PATIENT INFORMATION FORM (DR. HARCHETAN SINGH SANDHU)

PATIENT NAME:_____

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

ADDRESS_____ WORK PHONE: ( )_____

_____ HOME PHONE: ( )_____

_____ CELL PHONE: ( )_____

EMPLOYER_____ EMAIL: _____

NAME OF PERSON RESPONSIBLE FOR BILL_____

ADDRESS_____

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_____

ANY OTHER COVERAGE?_____

IF YES, PLEASE PROVIDE INSURANCE NAME_____ GROUP #_____

SUBSCRIBER NAME_____ POLICY/CERTIFICATE #_____

Authorization for Release of Medical Records:

Initials _____ I authorize Harchetan Singh Sandhu, 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 Harchetan Singh Sandhu, MD to provide medical care to myself. By signing below, I agree to permit Harchetan Singh Sandhu, 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 Harchetan Singh Sandhu, 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 Harchetan Singh Sandhu, 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 :_____ **Date:**_____

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. Sandhus' 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:_____

HARCHETAN SINGH SANDHU, MD - RHEUMATOLOGY

The following information is very important to your health. Please take the time to fully and accurately fill out this information.

Date of first appointment ____/ ___/ _____ Date of Birth ____/____/____
mm dd yr mm dd yr

Name_____ Age _____ Gender: F M
Last First

Name of Doctor making referral:
_____

For the doctor who referred you, please give the following:
Street address
_____

City _____ State _____ Zip_____ Office tel:( )____-_____

Please list other practitioners you have seen for this problem:
_____
_____

Briefly describe your present symptoms:
_____
_____
_____

Date symptoms began (approximately)_____
Diagnosis given _____

Current Medications including dose and times taken per day (please bring current Rx bottles). Add additional sheets, if necessary

MEDICATION	DOSE	TIMES PER DAY

Previous Medications taken for todays problem:

MEDICATION AND DOSE	WHEN TAKEN	REASON STOPPED

Please list any medications to which you appear to be allergic. Please indicate type of reaction:

_____

PREFERRED PHARMACY: _____

PREFERRED LAB FOR TESTS: _____

MEDICAL PROBLEMS:

Rheumatologic history: Do you or have you had any of the following (PLEASE CIRCLE):

Arthritis-unknown	Osteoarthritis	Rheumatoid Arthritis	Gout
Lupus or SLE	Ankylosing spondylitis	Childhood arthritis	Osteoporosis
Back Pain	Polymyalgia Rheumatica	Fibromyalgia	Vasculitis

Any Other Arthritis Conditions:

Past Medical History: Do you or have you had any of the following (PLEASE CIRCLE):

High Blood Pressure	Jaundice	Diabetes	Headaches	Cancer, if yes, then specify:_____
Stroke	Pneumonia	Thyroid problems	Psoriasis	Uveitis/Iritis
Heart attack	Asthma	Chronic infection	Ulcers	Tuberculosis, including positive test
Kidney disease	Epilepsy or multiple sclerosis	Cataracts	Colitis/ Crohns disease	Anemia

Please list any other illnesses:

_____ _____

Past Surgical History: N Y List type and approximate year:
Type: Year Type: Year

_____

_____

GYN: Beginning date of last period ____/____/____ History of Eclampsia: Yes__No____
Number of pregnancies_____ Number of miscarriages_____
Current Contraceptive measure:_____

Preventative Maintenance: Pneumoccal Vaccine___/___/___ Influenza vaccine:___/___/___
Colonoscopy___/___/___/Mammogram:___/___/___

Systems Review: As you review the following list, please check any of those problems that apply to you:

GENERAL
- Recent weight gain_____ □
- Recent weight loss_____ □
- Fatigue □
- Weakness □
- Fever □
- Night Sweats □
- Sleep Disturbance □

HEAD
- New Headaches □
- Aches in jaw while chewing □
- Scalp pain □

NERVOUS SYSTEM
- Headaches □
- Dizziness □
- Fainting □
- Muscle Spasm □
- Loss of consciousness □
- Numbness or tingling of hands and/or feet □
- Memory loss □

EARS
- Ringing in the ears □
- Loss of hearing □

EYES □
- Pain □
- Redness □
- Loss of vision □
- Double Vision □
- Blurred Vision □
- Dryness □
- Foreign body sensation □

NOSE
- Nosebleeds □
- Loss of smell □
- Dryness □
- Sinus pain □

MOUTH
- Sore tongue □
- Bleeding Gums □
- Sores in the mouth □
- Loss of taste □
- Dryness □

THROAT
- Frequent sore throats □
- Hoarseness □
- Difficulty in swallowing □

NECK
- Swollen glands □
- Tender glands □

HEART AND LUNGS
- Pain in chest □
- Irregular heartbeat □
- Sudden change in heartbeat □
- Shortness of breath □
- Swollen legs or feet □
- High blood pressure □
- Heart murmurs □
- Cough □
- Coughing up blood □
- Wheezing □

GI SYSTEM
- Nausea □
- Vomiting of blood or coffee ground material □
- Stomach pain relieved by food or milk □
- Jaundice □
- Constipation □
- Persistent diarrhea □
- Blood in stools □
- Black stools □
- Heartburn □

KIDNEY/URINE/BLADDER
- Difficult urination □
- Pain or burning on urination □
- Discharge from penis/vagina □
- Frequent urination □
- Getting up in the night to urinate. # of times □
- Vaginal Dryness □
- Sexual difficulties □
- Prostate problem □
- Sexually transmitted disease □

SKIN
- Easy bruising □
- Rash □
- Hives □
- Sun-sensitive (Sun-allergy) □
- Tightness □
- Nodules/bumps □
- Color change of hands and feet in the cold □

BLOOD
- Anemia □
- Bleeding tendency □
- Enlarged glands □
- Low WBC count □

MUSCLES/JOINTS/BONES
- Morning stiffness □
- How long___Hrs_____Min
- Joint pains □
- Muscle weakness □
- Muscle soreness □
- Joint swelling □

MARK JOINTS AFFECTED
- Jaw □
- Shoulders □
- Elbows □
- Wrists □
- Thumbs □
- Fingers □
- Hips □
- Knees □
- Ankles □
- Feet □
- Neck □
- Middle back □
- Lower back □

PSYCHIATRY
- Depression □
- Sleep difficulty □
- Anxiety □

ENDOCRINE
- Steroid Treatment □
- Excessive thirst □
- Excessive urination □

ALLERGIC/IMMUNOLOGIC
- Recurrent infections □
- Drug reactions □
- Itchy eyes □
- Sneezing □

Family Rheumatologic (arthritis) History: if your blood relatives have had any of the following(PLEASE CIRCLE):

Osteoarthritis Rheumatoid arthritis Lupus or SLE Connective tissue ds

Gout Spondylitis Osteoporosis Psoriatic arthritis

Others_____

Family History:

Parents	Age	Health Problems	Age at Death	Cause
Father				
Mother				

Relation	Health Problems	Age at Death	Cause
Brothers			
Sisters			
Children			

Social History:(PLEASE CIRCLE)

Marital status: Single Married Divorced Separated Widow/Widower

Education: Junior high High School Some College College Graduate school

Occupation, current or former: Employed by:
Retired: Y N Approximate month and year:
Disabled: Y N Approximate month and year:
Please indicate reason for disability:_____
Are you applying for disability? Yes No
Do you have a medically related lawsuit pending? Yes No

Health Habits: (PLEASE CIRCLE)
Do you smoke? Y N
If yes,____packs per day. Previously for ____years,_____packs per day. Quit____years ago
Do you drink alcohol? Y N
If yes,____servings day/week Drinks: beer wine hard alcohol
Illicit drug use: Y N
Type of drug:_____ Quit Date:_____

Do you exercise: Y N If yes, ____ times per day/week.
Type of exercise: Walking Running Swimming Bicycling Weights Aerobics Cardio

Current overall level of function: On the scale below, circle a number which best describes your situation (most of the time function):

Very Well 1 2 3 4 5 6 7 8 9 10 Very Poor

PATIENTS SIGNATURE:_____ Date:_____

DOCTORS SIGNATURE:_____ Date:_____