Monroe Rheumatology and Endocrinology

Nisheet Prasad MD, Shilpi Singh MD, MPH

PATIENT DEMOGRAPHIC INFORMATION SHEET

(PLEASE PRINT CLEARLY)

Name: _____ Social Security #: ___-___-_____
(Last) (First) (Middle Initial)

Address: _____ Apt. # _____

City: _____ State _____ Zip _____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____- _____

Cell Phone: (_____)_____-_____ Email Address: _____

Date of Birth: _____ Sex: (M / F) Marital Status : (S / M / W / D)

In Case of Emergency Contact: _____ Phone: (_____)_____- _____

Purpose of visit or Diagnosis: _____

Referring Physician's Name: _____Phone (_____)_____-_____

Primary Care Physician: _____ Phone (_____) _____-_____

Pharmacy: _____ Phone (_____)_____- _____

Employer Name: _____

PRIMARY INSURANCE

Ins. Co. Name:_____

Policy #: _____ Group # _____

Relationship to Patient: _____ ___

Insured Name : _____ ___

Insured Date of Birth: _____ M / F

Insured SS#: _____-_____-_____ ___

SECONDARY INSURANCE

Ins. Co. Name: _____

Policy #: _____ Group # _____

Relation to Patient: _____

Insured Name : _____

Insured Date of Birth: _____ M / F

Insured SS#: _____-_____-_____

To protect patient confidentiality, we will only disclose your medical information as you instruct us to. Please answer the following:

May we leave message on your answering machine with the appointment time?_____Yes _____ No

May we leave messages on answering machine about medication changes? _____ Yes _____ No

May we call you at work? _____ Yes _____ No

What family member may we discuss your medical condition with?

Name: _____ Relation: _____

Name: _____ Relation: _____

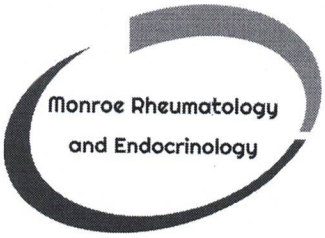
I have read the Office Policies: _____

(Sign)

I hereby authorize my insurance company benefits to be paid directly to **Monroe Rheumatology and Endocrinology LLC.** I realize I am responsible to pay any non-covered services, co-payment and co-insurance. I hereby authorize the release of pertinent medical information to the insurance company. I also realize that if my insurance plan requires referral, I am responsible to have a valid referral at every office visit. If for any reason my insurance does not cover services rendered, I am responsible for payment in a timely manner.

_____

(Signature)



PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Describe briefly your present symptoms:

Preferred Pharmacy:

Preferred Lab:

Preferred Imaging Facility:

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Social History

Occupation:_____
Smoking status: _____
Smoking (how much): _____
Tobacco years of use: _____
Former smokers quit time: _____
Illicit Drug Use: _____
What is your alcohol Intake: ❑ None ❑Occasional ❑Moderate ❑Heavy

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Anemia
- ❑ Ankylosing Spondylitis
- ❑ Anxiety Disorder
- ❑ Back Problems
- ❑ Bladder or Kidney Problems
- ❑ Blood Clot
- ❑ Cancer Type:_____
- ❑ Coronary Artery Disease
- ❑ Chrohn's Disease
- ❑ Depression
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ High Cholesterol
- ❑ Hyperlipidemia
- ❑ Hypertension
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Inflammatory Bowel Disease
- ❑ Kidney Disease
- ❑ Lung Disease
- ❑ Lupus
- ❑ Muscle/Joint/Bone Problems
- ❑ Osteoporosis
- ❑ PCOS
- ❑ Pituitary Disorder
- ❑ Psoriasis
- ❑ Rheumatic Fever
- ❑ Sjogrens Syndrome
- ❑ Skin Probems
- Thyroid Disease
- Tuberculosis

Other medical conditions (please list):

Surgical History (please list starting with the most recent):

FAMILY HISTORY(PLEASE LIST IF ANY MEDICAL CONDITIONS RUN IN YOUR FAMILY):

ex: Hypertension, cancer, diabetes, etc.

Condition	Relationship to you:

Monroe Rheumatology and Endocrinology

Statement of Patient Financial Responsibility

Patient Name: _____ **DOB:** _____

Monroe Rheumatology and Endocrinology LLC appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Monroe Rheumatology and Endocrinology LLC, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Monroe Rheumatology and Endocrinology LLC, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Cancellation / No Show Policy

We try to remind all of our patients of appointment at least 1 day prior. This is just a courtesy call. It is ultimately the patient's responsibility to remember their appointment. 24-hour notice is required when cancelling an appointment. A "NO SHOW" fee of $50 will be charged if you fail to notify the office. Your appointment will be rescheduled on the next available time.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

The Practice will notify you in writing via mail or via electronic methods of communication, if you are discharged from care.

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Monroe Rheumatology and Endocrinology LLC. I agree to pay Monroe Rheumatology and Endocrinology LLC, the full and entire amount of treatment given to me or to the above named patient at each visit.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

Monroe Rheumatology and Endocrinology LLC

Consent for Treatment and Authorization to Release Information
HIPAA Acknowledgement

I hereby authorize Monroe Rheumatology and Endocrinology LLC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Monroe Rheumatology and Endocrinology LLC, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

I, _____, acknowledge that I have received and reviewed the notice of Privacy practices of Monroe Rheumatology and Endocrinology, LLC and HIPAA regulations.

Patient Signature _____ Date _____

Monroe Rheumatology and Endocrinology

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REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby request that my records be released and sent to:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I hereby request that my records be released from:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Patient requesting transfer:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Dates of treatment: _____

Patient's Date of Birth: _____

_____ _____

Patient's Signature Date