ANIL SHAH MD FACS SC

Patient Information

Name (Last, First, MI)				Date
Street Address			E-Mail	
City	State	Zip	Age	Date of Birth
Social Security Number	Home Phone ( ) -		Cell Phone ( ) -	
Occupation	Employer	Marital Status (Circle one) Single Married Divorced Widowed Separated		

Emergency Contact

Name	Relationship to Patient
Daytime Phone ( ) -	Evening Phone ( ) -

Referal Info

Referring Phsician's Name (if applicable)	Phone Number (if known) ( ) -
Address (if known)	

Primary Care Physician	Phone Number ( ) -	Pharmacy and Phone Number ( ) -

Insurance Information

Primary Insurance Company	Policy Number	Group Number		
Claims Address	City	State	Zip	Phone ( ) -
Patient Relationship to Insured (Circle One) Self Spouse Child Other _____	Name of subscriber (if other than patient)			
Subscriber's Social Security Number	Gender Male Female	Date of Birth		
Secondary Insurance Company	Policy Number	Group Number		
Claims Address	City	State	Zip	Phone ( ) -
Patient Relationship to Insured (Circle One) Self Spouse Child Other _____	Name of subscriber (if other than patient)			
Subscriber's Social Security Number	Gender Male Female	Date of Birth		

Assignment and Release

Please read the following and sign below:

Assignment of Benefits and Release of Information
I hereby authorize my insurance benefits to be paid directly to the undersigned physician. I understand that I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

Medicare Patients
I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine benefits for this or a related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or to the party who accepts assignment.

Notice of Privacy Practices Acknowledgment
By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Signature: _____ Date: / / .

ANIL SHAH MD FACS SC

MEDICAL QUESTIONNAIRE

PATIENT's NAME
(Last, Middle, First)_____Date:_____

What brings you to the doctor's office today?
_____

How did you hear about us?
_____

PAST MEDICAL HISTORY:
_____
_____
_____
_____
_____
_____

Please list any prior surgeries (Date/ Procedure):
_____
_____
_____
_____
_____

What PRESCRIPTION medications do you take?

MEDICATION	MEDICATION

Non-prescription (over the counter/herbal/homeopathic/vitamins) medications?
_____
_____

Do you have any allergies to medications? Please list the names and type of reaction:

ALLERGIC TO	REACTION	ALLERGIC TO	REACTION

Height_____ Weight_____

FAMILY HISTORY: Do any of your blood relatives have problems with the following. Check any that apply.
□ Asthma □ Diabetes □ Tuberculosis □ High blood pressure □ Stroke□ Headaches
□ Hearing Loss □ Heart Disease □ Allergies □ Thyroid Disease □ Cancer □ Bleeding Problems
□ Problems with Anesthesia □ Autoimmune Disease □ Brain Tumor

SOCIAL HISTORY:
Do you smoke? NO YES *How Much?* _____*packs per day*. *How Long?* ____years. Quit? _____*years ago.*
Do you drink: Caffeinated beverages? NO YES ____ *Cups per day?*
Alcohol? NO YES *How much?* _____

DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY

GENERAL	NO	( )Fever ( )Weight Change ( )Fatigue ( ) Radiation
EYES	NO	( )Visual Loss ( )Glaucoma ( )Cataracts ( )Itchy Eyes ( )Tearing ( )Blurred Vision ( )Dry Eyes
EARS	NO	( )Vertigo ( )Dizziness ( )Ringing Noises ( )Hearing Loss ( )Hearing Aid ( )Infections
NOSE	NO	( )Discharge ( )clear ( )colored ( )thick ( )thin ( )Post nasal drip ( )Obstruction ( ) Bleeding ( )Sneezing
MOUTH	NO	( )Lumps ( )Dental Problems ( )Tonsillitis ( )Mouth Sores
THROAT	NO	( )Hoarseness ( )Voice Change ( )Problem Swallowing ( )Pain
NECK	NO	( )Pain ( )Lumps ( )Thyroid nodules ( )Swollen Glands
SKIN	NO	( )Breast Lumps ( )Psoriasis ( )Skin Growths ( )Rash ( )Itching
LUNGS	NO	( )Wheezing ( )Asthma ( )COPD ( )Bronchitis ( )Emphysema ( )Coughing up Blood ( )Chronic Cough ( )Pneumonia ( )Positive TB Test ( )Shortness of Breath
SLEEPING	NO	( )Snoring ( )Apnea ( )Insomnia ( )Waking up tired ( )Daytime Tiredness
HEART	NO	( )High Blood Pressure ( )Coronary Artery Disease ( )Myocardial Infarction ( )Chest Pain ( )Mitral Valve Prolapse ( )Congestive Heart Failure ( )Heart Valve Disease ( )Angina ( ) Murmurs ( )Rheumatic Fever
GASTROINTESTINAL	NO	( )Hiatal Hernia ( )Heartburn ( )Reflux ( )Rectal Bleeding ( )Ulcers ( ) Hepatitis Type___ ( )Jaundice ( )Nausea ( )Vomiting ( )Colitis
GENITO-URINARY	NO	( )Frequent Urination ( )Pain ( )Discharge ( )Incontinence ( )Bloody Urine **MEN**: ( )Prostate Problems ( )Hernias **WOMEN** ( )Abnormal Periods ( ) Menopause ( )Are you Pregnant? L ( )Yes ( )No
MUSCLE/JOINTS	NO	( )Muscle Pain ( )Back Pain ( )Joint Pain ( )Arthritis ( )Lupus ( ) Gout
NEUROLOGICAL	NO	( )Headaches ( )Migrane headaches ( )Imbalance ( )Alzheimer's Disease ( )Loss of Consciousness ( ) Parkinson's Disease ( )Head Trauma ( )Tremors ( )Fainting ( ) Seizures ( )TIA's ( )Stroke
PSYCHIATRIC	NO	( )Nervousness ( )Anxiety ( )Depression ( )Mood Swings
ENDOCRINE	NO	( )Thyroid Disease ( )Diabetes ( )Glandular/Hormonal Problems
HEMATOLOGIC	NO	( )Slow to Heal After Cuts ( )Easy Bruising or Bleeding ( )Immunocompromised Status ( ) Transfusions ( )Phlebitis ( )Anemia
IMMUNE	NO	( ) HIV/AIDS

If this form is filled out by another other than the patient, please write the name and relationship.

Name _____Relationship to Patient_____

I certify that this information is true and correct to the best of my knowledge.
I will notify you if any changes occur.

SIGNATURE: _____Date _____

I have reviewed the above information with the patient:

MD SIGNATURE _____