ACHARYA & SHARMA
MEDICAL CORPORATION

SHASHI B. ACHARYA, M.D., F.A.C.P.
Diplomate, American Board of Internal Medicine & Geriatrics
PRAVIN V. SHARMA, M.D.
Diplomate, American Board of Internal Medicine

INTERNAL MEDICINE, HISTORY AND PHYSICAL

Name ______________________ SS# ______________ Date ______________

Address ______________________________ Occupation ______________

Phone (Home) ______________ (Work) ______________ Date of Birth ______________

Chief complaint ______________________________

DRUG ALLERGIES

____
____
____
____
____

CURRENT MEDS

____
____
____
____
____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart disease	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

HOSPITALIZATION OR SURGERY

Reason ______________________________
______________________________ Date ______________

Reason ______________________________
______________________________ Date ______________

WOMEN ONLY Pregnant? ☐ Yes ☐ No Planning Pregnancy? ☐ Yes ☐ No

PAST MEDICAL HISTORY

☐ Headaches	☐ Claudication	☐ Liver disease	☐ Incontinence	☐ Chest pain/Angina
☐ Hypertension	☐ MI	☐ Ulcer	☐ Venereal disease	☐ Dizziness/Fainting
☐ Stroke/TIA's	☐ Congenital heart disease	☐ GI disorder	☐ Anemia	☐ Asthma
☐ Epilepsy	☐ Orthopnoea	☐ Lactose Intolerance	☐ Gout	☐ COPD
☐ Fatigue	☐ Hyperlipidaemia	☐ Renal disease	☐ Scarlet fever	☐ Bowel irregularity
☐ Shortness of breath	☐ Congestive heart failure	☐ GU disorder	☐ Rheumatic fever	☐ Prostate Disease
☐ Heart palpitations	☐ Arrhythmia	☐ Sexual dysfunction	☐ Diabetes	☐ Arthritis
☐ Heart murmur	☐ Allergies/Hay fever	☐ Menstrual dysfunction	☐ Endocrine disease	☐ Osteoporosis
			☐ Anxiety	☐ Osteoporosis

____

PAST MEDICAL HISTORY

☐ Smoke: Pack daily ______________ How long ______________ When stopped ______________

☐ Exercise routine: ______________ ☐ Coffee: Cups daily ______________ Other caffeines ______________

☐ Alcohol: type/Amount ______________ Diet: Salt intake ______________ Fat intake ______________

☐ Sleep: Difficulty falling asleep ______________ Continuity disturbances ______________ Early morning awakening ______________

Snoring ______________ Daytime drowsiness ______________

☐ Contact with blood or body fluid at work: ______________________________

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A SPECIAL WORD TO OUR PATIENTS ABOUT YOUR RESERVATION TIME WITH US

The unique quality of our practice is shown by the high level of professional care provided to each of our patients. Health care is expensive and quality care should not be compromised. We believe on faith, that if a patient says they are going to arrive for an appointment that they will be here at out office on time. This means that we will hold your appointment especially for you and not give it to any other patient. If you miss your appointment we still have to pay our professional staff who was available for you.

Please understand our policy related to your appointment:

1. There will be no penalty for patients who cancel their appointment twenty-four (24) hours in advance. Thank you for your courtesy. We will reschedule you for another date.

2. If you cancel your appointment with less than twenty-four (24) hours notice to us, or do not show up for your appointment you will be charged as follows,
   a) Office Visits - $ 80
   b) Physical exams - minimum $ 100
   c) Procedure Appointment - minimum $ 100

Remember, our costs continue, whether or not you are treated. If we do not have the opportunity to treat you, then we cannot bill your insurance. Understand, please, that any type of insurance coverage never covers charges for missed appointment, and these expenses will be directly out of your pocket.

We really do not want to apply any of the regulations found in this letter. Our goal is to achieve for you the highest quality of care in an efficient and timely manner. We hope you understand our position in these sensitive matters and we look forward to working with you.

Date ______________________ Signature ____________________________________

Print Name: ____

Please Note: This does NOT pertain to any delay either being seen by the physician or a delay to your appointment for unforeseen reasons. Every attempt will be made to accommodate you in case you are late for your appointment.

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NOTICE OF PRIVACY PRACTICE

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information.

We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfil your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or charge to your health information. Give us a your request to make changes in writing, If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we will be happy to include your statement in your file, If we agree to an amendment or changes, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

ACKNOWLEDGEMENT

I have received a copy of Acharya & Sharma Medical Corporation Notice of Practices. Date ______________________

Signed ______________________ Print Name ______________________

If Signing as parent or guardian, please note the name of the patient

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"STAYING HEALTHY " ASSESSMENT
ADULTS, 18 YEARS OF AGE AND OLDER

Patient's name (first, last) ______________________________ Date of birth ______________

Sex ☐ Male ☐ Female Today's date ______________________________

You and you health care team can work together better health. Please answer these questions as best you can. You may check (✓) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your medical record.

Do You:

1. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, chiropractor, or other healer)? ☐ Yes ☐ No ☐ Skip
2. See the dentist at least once a year? ☐ Yes ☐ No ☐ Skip
3. Drink milk or eat yogurt or cheese at least 3 times each day? ☐ Yes ☐ No ☐ Skip
4. Eat fruits and vegetables every day? ☐ Yes ☐ No ☐ Skip
5. Try to limit the amount or fried or fast foods that you eat? ☐ Yes ☐ No ☐ Skip
6. Exercise or do moderate physical activity such as walking or gardening 5 days a week ☐ Yes ☐ No ☐ Skip
7. Think you need to lose or gain weight? ☐ Yes ☐ No ☐ Skip
8. Often feel sad, down, or hopeless? ☐ Yes ☐ No ☐ Skip
9. Have friends or family members that smoke in your home? ☐ Yes ☐ No ☐ Skip
10. Often spend time outdoors without sunscreen or other protection such as hat or shirt? ☐ Yes ☐ No ☐ Skip
11. Use any recreational drugs like marijuana, cocaine, speed or other street drugs ☐ Yes ☐ No ☐ Skip

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Name: ______________________________ DOB: ______________

Your answers to questions about alcohol and drug use cannot be released to others without your special written permission.

Do You:

11. Some cigarettes or cigars or use any other kinds of tobacco?	❑ Yes	❑ No	❑ Skip
12. Use any drugs or medicines to go to sleep, relax clam down, feel better, or lose weight?	❑ Yes	❑ No	❑ Skip
13. Often have more than 2 drinks containing alcohol in one day?	❑ Yes	❑ No	❑ Skip
14. Think you or your partner could be pregnant?	❑ Yes	❑ No	❑ Skip
15. Think you or your partner could have a sexually transmitted disease?	❑ Yes	❑ No	❑ Skip

Have You:	❑ Yes	❑ No	❑ Skip
16. Or you partner(s) had sex without using birth control in the last year?	❑ Yes	❑ No	❑ Skip
17. Or your partner(s) had sex with other people in the past year?	❑ Yes	❑ No	❑ Skip
18. Or you partner(s) had sex without a condom in the past year?	❑ Yes	❑ No	❑ Skip
19. Ever been forced or pressured to have sex?	❑ Yes	❑ No	❑ Skip
20. Ever been hit, slapped, kicked, or physically hurt by someone?	❑ Yes	❑ No	❑ Skip
21. Do you have other questions or concerns about your health	❑ Yes	❑ No	❑ Skip

(Please identify) ____

____

____

____

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ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

Name: ______________________________ DOB: ____________________

Medicare/P.P.O may not pay for the item(s) or service(s) that are described below. Medicare/P.P.O may not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare/P.P.O rules are met. The fact that Medicare/P.P.O may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it.

Items or Services:

Annual Physical exam : 99215 = $200.00
Preventive medical exam : 99397 or 99396 or 99395 = $150.00

Because:

Medicare & P.P.O Insurance may not cover the Preventive Care. Medicare & P.P.O Insurance may not cover at this level of service and frequency.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, **you should read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you **(Estimated cost: $150 / $200)**, in case you have to pay for them yourself or through other insurance.

Please choose **one** option by checking **one** box. **Sign** and **Date** your choice

☒ **Option 1. Yes. I want to receive these items or services.**

I understand that Medicare/P.P.O will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare/P.P.O. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare/P.P.O is making their decision. If Medicare/P.P.O does pay, you will refund to me any payments I made to you that are due to me. If Medicare/P.P.O denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare/P.P.O.'s decision.

☐ **Option 2. No. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare/P.P.O. and that I will not be able to appeal your opinion that Medicare/P.P.O. won't pay.

Date ______________ **Signature of patient or person acting on patient's behalf** ____________________

Print Name: ______________________________

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare/P.P.O., your health information on this form may be shared with Medicare/P.P.O. Your health information which Medicare/P.P.O. sees will be kept confidential by Medicare/P.P.O.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

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FALL PREVENTION BALANCE AND DIZZINESS SURVEY

Patient Name: ______________________ Age: __________ Date: __________

To help determine if you may be headed for a fall or have a balance disorder, take the Balance Self Test below. If you answer yes to one or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with the doctor any fears or concerns you have regarding falling, dizziness or vertigo, so that he or she may help determine the cause of your symptoms.

Please read each question and check the box that most describes your answer.	Yes or Often	Some-times	No or Never
1. Do you ever lose your balance or feel dizzy or unsteady?			
2. Have you continued to experience dizziness after an injury or accident?			
3. Do you feel unsteady when you are walking or climbing stairs?			
4. Do you feel dizzy while sitting down or rising from a seated or lying position?			
5. Does walking down the isle of a supermarket or stopping next to moving traffic make you dizzy?			
6. Does moving your head quickly make you dizzy or cause you to feel nauseous?			
7. Are you dizzy or unsteady when you first get up in the morning?			
8. Do you ever fall or feel like you are about to fall for no apparent reason?			
9. Do you use a walker, cane, or any other form of assistance for your mobility?			
10. Have you had a recent loss of, or decrease in, your vision or hearing?			
11. Do you fear falling?			
12. Have you experienced dizziness, vertigo, or serious imbalance in the past six months?			
13. Has your balance problem caused problems in your social life?			
14. Have you fallen more than once in the past year without an obvious cause?			
15. Does dizziness or imbalance interfere with your job or your household responsibilities?			

Please fill out the top with your name and date, sign the survey at the bottom and provide this to your physician during your visit.

Patient Signature ______________________ Phone ______________________

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Dear Patient,

Welcome to out practice. We intend to provide you with the care and service that you expect and deserve. Achieving your **best possible health** requires a "partnership" between you and your doctor. As our "Partner in health", we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for me age, gender, and personal and family history. I understand I may need to complete these recommended health screenings or any other testing. These health screening are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screening, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-Up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover an treat a serious health condition. If I miss an appointment and do not reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make ever effort to reschedule missed appointments as soon as possible.

Call the Office When I do not Hear the Results of Labs and other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform my Doctor if I Decide to **Not** Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that **not** following my treat plan can have serious negative affects on my health. I will let my doctor know whenever I decide to **not** follow his or her recommendation so that he or she may fully inform me of any risk associated with my decision to delay or refuse treatment.
Thanks you for you partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health conditions please ask.

Patient Signature ____ Date ____________________

Print Name: ____

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PHQ-9 DEPRESSION SCREENER SCORING TALLY SHEET
PATIENT HEALTH QUESTIONNAIRE

Name: ______________________________ DOB: ______________

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and mark your response.

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless				
Trouble falling asleep, staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, or feeling that you are a failure, or feeling that you have let yourself or your family down				
Trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
Thinking that you would be better off dead or that you want to hurt yourself in some way				
TOTALS				

2. If you marked any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
0	1	2	3

Patient Name ______________________________ Date ______________

PHQ-9 scoring for severity determination
For healthcare professional use only

Scoring-add up all checked boxes on PHQ-9

For ever: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3.

Total Score	Depression Serverity
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

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SLEEP QUESTIONNAIRE

PATIENT INFORMATION

Patient Name: ______________________ DOB ______________ Gender: ❑ M ❑ F

Pt. Height __________ Pt. Weight: __________ Reffering Physician: ______________

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired or fatigued? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to imagine how they would affect you. Use the following scale to choose the most appropriate number in each situation.

0 = Would Never Doze 1 = Slight Chance of Dozing 2 = Moderate Chance of Dozing 3 = High Chance of Dozing

Sitting and reading	0	1	2	3
Watching T.V.	0	1	2	3
Sitting, inactive in a public place (theatre, meeting, classroom)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down for a rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total Score: ______________

Sleep Questionnaire

Do You Snore?	❑ Yes	❑ No	Do you wake up tired?	❑ Yes	❑ No
Do you have trouble falling asleep?	❑ Yes	❑ No	Do awaken from gasping/choking?	❑ Yes	❑ No
Do you have high blood pressure?	❑ Yes	❑ No	Are you depressed?	❑ Yes	❑ No
Do you wake up with a headache?	❑ Yes	❑ No	Do you have night sweats?	❑ Yes	❑ No
Are you tired throughout the day?	❑ Yes	❑ No	Do you have shortness of breath	❑ Yes	❑ No

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PREPARING FOR YOUR DOCTOR'S VISIT

Name: ______________________________ DOB: ______________

Fill out the information below to the best of your ability. Share it with your doctor. Be open and honest in answering any questions your doctor may ask you about the changes you've been experiencing.

Has your health, memory or mood changed?

____

____

How did it change?

____

____

When did you first notice the change?

____

____

How often does it happen?

____

____

When does it happen? Is it always at a certain time of day?

____

____

What do you do when it happens?

____

____

What behaviours are the same?

____

____

Do you have problems with any of the following?

Please check the answer.

Repeating or asking the same thing over and over?

☐ Not at all ☐ Sometimes ☐ Frequently ☐ Does not apply

Remembering appointments, family occasions, holidays?

☐ Not at all ☐ Sometimes ☐ Frequently ☐ Does not apply

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Name: ______________________________ DOB: ______________________

Writing checks, paying bills, balancing the checkbook?

❑ Not at all ❑ Sometimes ❑ Frequently ❑ Does not apply

Shopping independently (e.g., for clothing or groceries)?

❑ Not at all ❑ Sometimes ❑ Frequently ❑ Does not apply

Taking medications according to the instructions?

❑ Not at all ❑ Sometimes ❑ Frequently ❑ Does not apply

Getting lost while walking or driving in familiar places?

❑ Not at all ❑ Sometimes ❑ Frequently ❑ Does not apply

Medications and medical history

List medications (dosage, frequency) including over-the-counter and prescription:

____

____

List vitamins and herbal supplements:

____

____

List current medical conditions:

____

____

List past medical conditions:

____

____

Questions to ask the doctor

What are the tests I need to take and how long will it take to get a diagnosis?

Will you refer me to a specialist?

Could the medicines I'm taking be causing my symptoms?

Do I have any other conditions that could be causing my symptoms or making them worse?

What should I expect if it is Alzheimer's?

Which treatments are available for Alzheimer's? What are the risks and benefits and possible side effects?

What about participating in a clinical trial? What are the risks and benefits?

Is there anything else I should know?

When should I come back for another visit?

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MAINTAINING A HEALTHY LIFESTYLE

Name: ______________________________ DOB: ______________

Our main focus on health is to prevent disease. The following advice will help you stay in good health.

1. Eat healthy food. Increase fiber in your diet by including plenty of fruits and vegetables.
2. Excercise regularly. Excercise physiologists recommend 30 minutes of exercise 7 times a week. Brisk walking, jogging, swimming, cycling, treadmill, or any excercise which gives you pleasure is ok.
3. It has been proven that wearing a seat belt while driving and a helmet when cycling prevents injuries.
4. Using sunscreen when exposed to sun will prevent skin cancers. The higher the number, the greater the protection.
5. Self-examination once a month of breasts for all women, and breasts and testicular examination for all men, is recommended. This will detect tumors, and if found early, may cure cancer.
6. You should be immunized with Tetanus Toxoid every 10 years and Influenza vaccine every year in the fall season. If you are 65 and older or suffer from diabetes, lung diseases, cancer, heart or any chronic illness, Pneumonia vaccine is advised.
7. Protected sex has been proven to prevent sexually transmitted diseases like Chlamydia, Gonorrhea, Syphilis, Aids, Hepatitis and others.
8. A daily dose of 81 mg of aspirin is known to prevent heart attack and stroke. It is available as Ecotrin, Bayer's Coated Aspirin, or as coated generic aspirin.
9. A daily dose of 1000 units of Vitamin E helps improve memory.
10. To prevent Osteoporosis, all women should take calcium with vitamin D every day (1200 mg to 1500 mg of calcium, and 400 units of vitamin D). It is available as Tums, Oscal, and Caltrate etc. The pharmacist may suggest other brands.
11. Cigarette smoking is known to cause cancer, heart disease and stroke. We encourage you to discuss smoking cessation with your doctor.
12. Illicit street drugs are dangerous to health.

1240 E. Chapman Ave, Orange, CA 92866 (714) 771-2800 (714) 771-3200

ACHARYA & SHARMA
MEDICAL CORPORATION

SHASHI B. ACHARYA, M.D., F.A.C.P.
Diplomate, American Board of Internal Medicine & Geriatrics
PRAVIN V. SHARMA, M.D.
Diplomate, American Board of Internal Medicine

FALL PREVENTION TIPS

Name: ______________________________ DOB: ______________

Falls are the leading cause of injury and accidental death in adults over the age of 65 years. New or unfamiliar surroundings, improper footwear, cumbersome furniture arrangements, and distractions all can cause a person to accidentally stumble and fall, causing a serious injury, even death. Grace L. Walker, PT, DPT, OTD, says, "If a patient is unable to stand on one leg for one minute without support, this may bee a good candidate for our balance and fall prevention program." Grace goes on to say, "Implementing a few prevention practices at home can decrease a person's risk of an unnecessary fall."

Grace recommends:

Be sure you have adequate lighting throughout the house.

Wear appropriate footwear. When walking long distances or in unfamiliar areas, wear flat, nonslip shoes that fit well, and are comfortable.

Install railings in hallways and grab bars in the bathroom and shower to prevent slipping.

Arrange furniture so that it creates plenty of room to walk freely. If you are using a walking aid, ensure that doorways and hallways are large enough to get through with any devices you may use.

Install nonslip strips or a rubber mat on the floor of the tub or shower.

Do not walk and talk at the same time. Concentrate on the task of walking and continue the conversation after you've reached a safe place.

Remove throw rugs or secure them firmly to the floor.

Know your limitations. If there is a task you can not complete with ease, do not risk a fall by trying to complete it.

Use caution when carrying items while walking.

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PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT)

GENERAL

Name (Last, First, Middle) : ____________________

Date of Birth (M/D/Y): ____________________ Social Security#: ____________________

Gender: __________ Driver's Licence Number: __________ State: __________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partner ☐ Other

CONTACT INFORMATION

Home Address: Street ____________________ City __________ State __________ Zip __________

Home Phone #: __________ Fax # : __________ Cell Phone # : __________

Employer Name: ____________________ Occupation : ____________________

Work Address: Street ____________________ City __________ State __________ Zip __________

Work Phone #: ____________________ Email # : ____________________

Emer. Contact: __________ Relationship: __________ Phone # : __________

Different from yours

PRIMARY INSURANCE

Name of Primary Insurance Co: ____________________ Phone # : ____________________

ID / Policy # : ____________________ Group # : ____________________

Subscriber/Insured : __________ Relationship : __________ Gender: __________

Date of Birth(M/D/Y): ____________________ Social Security # : ____________________

Employer Name: ____________________ Emp. Phone # : ____________________

SECONDARY INSURANCE

Name of Primary Insurance Co: ____________________ Phone # : ____________________

ID / Policy # : ____________________ Group # : ____________________

Subscriber/Insured : __________ Relationship : __________ Gender: __________

Date of Birth(M/D/Y): ____________________ Social Security # : ____________________

Employer Name: ____________________ Emp. Phone # : ____________________

PLEASE SIGN AND RETURN TO RECEPTIONIST

I, the undersigned, assign directly to Acharya & Sharma Medical Corp., all surgical and / or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid by insurance or not. I hereby authorize the Doctor to release all information necessary to secure payment of benefits.

Signature : ____ Date: ____________________

(If patient is a minor, Signature of parent or Guardian authorizing treatment)

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