PATIENT INFORMATION FORM - DIABETES

PATIENT NAME: ____

DATE OF BIRTH _____/_____/________ (mm/dd/yr) SOCIAL SECURITY NO______-_____-________

ADDRESS____ HOME PHONE: ( ) __________________________

____ CELL PHONE: ( ) __________________________

____ WORK PHONE: ( ) __________________________

EMPLOYER____ EMAIL: ____

MARITAL STATUS S M W D SEP

PERSON RESPONSIBLE FOR BILL (If not self) ____

ADDRESS (if different)____

EMERGENCY CONTACT NAME________________________________ PHONE ( ) __________________________

PRIMARY INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST)

INSURANCE NAME____________________________SUBSCRIBER NAME _______________________________

(IF PRIMARY SUBSCRIBER IS NOT SELF, PLEASE FILL REQUIRED INFORMATION IN LINE BELOW)

RELATION TO SUBSCRIBER________________________ SUBSCRIBER DATE OF BIRTH______________________

GROUP #________________________ POLICY #________________________ EFF. DATE______________________

SUPPLEMENTAL INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST)

INSURANCE NAME_________________________________ SUBSCRIBER NAME___________________________

RELATION TO SUBSCRIBER________________________ SUBSCRIBER DATE OF BIRTH______________________

GROUP #________________________ POLICY #________________________ EFF. DATE______________________

Authorization for Release of Medical Records:

Initials _______ I authorize Leena Singh, MD to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, continuity of care and medical treatment.

Consent for treatment:

Initials _______ As a consulting adult and/or legal guardian, I agree to Leena Singh, MD to provide medical care to myself. By signing below, I agree to permit Leena Singh, MD to perform necessary or appropriate medical care including physical examination, diagnosis, and treatment.

Assignment of Benefits:

Initials _______ I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans, to Leena Singh, MD. I understand that I am responsible to follow up with insurance plan due to any discrepancy in coverage. I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Leena Singh, MD to release all information necessary to secure payment.

I have read the Authorization Release of Medical Records, Consent for Treatment and Assignment of Benefits.

Patient Name: ____

PLEASE PRINT

Signature of Patient or Legal Guardian: ____________________________________ **Date:** ________________

Relationship to Patient: ____

Witness: ____ **Date:** ________________

OFFICE POLICIES

- **CANCELLATIONS:**
  - Please call at least 24 hours ahead of time if you need to cancel your appointment.
  - There is a $25 charge if you fail to show up for a scheduled appointment or cancel an appointment with less than 24 hours' notice.
  - If you are late for your appointment, the appointment may be rescheduled.

- **PRESCRIPTIONS AND REFILLS:** Prescriptions and refills are processed during regular business hours and requests made after 4 p.m. will not be processed until the following day. Please allow up to 72 hours to process refills. Also, if you have not kept your follow up appointment, an appointment may be required.

- **FINANACIAL RESPONSIBILITY:**
  - Although we file your insurance claims and accept assignment of benefits, you are ultimately responsible for any services not covered in your plan (deductibles, co-payments, co-insurance, etc.). We will mail you a statement.
  - All copayments are due at the time of service.
  - All prior balances are due before your next appointment.
  - We accept cash, personal checks, VISA and MasterCard.
  - There is a $25 charge for returned checks.

- Established patients who have **two or more** consecutive canceled, rescheduled or missed appointments may be discharged from the practice.

- If your account is turned over to collections, you will be dismissed from the practice and will not be entitled to any medical services except in the event of an emergency and only for thirty (30) days after you are reported to collections; unless your account is paid in full or is being paid pursuant to a payment plan. A list of other physicians in the area is available upon request.

We welcome the opportunity to discuss any aspect of our financial policy with you.

I, ______________________________, hereby acknowledge receipt of Dr. Singhs' Office Policies. I understand that the practice reserves the right to change its policies and procedures at any time. The current office policies are available upon request.
I have read and agree to the aforementioned policies.

Signature:_____________________________________ Date:________________

TO ALL PATIENTS, PLEASE READ THE FOLLOWING BEFORE SIGNING

This office is not able to accept new Medi-CAL patients at this time. If you are accepted as a patient at this clinic, then you must understand we accepted you as a private patient only.

I am not covered by Medi-CAL. I understand that should I obtain Medi-CAL while being treated at this clinic, I may no longer be able to continue medical care here.

Signature: _____________________________________ Date: ________________

PATIENT NAME: ____

DIABETES

The following information is very important to your health. Please take the time to accurately fill this form. PLEASE BRING YOUR BLOOD SUGAR METER AND LOGBOOK TO YOUR APPOINTMENT.

Date of first appointment: ____/_____/__________
Name: ____
Date of birth: ____/_____/__________
Gender: Male___ Female___
Ethnicity: White ___African American ___Hispanic ___Asian ___ Other___
Referred by: _________________________ Referring doctor's phone #:______________
Referring doctor's address: ____

Describe your present symptoms briefly:
____
____
____
____
How long have you had these symptoms: _____________________

Current medications: (Please include over the counter medicines and vitamins):

Medication	Dose	Times per day

Attach additional sheet if needed.

Preferred pharmacy: ____

Preferred lab for blood tests: ____

Medication allergies:

Medication	What reaction did you have?

Attach additional sheet if needed.

Past Medical History:

	Yes	No	How long	Type
Diabetes				
Thyroid problems				
High blood pressure				
High cholesterol				
Heart disease				
Stroke				
Osteoporosis				
GI disorder				
Cancer				

Other medical problems:

Past Surgeries:

____

____

Ophthalmologist: ________________________________**Last seen:** ___________
Podiatrist: _____________________________________**Last seen:** ___________
Nephrologist: __________________________________**Last seen:** ___________
Cardiologist: __________________________________**Last seen:** ___________

Gynecology history (for females):

Age when periods started: _____ Regular/Irregular Date of last period: ___________
Number of pregnancies: Number of miscarriages: Number of abortions:
__Use Birth control pills __Use hormone replacement
Last mammogram: _________ Last Pap smear: ________ Last DEXA scan: _______

Family History:

Thyroid disorder	
Diabetes	
Heart disease	
High blood pressure	
High cholesterol	
Cancer	
Osteoporosis	
Other	

M-Mother F-Father S-Sister B-Brother GM-Grandmother GF-Grandfather A-Aunt U-uncle

Social History:

Occupation: ____
Education: Junior High High school College degree Post-graduate degree
Marital status: Single Married Divorced Separated Widowed
Children: ____________________
Smoking: Yes-packs/day: No Quit ______ years ago
Alcohol: Yes (how often): No Quit ______ years ago
Illicit drug use: Yes/No Type of drug: Quit ______ years ago
Exercise: Yes/No Type of exercise: Days/week:

Diet history:

Typical Breakfast: ____
Typical Lunch: ____
Typical Dinner: ____

PATIENT NAME: ____

Review of Systems: (please check)

General:

__Increased appetite __Decreased Appetite __Fatigue __Fever
__Weight loss __Weight gain __Sweats __Increased thirst
__Heat intolerance __Cold intolerance __Snoring __Trouble sleeping
__Excess hair __Hair loss __Tremors

Nervous system:

__Headache __Dizziness __Lightheadedness
__Numbness or tingling __Memory loss __Decreased concentration

Ears/Nose/Throat:

__Ringing in the ears __Loss of hearing __Nose bleeds
__Loss of smell __Hoarseness __Difficulty swallowing

Eyes:

__Double vision __Blurred vision __Loss of vision
__Dryness __Grittiness __Redness

Neck:

__Pain in neck __Swelling in neck __Difficulty swallowing

Lungs:

__Shortness of breath __Cough

Heart:

__Chest pain __Palpitations __Swelling of legs __Fainting

Gastrointestinal:

__Nausea __Vomiting __Diarrhea __Constipation
__Abdominal pain __Heartburn __Early feeling of fullness after eating

Genitourinary:

__Vaginal dryness __Decreased libido __Impotence
__Difficulty urinating __Frequent urination
__Getting up at night to urinate __Last prostate exam:

Blood:

__Anemia __Low WBC count __Bleeding tendencies

Skin:

__Dry skin __Easy bruising __Rash

Muscles/Joints/Bones:

__Joint pain __Stiffness __Muscle weakness
__Muscle soreness __Joint swelling __Fractures

Psychiatry:

__Mood changes __Anxiety __Depression

Reviewed by: ____

Leena Singh, MD, PhD Date

PATIENT NAME: ____