

New Patient Medical History - Please complete this two-sided form prior to your first appointment

Name: _____ Date of Birth: ___ / ___ / 19___ Age: ___ Sex: ___
 How did you hear about our practice?

◆ Please briefly state in the box below the reason for your visit ◆

◆ Past Medical History ◆

<i>Condition / Disease</i>	<i>Year Began</i>	<i>Condition / Disease</i>	<i>Year Began</i>
<input type="checkbox"/> Hypertension		Other(s):	
<input type="checkbox"/> High Cholesterol			
<input type="checkbox"/> Hypothyroidism (low thyroid)			
<input type="checkbox"/> COPD, Emphysema or Asthma			
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> GERD			
<input type="checkbox"/> Depression or Anxiety			
<input type="checkbox"/> Heart Problems -			

◆ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ◆

<i>Operation / Hospitalization / Injury</i>	<i>Month / Yr</i>	<i>Operation / Hospitalization / Injury</i>	<i>Month / Yr</i>

◆ Other Physicians and Specialists ◆
List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

◆ Medication or Food Allergies or Intolerances ◆
List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

<i>Medication / Food</i>	<i>Reaction</i>	<i>Medication / Food</i>	<i>Reaction</i>

◆ Medications, Vitamins and Herbal Supplements ◆

<i>Medication</i>	<i>Strength</i>	<i>Number of pills taken & frequency</i>	<i>Medication</i>	<i>Strength</i>	<i>Number of pills taken & frequency</i>
<i>Example: Tylenol</i>	<i>500 mg</i>	<i>1 - twice daily</i>			

◆ Social, Educational and Work History ◆		
Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

◆ Family Health History ◆				
<i>Please list below the health history of your blood (genetic) first degree relatives</i>				
<i>Relative</i>	<i>Living or Deceased</i>	<i>Current age or age at death</i>	<i>Cause of Death</i>	<i>Health Problems</i>
Father:				
Mother:				
Brother(s):				
Sister(s):				

◆ Review of Systems ◆				
<i>Please review the following symptoms and circle those items that are a problem for you</i>				
Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

□ Place an "X" in the box to the left if you have none of the above.

◆ Disease Prevention and Health Maintenance ◆				
<i>Please list below the most recent dates of your vaccines and health screening tests</i>				
	<i>Month/Yr</i>		<i>Month/Yr</i>	<i>Month/Yr</i>
Flu Vaccine		Mammogram		Eye Exam
Pneumonia Vaccine		Pap S mear		Heart Catheterization
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)
Hepatitis B Vaccine		Bone Density		Heart Stress Test
Shingles Vaccine		EKG		Ab Aneurysm Screen
Gardasil Vaccine		Chest X-Ray		HIV Test

Patient Record of Disclosure

NAME OF PATIENT OR INDIVIDUAL

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____ ALT. PHONE (____) _____

EMAIL ADDRESS (Optional): _____

I wish to be contacted in the following manner (check all that apply)

Home phone number _____

Cell phone number _____

Written Communication

ok to leave message with detailed info

ok to mail to my home address

leave message with call back number only

ok to mail to work/office

ok to fax to this number

Work Telephone _____

ok to leave message with detailed info

leave message with call back number only

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name *Terre Haute Internal Medicine*

Address *420 East Hospital Lane*

City *Terre Haute* State *IN* Zip Code *47802*

Phone *(812)238-0958* Fax *(812) 238-0960*

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person Name _____

Phone (_____) _____

Person Name _____

Phone (_____) _____

Person Name _____

Phone (_____) _____

Person Name _____

Phone (_____) _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- All health information
- History/Physical Exam
- Past/Present Medications
- Lab Results
- Physician's Orders
- Patient Allergies
- Operation Reports
- Consultation Reports
- Progress Notes
- Discharge Summary
- Diagnostic Test Reports
- EKG/Cardiology Reports
- Pathology Reports
- Billing Information
- Radiology Reports & Images
- Other _____

Your initials are required to release the following information:

- Mental Health Records (excluding psychotherapy notes)
- Genetic Information (including Genetic Test Results)
- Drug, Alcohol, or Substance Abuse Records
- HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date(optional) _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE

X _____
Signature of Individual or Individual's Legally Authorized Representative

DATE _____

Patient Registration

Patient Name: _____

DOB _____

Race: Please circle one of the following

Hispanic Black or African American White American Indian/Alaska Native
Asian Native Hawaiian Other Pacific islander Other Refuse to report

Ethnicity: Please circle one of the following

Hispanic or Latin Non Hispanic Refuse to report

Language: Please circle one of the following

English Spanish Russian Indian-including Hindi&Tamil Other

Email address _____

Authorization for Release of Information

I hereby authorize Terre Haute Internal Medicine to release information requested by my insurance carrier and/or Workers' Compensation carrier. Additionally, I authorize the release and or obtain information regarding my Rx history from any external sources such as hospitals, Physicians, Pharmacies and etc.

Authorization to send Information to Pharmacy

I hereby authorize Dr. Pardeep Kumar, MD and/or Dr. Tejaswini Kumar, MD to send any confidential information to the pharmacy of my choosing.

Authorization to Obtain Information From Pharmacy

I hereby authorize Dr. Pardeep Kumar, MD and/or Dr. Tejaswini Kumar, MD to obtain and view my prescription history from external sources.

Authorization for Treatment

I hereby authorize Dr. Pardeep Kumar, MD or Dr. Tejaswini Kumar, MD to treat me for any medical issues

Assignment of Benefits

I hereby authorize assignment and payment be made directly to Terre Haute Internal Medicine of any medical benefits and/or Medicare assignment. I understand that insurance may not and the Medicare does not pay 100% of the medical charges.

I hereby acknowledge and agree to pay any and all charges that exceed or that are not covered by insurance, including any deductible, co-pays and co-insurances. I am aware that all co-pays are due at the time of service, unless prior arrangements have been made. I am aware that if I do not have insurance that services are to be paid at the time of service.

Collections

I hereby acknowledge that I am responsible for reasonable interest, collection fees, attorney fees of 38% or \$300.00 added to the outstanding balance, and/or court cost incurred in connection with any attempt to collect amounts I may owe. I am aware that my account will become inactive due to non compliance of payment on my account and no services will be provided until debt has been paid in full.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge I have received a copy of Terre Haute Internal Medicine Associates Notice of Privacy Practice

Signature _____

Date _____