New Patient Package

Name _____ DOB _____

L6 - Patient Demographics & Preferences

Patient Information

				Contact Information
First Name Middle Last Name				E-mail
Pharmacy name Town / Location				Pharmacy Telephone
Date of Birth	Social Security #	Gender ☐ Male ☐ Female		Home Telephone
Street Address (Apt#) City State Zip Code				Cell Telephone
☐ Single ☐ Married ☐ Widowed ☐ Divorced				Work Telephone
Other Family Members: First Name Last Name Relationship DOB 1. _____ _____ _____ 2. _____ _____ _____ 3. _____ _____ _____ 4. _____ _____ _____ 5. _____ _____ _____				*Family Member Phone # if different than above*
Emergency Contact 1 - Last Name, First Relationship				Emergency Contact 1 Tel
Emergency Contact 2 Last Name, First Relationship				Emergency Contact 2 Tel
School /College Currently Attending				School RN Tel
Occupation				Fax - *if private*

Patient Preferences

Little Silver Medicine is committed to providing quality health care for the whole family by caring for you when you are sick and helping you achieve long-term health through education and preventive practices. Wellness exams allow identification of health risks unique to you and inform you of appropriate steps, including cancer screening and lifestyle changes for health improvement.

For your convenience, we will call you to schedule **annual well visits** based on your preferences:

When would you like us to call? ☐ 1 month before ☐ 2 months before ☐ schedule it every year in _____(mo)

How can we best reach you for such reminders and other health alerts?

☐ Home Phone (above) ☐ Work Phone (above) ☐ Cell Phone (above) ☐ Cell Text ☐ Email (above)

If you prefer phone call, what is the best time to reach you?
Day(s): _____ Time: _____ AM / PM

Print Name _____ Signature: _____ Date: _____
(Patient or parent of minor)

Name _____ DOB _____

L6 – Demographics / Preferences Continued

Insurance

Medical Insurance ☐ Yes ☐ No Insurance Company Effective Date		Insurance Tel *(See Ins Card)*
Policy Number	Group Number	Office Co-Payment
Does this plan cover all family members? ☐ Yes ☐ No *If No, specify those covered:*		

Responsible

Complete the following *if person responsible for payment / policy holder is other than the patient*			
Subscriber First Name Middle Last Name			*Tel# if different than above*
Date of Birth	Social Security #	Relationship to Patient	Home Tel
Street Address (Apt#), City, State Zip Code			Cell
Occupation	Employer		Work Tel
Other Insurance Coverage Insurance Company Effective Date ☐ **Yes** ☐ **No**			Employer / HR Tel

To ensure that you don't get billed in error for medical services, please:

- **Allow 2 business days for referrals**. It takes up to 48 hours for some insurance companies to process referrals and authorize services requiring precertification. Without such authorizations, your insurance company may deny payment and you may get billed.
- **Call 24 hours ahead to cancel your appointment**. You may be responsible for the usual and customary charges for missed appointments.
- Call your insurance company and confirm that we are assigned as your primary doctor(s)
- Call us to inform us of any changes in your health insurance plan.
- Know your health plan requirements and participating providers before making appointments.

If you have questions about your insurance coverage or need some clarification, please call our office. Our Office Manager will be happy to assist you with questions.

Assignment of Insurance Benefits / Release of Information

I hereby request that payment of authorized medical benefits be made on my behalf to Drs. Vaman Chaubal, Deepti Mehra, or Neeraj Mehra for any services furnished me at this office or through a third party. I hereby authorize the aforementioned physicians to release to the health care administrator and it's agents any medical information necessary to determine these benefits payable for services rendered. I understand that I am financially responsible for any balance not covered by an insurance company.

Print Name _____ Signature: _____ Date: _____
(Patient or parent of minor)

Who referred you to us?

New Patient Package

Name _____ DOB _____

R4 – Medical History

Please Print Clearly

NAME: FIRST MIDDLE LAST	AGE	TODAY'S DATE	THIS INFORMATION BECOMES PART OF YOUR CONFIDENTIAL MEDICAL RECORD

PAST HISTORY (Give names and dates)

Major illnesses _____

Previous Surgeries or Hospitalization _____

SMOKING: Packs per day _____ Number of years _____ Year stopped _____ ☐ Pipe ☐ Cigar ☐ Chew

ALCOHOL: ☐ Never ☐ Occasional ☐ Moderate ☐ Heavy Alcohol Problem? ☐ Yes ☐ No How much each week? _____

GENERAL: Coffee: _____ cups per day Tea: _____ cups per day Exercise: _____

OCCUPATIONAL EXPOSURES: ☐ Asbestos ☐ Other (describe) _____

Weight _____ Weight at age 20 _____ Weight change last year: gained _____lbs. lost _____ lbs.

DRUGS - Please check (•) drugs presently used and explain frequency of use (daily, weekly, etc.)

	Sleeping Pill:		Thyroid:		Decongestant:
	Tranquilizer:		Heart Pill:		Vitamins:
	Anti-Depressant:		Digitalis:		Iron:
	Pain Pill:		Nitroglycerin:		Antibiotics:
	Diet Pill:		Water Pill (or Diuretic):		Asthma Medicine:
	Diabetes Pill:		Blood Pressure Pill:		Shots:
	Estrogen Hormone:		Blood Thinner:		Other(s) - Specify:
	Birth Control Pill:		"Hard Drugs":		
	Insulin:		Marijuana:		
	Allergy Medicines:		Cocaine:		
	Nose Sprays:		Laxative:		
	Cortisone/Steroids:		Antacids:		

ALLERGIES:

Drugs: **Others**:

PT. I.D.

FAMILY HISTORY (Check at left & list family member at right)

	Diabetes:		Ulcers:
	Heart Trouble:		Mental Illness:
	Heart Attack:		Thyroid Trouble:
	High Blood Pressure:		Cancer - Breast:
	Stroke:		Cancer - Colon:
	Tuberculosis:		Cancer - Other:

Name _____ DOB _____

R5 First Visit Checklist

Please state your chief complaint, main problem or reasons for seeing the doctor.

_____

_____

_____

System Review: Check if you have symptoms or problems listed to a significant degree.

	Tired often		Shortness of breath		Vomiting blood		Sugar in urine
	Don't feel well		Asthma/ Wheezing		Black/bloody stools		Hypoglycemia
	Weakness		Hay fever		Rectal bleeding		Low blood sugar
	Weight problem		Pleurisy		Abdominal Pain		Thyroid trouble
	Fluid Retention		Chest pain		Spastic colon		Urine/bladder
	Lack of exercise		Heart trouble		Colitis		Bladder problems
	Headache		Heart murmur		Diarrhea		Kidney infection
	Migraine		Heart Palpitations		Constipation		Kidney trouble
	Fainting		Chest tightness		Changed bowel		Kidney stone
	Dizziness		Angina		Hemorrhoids		Trouble urinating
	Epilepsy/Seizure		Tire Easily		Gall bladder trouble		Protein in urine
	Ear/hearing issue		Enlarged heart		Yellow Jaundice		Blood in urine
	Ears ringing		Rheumatic fever		Hepatitis		STD
	Stuffy nose		Leg pain while walking		Liver Disease		Skin Rash
	Nose bleeds		Varicose veins		Hernia		Skin Trouble
	Sinus trouble		Phlebitis		Food tolerance		Allergy
	Persistent hoarseness		Ankle/ leg swelling		Nervous		Bleed/bruise easy
	Glasses		Arthritis/ Joint pain		Tense/ Irritable		Anemia
	Vision/Eye Trouble		Gout		Bored		Blood Disease
	Glaucoma		Neck Pain		Depressed		Infertility
	Cataract		Back Pain or Trouble		Trouble sleeping		Sexual Difficulty
	Frequent cough		Bursitis/ Tendonitis		Relationship trouble		**MEN ONLY**
	Cough with phlegm		Trouble swallowing		Job problems		Discharge from
	Cough with blood		Indigestion		Personal problems		Prostate Trouble
	Frequent chest colds		Heartburn		Nervous breakdown		Weak/ slow stream
	Bronchitis		Nervous Stomach		Psychiatrist seen		Painful/ swollen
	Pneumonia		Ulcers		High blood pressure		Vasectomy date:
	Date of last physical exam: / /		Date of last Dental exam: / /		Date of last eye exam: / /		Date of last EKG: / /

WOMEN ONLY

Age menstruation began__ Periods: □Regular □Irregular L.M.P._____

Vaginal discharge □ Yes □ No Hot Flashes □Yes □No Breast lump/discharge □Yes □No
Number of miscarriages/abortions _____ Type of birth control_____
I.U.D.? □Yes □No If yes, year inserted_____ Date of last Mammogram_____

PHYSICIAN USE ONLY

_____

_____

Name _____ DOB _____

Little Silver
Pediatric & Family Medicine

Quality Healthcare for the Whole Family!

L7 - Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations (HIPPA)

I have received a copy of the HIPPA privacy policy and understand that as a part of my treatment, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communicating among any other health care professionals who might contribute to my care, via telephone, fax, etc.
- A source of information for applying my diagnosis and surgical information to my account to process for payment.
- A means by which a third-party payer can verify the services that are billed and are accurate and actual.
- As a tool for routine healthcare operations, such as assessing quality, and reviewing the competence of healthcare officials.

I understand this practice will take great care to insure that any and all information pertaining to me, and my treatment here will be handled with an emphasis on maintaining my privacy at all times. I understand that I have the right to request restrictions as to how my health information may be used, or disclosed to carry out treatment, payment, or healthcare operations, and that this practice is not required to agree to these restrictions. I understand that I may revoke this consent in writing, at any time, but not to the extent that the organization has already acted in.

_____ I request the following restrictions to the use, or disclosure of my health information.

_____
_____
_____

☐ Accepted ☐ Denied

Patient or Legal Guardian:

_____

Name (Print) Signature Date

Name _____ DOB _____

Little Silver
Pediatric & Family Medicine

L9 - Acknowledgement & Consent Form

Little Silver Medicine provides quality healthcare for the whole family with extended hours to meet the needs of busy families. We are proud of our commitment to ensure that all patients receive the time they need without extensive wait times. We are thankful to our patients for helping us fulfill our commitment.

Please initial to the left of each item after careful review.

_____ I understand that missed appointments, without prior notification, may prevent Little Silver Medicine from accommodating other patients. As a courtesy to other patients, I will notify the office of cancellations or delays. I understand that Little Silver Medicine may charge a $25.00 no show fee for missed appointments.

_____ I understand that my co-pay is due at the time services are rendered for each office visit. I also understand that there is a service charge of $35 for each returned check.

_____ I understand that Little Silver Medicine, in order to protect patients from medical identity theft, will require valid proof of identification, at **each visit**. I understand that I am required to bring a valid ID in addition to proof of insurance, where applicable.

_____ I understand and agree that if it is later determined that I am not eligible to receive benefits through the insurance company I provided on the date of service, I will be personally responsible for payment to the doctors for the services I received. I authorize Little Silver Medicine to apply for benefits on my behalf to my insurance company. I authorize my insurance company to make payment directly to Little Silver Medicine. I am aware that I may revoke this authorization at any time.

_____ I understand that it is my responsibility to provide current insurance and demographic information to Little Silver Medicine and to verify that my information is correct at **each visit**. Any billing problems that arise due to the patient's negligence for not supplying us with correct information will result in patient's liability of all outstanding balances.

_____ Little Silver Medicine may leave messages for me at □ **home** □ **work** □ **cell** □ **email** □ **all**

Please indicate any persons that your doctor may discuss your medical information with. Please note: No medical information of any kind will be released to anyone not addressed in the HIPPA Privacy Policy without this consent. This includes spouse, parents, children.

First Name	Last Name	DOB	Date
First Name	Last Name	DOB	Date

Parents: Please indicate any persons that may give Little Silver Medicine permission to treat your child.

First Name	Last Name	DOB	Date
First Name	Last Name	DOB	Date

PATIENT / GUARDIAN:

Name (Print)	Signature	Date