONS.

X____

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3350 SIX FORKS ROAD, RALEIGH, NC 27609
PHONE: 919-782-5288/EMAIL:APPTDRPATEL@GMAIL.COM

DATE:________________________

PATIENT DEMOGRAPHICS

FULL NAME:____ DOB:__________________GENDER: ☐ FEMALE ☐ MALE

HOME ADDRESS:____

PRIMARY PHONE:_____________________________________ EMAIL/SECONDARY PHONE: ______________________________

DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)? ☐ YES ☐ NO

LIST ANY CURRENT MEDICAL PROBLEMS OR CHRONIC ILLNESSES

1. ____ 4. ____

2. ____ 5. ____

3. ____ 6. ____

LIST ANY PHYSICIANS AND/OR PRACTIONERS YOU CURRENTLY SEE

NAME: ____ SPECIALTY: _________________________________

NAME: ____ SPECIALTY: _________________________________

NAME: ____ SPECIALTY: _________________________________

LIST ANY MEDICATION THAT YOU CURRENTLY TAKE, NOT OVER-THE-COUNTER

1.			
2.			
3.			
4.			
5.			

LIST ANY ALLERGIES TO MEDICATION, X-RAY DYES OR FOOD

1. ____________________ REACTION(S): ____________________

2. ____________________ REACTION(S): ____________________

3. ____________________ REACTION(S): ____________________

RECORD THE LAST YEAR YOU HAD THE FOLLOWING. IF YOU DO NOT KNOW, LEAVE BLANK

FLU VACCINE	LIPID PANEL	PELVIC EXAM/PAP SMEAR
TDAP/TETANUS VACCINE	GLUCOSE/HBA1C READING	MAMMOGRAM
SHINGLES VACCINE	PSA TEST	COLONOSCOPY/COLOGUARD
PNEUMONIA VACCINE	PROSTATE/RECTAL EXAM	BONE DENSITY SCAN
HEPATITIS B SHOT	GLAUCOMA/EYE EXAM	HEARING EXAM

LIST ANY PAST SURGERIES OR HOSPITALIZATIONS

1. ____________________ YEAR: ________ 2. ____________________ YEAR: ________

3. ____________________ YEAR: ________ 4. ____________________ YEAR: ________

5. ____________________ YEAR: ________ 6. ____________________ YEAR: ________

LIST ANY CHILDHOOD ILLNESSES

____

LIST HEALTH PROBLEMS AND CAUSES OF DEATH IF APPLICABLE

LIVING (L) OR DECEASED (D)		AGE	MEDICAL PROBLEMS OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHER(S)			
SISTER(S)			
MOTHER'S FATHER			
MOTHER'S MOTHER			
FATHER'S FATHER			
FATHER'S MOTHER			

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER:_______________________

OCCUPATION: ______________________

DIET: ☐ BALANCED ☐ VEGETARIAN ☐ DIABETIC ☐ LOW FAT ☐ LOW CARB ☐ OTHER:_________________________

DO YOU DO ANY FORM OF REGULAR EXERCISE EVERY DAY? ☐ YES ☐ NO IF YES, HOW MUCH? ___________________

DO YOU WEAR SEATBELTS? ☐ YES ☐ NO

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW MUCH? ____

ARE OTHERS CONCERNED ABOUT YOUR DRINKING? ☐ YES ☐ NO

TOBACCO USE- NEVER/PAST/CURRENT CIGARETTE/CIGAR/PIPE DIP/CHEWING DATE START__________STOP______

QUANTITY PER DAY________________

DO/HAVE YOU USE/USED ANY ILLICIT DRUGS? ☐ YES ☐ NO IF YES, THEN WHAT AND WHEN LAST USED?_____________

ENGAGED IN HIGH RISK SEXUAL ACTIVITIES? ☐ YES ☐ NO

AUTHORIZED SIGNATURE: ____ DATE: ________________________

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3350 SIX FORKS ROAD, RALEIGH, NC 27609. Ph: 919-782-5288, Fax: 919-782-5287

MEDICAL RECORDS RELEASE REQUEST

RELEASE MEDICAL RECORDS

FROM: (Name, Address, Ph/fax no.) **TO**: (Name, Address, Ph/fax no.)

____
____

____
____

____
____

___ ___

PATIENT INFORMATION

Full name:____

DOB:________________________

Address:

____

Phone:__________________________________

Email:____

___ ___

Date range from ________________**To**______________

___All office notes ___Cardiology/EKG reports

___Labs/Path reports ___Immunizations

___Radiology reports ___Other_______________

For the purpose of:

___Transfer care/Continuity of care or Referral

___Insurance/legal matter

___Personal Copy (charge may apply)

____

___I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I do not need to sign this form to in order to assure treatment. I understand that any disclosure of information carries with it the potential of an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

___I understand that information in my health record may include information relating to sexually transmitted disease, AIDS/HIV and other communicable disease, behavioral health and treatment of alcohol and /or drug abuse.

___I understand that I can revoke the authorization at any time, except to the extent that action based on the authorization has already been taken. I understand that if I revoke this authorization I must do so in writing.

___I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

____

____

(Signature of Patient/Guardian or Authorized Representative) Date(This authorization expires 1 year from today)

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PATIENT CONSENT FOR PHYSICIAN TO USE OR DISCLOSE HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE.

PATIENT'S NAME:____

DATE OF BIRTH:________________________ **SOCIAL SECURITY NUMBER:**__________________________

TO GIVE CONSENT TO DISCLOSE HEALTH CARE INFORMATION TO SOMEONE OTHER THAN THE PATIENT, PLEASE WRITE THEIR NAME BELOW: (E.G. FAMILY MEMBER, CARETAKER)

NAME:____**RELATIONSHIP:**__________________

I UNDERSTAND THAT MY HEALTH INFORMATION IS PRIVATE AND CONFIDENTIAL. I UNDERSTAND THAT **RAKESH PATEL INTERNAL MEDICINE** WORKS VERY HARD TO PROTECT MY PRIVACY AND PRESERVE THE CONFIDENTIALITY OF MY PERSONAL HEALTH INFORMATION.

I UNDERSTAND THAT SIGNING THIS DOCUMENT MEANS THAT **RAKESH PATEL INTERNAL MEDICINE** MAY USE AND DISCLOSE MY PERSONAL HEALTH INFORMATION TO HELP PROVIDE HEALTH CARE TO ME, TO HANDLE BILLING AND PAYMENT, AND TO TAKE CARE OF OTHER HEALTH CARE OPERATIONS. FAILURE TO SIGN THIS CONSENT MAY RESULT IN THE PHYSICIAN DECLINING TO TREAT ME.

UNDER THE TERMS OF THIS CONSENT, I CAN ASK **RAKESH PATEL INTERNAL MEDICINE** TO RESTRICT HOW MY PERSONAL HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. I UNDERSTAND THAT **RAKESH PATEL INTERNAL MEDICINE** DOES NOT HAVE TO AGREE TO MY REQUEST. IF IT DOES AGREE TO MY REQUEST, I UNDERSTAND THAT IT WOULD FOLLOW THE AGREED LIMITS.

I UNDERSTAND THAT I HAVE THE RIGHT TO CANCEL THIS CONSENT IN WRITING AT ANY TIME. IF I DO CANCEL THE CONSENT, I UNDERSTAND THAT **RAKESH PATEL INTERNAL MEDICINE** MAY HAVE ALREADY USED OR DISCLOSED INFORMATION ABOUT ME AND CANCELING THIS CONSENT WOULD NOT AFFECT THE INFORMATION ALREADY USED OR DISCLOSED.

I MAY CANCEL THIS CONSENT AT ANY TIME BY DOING THE FOLLOWING:

WRTING, SIGNING, AND DATING A LETTER TO **RAKESH PATEL INTERNAL MEDICINE** THAT SAYS I WANT TO REVOKE MY CONSENT TO AUTHORIZE THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPTIONS.

I UNDERSTAND IF I CANCEL THIS CONSENT, **RAKESH PATEL INTERNAL MEDICINE** IS NOT OBLIGATED TO PROVIDE FURTHER HEALTH CARE SERVICES TO ME.

MY SIGNATURE BELOW INDICATES THAT I AGREE TO THE POLICIES OUTLINED BY THIS DOCUMENT AND ALL STATEMENTS THEREIN.

____ ____________________

PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL'S SIGNATURE **DATE**

____

RELATIONSHIP TO THE PATIENT IF SIGNED BY ANYONE OTHER THAN HIM/HER (PARENT, LEGAL GUARDIAN, PERSONAL REPRESENTATIVE, ETC.)