NEW PATIENT INFORMATION

PLEASE PRINT

Today's Date: _____

Rendering Provider (PCP): ☐ Dr. Raman ☐ Dr. Ashar

Patient Information:

LAST NAME _____ FIRST NAME _____ MI _____

Date of Birth __ __/__ __/__ __ __ __ (mm/dd/yyyy) Social Security No. _____ Sex: ☐ Male ☐ Female

Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed
☐ Legally Separated ☐ Partner ☐ Unknown

Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Cell Phone No. _____

Work Phone No. _____ Ext. _____

Billing Address (if different from mailing):

Address _____

City _____ State _____ Zip _____

☐ **OK to leave message at home** ☐ **OK to leave message on cell phone**

Previous PCP: _____ Tel. #: _____ Fax #: _____

E-mail _____ Language _____ Race (optional) _____

Responsible Party Information: (statements will be addressed to the responsible party)

Name _____

Address _____

City, State, Zip _____

Home Phone No. _____ Work Phone No. _____

Date of Birth: __/__/____ Social Security No.: _____

Sex: ☐ Male ☐ Female ☐ OK to leave message

Advance Directive (Living Will):

☐ HAS – has one will bring it at next office visit
☐ INP – in the process of making one
☐ WM – will make one

Insurance Information: (Primary Insurance)

Insurance Name: _____

Address: _____

Phone No.: _____

Subscriber's Name: _____

Subscriber ID No.: _____ Group No.: _____

Patient relationship to Subscriber (check one): ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Subscriber's Date of Birth : __/__/____ Co-Payment Amount: _____

Insurance Information: (Secondary Insurance)

Insurance Name: _____

Address: _____

Phone No.: _____

Subscriber's Name : _____

Subscriber ID No.: _____ Group No. _____

Patient relationship to Subscriber (check one): ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Subscriber's Date of Birth: __/__/____ Co-Payment Amount : _____

Responsible Party's Employer Information:

Company: _____

Address _____ City _____

State _____ Zip _____ Phone No. _____

Emergency Contact #1

Name: _____
Phone: _____
Address: _____
_____
Relationship: _____

Emergency Contact #2

Name: _____
Phone: _____
Address: _____
_____
Relationship: _____

Pharmacies: (Retail)

Name: _____
Cross Streets: _____
Phone No.: _____
Fax No.: _____
Plan Type: _____

(Mail Order)

Name: _____
Address: _____
Phone No.: _____
Fax No.: _____
Plan Type: _____

AZ INTERNAL MEDICINE

MEDICAL HISTORY

NAME: _____ **DOB:** ___/___/_____ **Date of Visit:** _____

Previous PCP: _____ Tel. #: _____ Fax #: _____

REASON FOR VISIT

[ ] Establish as New Patient
[ ] Specific Concerns (please list)

_____
_____

MEDICATIONS

_____
_____
_____
_____
_____

PAST MEDICAL HISTORY

[ ] High Blood Pressure
[ ] Diabetes
[ ] Heart Failure
[ ] Breathing Problems
[ ] Cancer
[ ] High Cholesterol
[ ] Heart Attack
[ ] Abnormal Heart Rhythm
[ ] Ulcer or Gastritis
[ ] Thyroid Problems

If yes, please specify below: _____
_____
_____
_____

FAMILY HISTORY

Family Member	Alive/Age	Deceased/Age	Illness
Father			
Mother			
Brothers			
Sisters			
Children			

SURGICAL HISTORY

Have you ever had surgery? [ ] No [ ] Yes
[ ] Appendectomy [ ] Gallbladder Removed
[ ] Hysterectomy [ ] Ovaries Removed
[ ] Joint Replacement [ ] Heart Surgery
[ ] Other _____
_____

OTHER ILLNESSES IN THE FAMILY:

[ ] High Blood Pressure
[ ] Diabetes
[ ] Heart Failure
[ ] Breathing Problems
[ ] Thyroid Problems
[ ] Cancer
[ ] High Cholesterol
[ ] Heart Attack
[ ] Abnormal Heart
[ ] Ulcer or Gastritis
[ ] Stroke

ALLERGIES

Allergies to Medications: [ ] No [ ] Yes (Specify)
_____

HEALTH MAINTENANCE

Immunizations:
Influenza [ ] No [ ] Yes Date _____
Pneumovax [ ] No [ ] Yes Date _____
Tetanus [ ] No [ ] Yes Date _____
Other Vaccines: _____

Cancer Screening:
Colonoscopy: [ ] No [ ] Yes Date _____
Stool Cards: [ ] No [ ] Yes Date _____

Female:
Self Breast Exam: [ ] No [ ] Yes Date _____
Pap Smear: [ ] No [ ] Yes Date _____
Mammogram: [ ] No [ ] Yes Date _____
Location: _____
Bone Densitometry: [ ] No [ ] Yes Date _____

Male:
PSA: [ ] No [ ] Yes Date _____
Self Testicular Exam: [ ] No [ ] Yes Date _____

SOCIAL HISTORY

Who do you live with?
[ ] Self [ ] Spouse [ ] Family [ ] Other_____

Exercise: [ ] No [ ] Yes (specify type and frequency)
_____

Alcohol: [ ] No [ ] Yes (specify and frequency)
_____

Caffeine: [ ] No [ ] Yes (specify drinks/day) _____

Smoking: [ ] Never Smoked
[ ] Currently Smoke (pk/s per day) _____
[ ] Previously Smoked
How many years did you smoke? _____
How long ago did you quit? _____

AZ INTERNAL MEDICINE

MEDICAL HISTORY

NAME: _____ DOB: ___/___/_____ Date of Visit: _____

REVIEW OF SYSTEMS

General
Weight Loss [ ] No [ ] Yes (#) _____
Weight Gain [ ] No [ ] Yes (#) _____
Fever [ ] No [ ] Yes
Chills [ ] No [ ] Yes
Fatigue [ ] No [ ] Yes
Insomnia [ ] No [ ] Yes

HEENT
Visual Change [ ] No [ ] Yes
Photophobia [ ] No [ ] Yes
Eye Itching [ ] No [ ] Yes
Eye Redness [ ] No [ ] Yes
Loss of Hearing [ ] No [ ] Yes
Ear Infections [ ] No [ ] Yes
Nose Congestion [ ] No [ ] Yes
Nose Drainage [ ] No [ ] Yes
Nose Bleeding [ ] No [ ] Yes
Sinus Congestion [ ] No [ ] Yes
Sore Throat [ ] No [ ] Yes
Hoarse Voice [ ] No [ ] Yes

Chest
Shortness of Breath [ ] No [ ] Yes
Coughing [ ] No [ ] Yes
Wheezing [ ] No [ ] Yes

Heart
Chest Pain [ ] No [ ] Yes
Rapid Heart Rate [ ] No [ ] Yes
Abnormal Heart Rhythm [ ] No [ ] Yes
Leg Swelling [ ] No [ ] Yes

Gastrointestinal
Stomach Pain [ ] No [ ] Yes
Heartburn [ ] No [ ] Yes
Dysphagia [ ] No [ ] Yes
Constipation [ ] No [ ] Yes
Blood in Stool [ ] No [ ] Yes
Stool Incontinence [ ] No [ ] Yes
Hemorrhoids [ ] No [ ] Yes

Musculoskeletal
Joint Pain [ ] No [ ] Yes
Joint Swelling [ ] No [ ] Yes
Muscle Pain [ ] No [ ] Yes
Muscle Cramps [ ] No [ ] Yes
Back Pain [ ] No [ ] Yes
Neck Pain [ ] No [ ] Yes
Fractures [ ] No [ ] Yes

Skin
Rash [ ] No [ ] Yes
Hives [ ] No [ ] Yes
Moles [ ] No [ ] Yes
Dry Skin/Eczema [ ] No [ ] Yes
Skin Cancer [ ] No [ ] Yes

Lymphatic System
Enlarged Nodes [ ] No [ ] Yes

Hematologic System
Bleeding Disorder [ ] No [ ] Yes
Easy Bruising [ ] No [ ] Yes

Nervous System
Dizziness [ ] No [ ] Yes
Spinning [ ] No [ ] Yes
Numbness/Tingling [ ] No [ ] Yes
Gait Disturbance [ ] No [ ] Yes
Balance Difficulties [ ] No [ ] Yes
Seizures [ ] No [ ] Yes
Headaches [ ] No [ ] Yes

Psychiatric
Depression [ ] No [ ] Yes
Anxiety [ ] No [ ] Yes
Phobias [ ] No [ ] Yes
Eating Disorder [ ] No [ ] Yes

Female/Genitourinary
Burning with Urination [ ] No [ ] Yes
Frequent Urination [ ] No [ ] Yes
Night Time Urination [ ] No [ ] Yes
Blood in Urine [ ] No [ ] Yes
Vaginal Discharge [ ] No [ ] Yes
Vaginal Dryness [ ] No [ ] Yes
Sexual Difficulties [ ] No [ ] Yes
Breast Lumps [ ] No [ ] Yes
Nipple Discharge [ ] No [ ] Yes
Premenopausal: Date of LMP _____
Postmenopausal:
Vaginal Bleeding [ ] No [ ] Yes
Hot Flashes [ ] No [ ] Yes

Male/Genitourinary
Burning with Urination [ ] No [ ] Yes
Blood in Urine [ ] No [ ] Yes
Frequent Urination [ ] No [ ] Yes
Night Time Urinating [ ] No [ ] Yes
Difficulty w/ Urinary Stream [ ] No [ ] Yes
Sexual Difficulties [ ] No [ ] Yes
Scrotal/Testicular Lump [ ] No [ ] Yes

AZ INTERNAL MEDICINE, PLLC

3920 S. Alma School Rd., Ste. 8, Chandler, AZ 85248

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____

DATE OF BIRTH: ___/___/_____ **SOCIAL SECURITY NO:** _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE (HOME) _____ **(WORK)** _____

I hereby authorize _____

Tel. No._____ Fax No. _____

to send/release photocopies of my medical records to:

AZ INTERNAL MEDICINE, PLLC
DR. NANDINI RAMAN / DR. ANUPA ASHAR
3920 S. ALMA SCHOOL RD., STE. 8
CHANDLER, AZ 85248
Phone: (480) 855-8700
Fax : (480) 855-8701 ← Please fax all records to the number listed

NOTE: WE PREFER THAT MEDICAL RECORDS BE ON A CD. (except for hospitals)

For the purpose of: _____

I authorize the release of photocopies of the following records in the possession or control of _____, its employees and/or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" AND "X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S SECTION 36-611), CONFIDENTIAL ALCHOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2 ET SEQ.) AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

REQUESTED DATE(S): From _____ To _____

___ Complete Medical Records
___ Hospital Records
___ Consultation Reports
___ Laboratory Reports
___ Imaging Studies
___ Other _____

This consent will expire one (1) year after the signed date below. I have given my consent freely and voluntarily. I may revoke this authorization at any time provided I notify my PCP in writing to that effect. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____ _____
Patient Signature **Date**

_____ _____
Parent/Legally Authorized Representative **Relationship to Patient**

AZ INTERNAL MEDICINE, PLLC
Nandini Raman, M.D. Anupa Ashar, M.D.

PATIENT CONSENT FORM

I consent to the use or disclosure of my protected health information by AZ Internal Medicine PLLC for the purpose of my diagnosis, treatment, payment, or to conduct health care operations.

I understand the following:

- Diagnosis or treatment of me by Dr. Nandini Raman, M.D./ Dr. Anupa Ashar, M.D., may be conditioned upon my consent as evidenced by my signature on this consent.
- I have the right to request a restriction on the uses of my protected health information; the physician's practice may not agree with the restrictions. However, if they do agree, the restriction is binding.
- I have the right to revoke this Consent, in writing, at any time; all future disclosures will subsequently cease. Any disclosures previously made from my prior consent, will not be affected by this revocation.
- Prior to signing this consent, I have the right to review AZ Internal Medicine, PLLC Notice of Privacy Practices & Financial Policy, which have been provided to me.

My "protected health information" means health information, including my demographics information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

AZ Internal Medicine, PLLC has a Notice of Privacy Practices. The Notice of Privacy Practices describes how we may use and disclose protected health information about you. The Notice of Privacy Practices also describes patient rights under the law.

At any time, AZ Internal Medicine, PLLC may change the privacy practices as described in the Notice of Privacy Practices. I may contact the office to receive a revised copy.

This document is provided in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a courtesy to our patients, we will file up to 2 insurance companies. Because we are Medicare Providers, we must first file to your insurance companies of all Medicare patients.

Medical Information Release-Direct Physician Payment Release

By Signing below, I authorize the release of all medical information necessary for filing my insurance claims. I also authorize my insurance company to make direct payment to my physician. A copy of this release may be used in place of the original. I understand that I am responsible for any balance due on my account after my insurance carriers(s) have paid, including my yearly deductibles, co-payments and coinsurance. I also understand that any overpayment will be refunded if authorized by my insurance company.

FINANCIAL POLICY

It is your responsibility to be aware of your benefits. If you are unsure of your insurance benefits, you will need to contact your insurance carrier for clarification of your benefits.

This office will not change or re-code claims once they have been billed. This constitutes fraud and will not be done

This office bills only for services performed by our providers. The laboratory and radiology will bill you or your insurance company for all labs and imaging studies performed. If you have any questions regarding your lab or radiology bill please contact the laboratory/radiology directly or your insurance carrier.

All insurance information, including prior authorizations, referrals, and claim forms when necessary, must be provided at the time of service.

All co-pays, deductibles, and payments are due at the time of service, with co-pays being collected prior to you seeing the doctors. We accept cash, Visa, MasterCard, American Express and most debit cards displaying the Visa or MasterCard logo as forms of payments.

Any account left unpaid after 90 days will be turned over to an outside collection agency. Any collection fees necessary to collect this debt will be added to the outstanding balance. Please keep in mind that should your account go to our collection agency, any arrangements/payments will need to be made directly with/to the collection agency. In addition, once an account has been turned over to the collection agency, the patient may receive a letter of discharge from our practice.

We understand that situations arise that you must cancel your appointment. We do request a 24 hour notice of such cancellations. A fee of $25.00 will be charged to your account for three consecutive no shows.

Although we require you to fill out "update" on your first appointment of each New Year, it is your responsibility to notify our office immediately of any change of name, address, phone number, or insurance coverage.

I have read the above Financial Policy, and understand and agree to these terms.

Patient/Guardian Signature _____ Date _____

Relationship to Patient _____