**Sanjay Patel M.D.**

 **Jillian Dietz, NP Maggie Miller, NP Shannon McCarter, NP**

**New Patient Questionnaire**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of Visit: \_\_\_\_\_\_\_\_\_\_\_\_Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_letter sent

**(Nurse Only)** Vitals: HT\_\_\_\_\_ WT\_\_\_\_\_\_\_ BP\_\_\_\_\_\_\_\_\_ T\_\_\_\_ P\_\_\_\_\_ RR\_\_\_\_\_

 How did you find us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the main reason for your visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your symptoms (circle) **coughing, wheezing, nausea, vomiting, gas, congestion,**

**Diarrhea, hives, shortness of breath**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your symptoms worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your symptoms better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What seasons do your symptoms occur (circle): **Summer, Fall, Winter, Spring**

What medications have you tried?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What surgical treatment have you had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your occupation/Work (**patient**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

What diseases and conditions run in the family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Pets: \_\_\_\_(#) Dog \_\_\_\_ (#)Cat or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoke? Y / N How many years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Travel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Physician Area)

**Past Medical History:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy:**

Name of Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:**

Name Dose

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems (only circle all that apply)**

* **General:** Weight loss, night sweats
* **Head:** Headaches, dizziness
* **Eyes:** Double vision, eye pain.
* **Heart:** Chest pain, palpitations
* **Respiratory:** Cough, blood in sputum
* **Abdomen:** Pain, bloody stools
* **GU:** Painful urination,
* **Musculoskeletal:** Joint swelling, muscle pain
* **Neurologic:** Numbness, weakness,
* **Psychiatric:** Depression, Changes in sleep

#

# Sanjay C. patel, md

Jillian Dietz, NP Maggie Miller, NP Shannon McCarter, NP

9008 Indianapolis Blvd

Highland, IN 46322

219-513-8923

|  |
| --- |
|  |
| PATIENT INFORMATION (required) |
| Patient’s legal last name:  |  First: |  Middle: |
|  |
| Date of birth:  | Age: | Sex:  | Social security number: |
| Cell Phone #:(REQUIRED) | Home Phone #: | Email:(REQUIRED) |
| Street address:  | City: | State: | ZIP Code: |
|  |  |  |  |
|  Referring Doctor: First Name: Last Name: Phone #: |
|  |
| Responsible party (required)  |
| **Person responsible for bill:** | **Birth date:** | **Email (REQUIRED):** | **Phone #:** |
|  |  |  |  |
| ***Primary Insurance:*** |  **Address:**  |
| **Policy holder:** | **Subscriber’s S.S. #:** | **Birth date:** | **Group #:** | **Member ID #:** |
|  |  |  |  |  |
| **Patient’s relationship to subscriber** |  **Self** |  **Spouse** |  **Child** |  **Other** |
| ***Secondary Insurance:***  |
| **Policy holder:** | **Subscriber’s S.S. #** | **Birth date:** | **Group #:** | **Member ID #:** |
|  |  |  |  |  |
| **Patient’s relationship to subscriber** |  **Self** |  **Spouse** |  **Child** |  **Other** |
|  |
| eMERGENCY cONTACT (REQUIRED) |
| Name of local friend or relative (not living at same address): | Relationship to patient: | Phone #: |
|  |  |  |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I permit Allergy&Asthma Specialists or my insurance company to release any information required to process my claims. I also authorize and consent to all treatments, medications, exams, and procedures which Allergy&Asthma Specialists medical staff consider necessary or advisable for diagnosis and treatment. Additionally I hereby grant permission to Allergy&Asthma Specialists to send emails, text and voicemail messages as indicated above. Check box to decline above listed communications.  |
|  | ꭓ |
|  | **Patient/Guardian signature** |  | **Date** |  |



**Patient Financial Agreement Form**

|  |
| --- |
|  |

Welcome to Allergy&Asthma Specialists. Our professional staff is committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you read and sign prior to receiving treatment.

I hereby authorize the release of pertinent of medical information to my insurance carriers. I am aware that health insurance coverage varies and, while insurance carriers may use terms such customary, reasonable, prevailing, etc. to limit their coverage, I am ultimately responsible for services rendered by the physicians of Allergy&Asthma Specialists. If I have insurance that the doctors have contracted with, I understand that I will be responsible for any co-payments, deductibles, co-insurance, or any service that is considered medically necessary by my insurance company.

In the event I fail to pay the balance of my account to Allergy&Asthma Specialists of sixty (60) days of the date of service, my account will be turned to collections. In the event that it is necessary to turn my account over to collection, I will also be responsible for any and all costs of collection, including attorney fees and interest charges.

If you would like an estimate prior to services being rendered, please just let us know.  We'd be happy to help.

**Authorization and Release**

I have read and fully understand the Patient Financial Agreement as outlined above. I am also aware that I may obtain a copy of the Patient Financial Agreement form at any time as reference.

I understand that this authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, from this day forward until it has been revoked in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature Date Patient/Guardian Printed Name Date



**Patient Privacy Notice**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Allergy&Asthma Specialists is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties with respect to your protected health information.

Disclosure of your health care information

### **Treatment**

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.

### **Payment**

We many disclose your health care information to your insurance care provider for the purpose of payment or health care operations.

### **Workers’ Compensation**

We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

### **Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency of your death.

### **Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

### **Judicial and Administrative Proceedings**

We may disclose your health information in the course of any administrative or judicial proceedings.

### **Law Enforcement**

We may disclose your health information to a law enforcement official for the purpose such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, or other law enforcement purposes.

### **Deceased Persons**

We may disclose your health information to organizations involved to coroner’s medical examiners.

### **Organ Donation**

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

### **Research**

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

### **Public Safety**

It may be necessary to disclose your health information to appropriate person in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public. **Specialized Government Agencies**

We may disclose your health information for military, national security, prisoner and government benefit purposes.

### **Marketing**

We may contact you for marketing purpose or fund raising purposes.

**Change of Ownership**

In the event that Allergy&Asthma Specialists., is sold or merged with another organization, your health information/record will become the property of the new owner.

### **Your Health Information Rights**

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Allergy&Asthma Specialists., is not required to agree to the restriction of your request.

You have the right to have your health information received or communication through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that Allergy&Asthma Specialists amend your protected health information. Please be advised, however, Allergy&Asthma Specialists is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Allergy&Asthma Specialists

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

### **Changes to this notice of privacy practices**

Allergy&Asthma Specialists reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, Allergy and Asthma Specialists is required by law to comply with this notice.

Allergy&Asthma Specialists is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us.

### **Complaints**

Complaints about your Privacy rights or how Allergy&Asthma Specialists has handled your health your health information should be directed to us. You may submit a formal complaint to:

DHHS, Office of Civil Rights

200 Independence Avenue, SW

Room 509F HHH Building

Washington, DC 20201

**This notice is effective of today’s date listed below.**

I have read the Privacy Notice and understand my rights contained in the notice. By way of signature, I provide Allergy&Asthma Specialists with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



# Sanjay C. patel, md

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219-513-8923

Release of Medical Information

HIPAA Privacy Authorization Form

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Please check one of the following options:**

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may only be released to the following individual(s):

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] I do not authorize my information to be released to an individual(s).

This ***Release of Medical Information*** will remain in effect until terminated by me in writing.

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New Patient Paperwork Checklist

When receiving the new patient paperwork back from patient make sure the following is complete.

* Cell phone number
* Email address
* Subscriber name
* Subscriber date of birth
* Credit Card on file Agreement
* Testing

Checked by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_