Rakesh Passi M.D., LLC

Patient Information/Demographics

Todays Date (mm/dd/yyyy): _____

Patient Name: _____
(Last Name) (First Name)

Date of Birth (mm/dd/yyyy):_____/_____/_____ Sex: M_____ F_____

Address: _____/_____/_____/_____
(City) (State) (Zip)

Home Phone #_____-_____-_____Cell Phone #_____-_____-_____ Email address: _____

Social Security #_____-_____-_____ Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Preferred Language: _____ Race: _____ Ethnicity:_____

Primary Care Physicians Name: _____ Physicians Contact #_____-_____-_____

Emergency Contact Information

Name: _____ Relationship with the Patient:_____
(Last Name) (First Name)

Address (if different from above):_____/_____/_____/_____
(City) (State) (Zip)

Home Phone #_____-_____-_____Cell Phone #_____-_____-_____ Email address:_____

Patients Employer Information

Name: _____ Work Phone #_____-_____-_____ (ext :) _____

Address:_____/_____/_____/_____
(City) (State) (Zip)

Patients Insurance Information

Please fill the Workman's Comp section below only if the illness/visit to the doctor is employment related and kindly note that we may contact your employer (if required). If it is not employment related kindly skip this section and continue with Insurance Information on the next page.

Accident Cases – MVA/Workman's Comp (If Any / Only if applicable)

Name of Company:_____

Name of Contact Person: _____ Contact #_____-_____-_____

Address:_____/_____/_____/_____
(City) (State) (Zip)

(Insurance information continued on next page)

Patients Insurance Information

1. Primary Insurance:_____ Policy Id # _____

Subscribers Name: _____ Contact #_____-_____-_____

Subscribers SSN #_____-_____-_____ Subscribers Date Of Birth (mm/dd/yyyy):_____/_____/_____

Insurnace Company Address:_____/_____/_____/_____
(City) (State) (Zip)

Do you have any other Insurance? Yes_____ No_____ (If 'Yes' please fill out the information below):

2. Secondary Insurance:_____ Policy Id # _____

Subscribers Name: _____ Contact #_____-_____-_____

Subscribers SSN #_____-_____-_____ Subscribers Date Of Birth (mm/dd/yyyy):_____/_____/_____

Insurnace Company Address:_____/_____/_____/_____
(City) (State) (Zip)

Do you have any other Insurance? Yes_____ No_____ (If 'Yes' please fill out the information below):

3. Tertiary Insurance:_____ Policy Id # _____

Subscribers Name: _____ Contact #_____-_____-_____

Subscribers SSN #_____-_____-_____ Subscribers Date Of Birth (mm/dd/yyyy):_____/_____/_____

Insurnace Company Address:_____/_____/_____/_____
(City) (State) (Zip)

I HEAREBY AUTHORIZE RAKESH PASSI M.D., LLC, TO FURNISH INFORMATION TO INSURNACE CARRIERS CONCERNING MY ILLNESS AND TREATEMENTS AND I HEREBY ASSIGN THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE COMPANY OR WORKMAN'S COMP (if any).

PRINT NAME: _____ DOB: _____

Signature: _____ Today's Date: _____

Medical History Form

Name: _____ SS #_____ _____ _____

Education (highest level attended): _____Occupation: _____ Advanced Directives: Yes___ No___

GENERAL MEDICAL INFORMATION:

Describe the current medical problem/reason for today's visit:_____

List all doctors currently providing care: _____

Current Medications: _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Allergies to Medications (if any): _____

Allergies (e.g. itchiness or hives) to specific brands of soap/laundry detergent:_____

_____ _____ _____ _____ _____

Are you pregnant, planning a pregnancy or nursing a child (ladies only)? Yes___ No___

Do you smoke? Yes___ No___ Cigarettes: ____ Pipe:____ Cigars:____ illegal Drugs:___ No. of Years:_____ How much?_____

If you used to smoke and have stopped: When did you stop? _____ Interested in stopping? Yes___ No___

Do you Exercise regularly? Yes___ No___ Do you regularly drink alcohol? Yes___ No___ How much?_____

Do you regularly drink coffee?Yes___No___ How much?_____ Are you under a lot of pressure at work? Yes___ No___

PERSONAL MEDICAL/SURGICAL HISTORY:

Have you ever had any of the following (check all that applies to you):

__Chest Pain/Pressure	__Asthma	__Parkinson Disease	__Coronary Angio/Stent Year_____	__Tonsilectomy Year _____
__Hypertension	__Dizzy Spells	__Multiple Sclerosis	__Pacemaker Implant Year_____	__Gallbladder Year_____
__Heart Attack	__Diabetes	__Anemia	__Cardiac Cath Year_____	__Hysterectomy Year_____
__Stroke	__Cancer	__Lung Disorders	__Heart Valve Repair Year_____	__Thyriodectomy Year_____
__Headaches	__Memory Loss	__Skin Disorder	__Ablation Year_____	__Knee Surgery Year_____
__ Glaucoma	__Arthritis	__Cataract(s)	__ Allergies or Eczema	__Aneurysm Repair Year_____
__Blood Clots	__ Depression	__Ulcers	__Pneumonia	__Back surgery Year_____
__Prostate Problem	__Alzheimer's	__Carotid Surgery	__Epilepsy	__Irregular Heart Beat
__Appendectomy	__Other	__HOSPITALIZATION(s) Year(s)_____ _____ _____ _____ _____ _____		

Reason(s) for Hospitalization:_____

FAMILY HISTORY:

__Heart Disease
__High Blood Pressure
__Diabetes
__Stroke
__Cancer (specify location)_____
__Asthma
__Other

IMMUNIZATIONS & TESTS (PLEASE MENTION 'YEAR' IF KNOWN):

__ Flu	__Blood work	__Nuclear Stress Test
__Pneumovax	__Rectal Exam	__Cardiac Cath
__Tetanus	__Vision Test	__Mammography
__Shingles	__Dental Exam	__Bone Density
__TB Test	__Pap Smear	__Sigmoidoscopy
__EKG	__Prostate Exam	__Other
__Chest Xray	__Echocardiogram	

Review Of Systems

General:
__Weight loss
__Weight gain
__Fatigue
__Fever or chills
__Weakness
__Trouble sleeping

Skin:
__Rashes
__Lumps
__itching
__Dryness
__Color changes
__Hair and nail changes

Head:
__Headache
__Head injury
__Neck Pain

Ears:
__Decreased hearing
__Ringing in ears
__Earache
__Drainage

Eyes:
__Vision loss/changes
__Use glasses or contacts
__Pain
__Redness
__Blurry or double vision
__Flashing lights
__Specks
__Glaucoma
__Cataracts

Nose:
__Stuffiness
__Discharge
__Itching
__Hay Fever
__Nosebleeds
__Sinus pain

Throat:
__Bleeding
__Dentures
__Sore tongue
__Dry mouth
__Sore Throat
__Thrush
__Non-healing sores
__Lumps
__Swollen glands

Neck:
__Lumps
__Swollen Glands
__Pain
__Stiffness

Breasts:
__Lumps
__Pain
__Discharge
__Self-exams

Respiratory:
__Cough
__Sputum
__Coughing up blood
__Shortness of breath
__Wheezing
__Painful breathing

Cardiovascular:
__Chest Pain or discomfort
__Tightness
__Palpitation
__Shortness of breath with activity
__Difficulty breathing lying down
__Swelling
__Sudden awakening from sleep with shortness of breath

Gastrointestinal:
__Swallowing difficulties
__Heartburn
__Change in appetite
__Nausea
__Change in bowel habits
__Rectal bleeding
__Constipation
__Diarrhea
__Yellow eyes or skin

Urinary:
__Frequency
__Urgency
__Burning or pain
__Incontinence
__Change in urinary strength
__Blood in urine

Vascular:
__Calf pain with walking
__Leg cramping

Musculoskeletal:
__Muscle or joint pain
__Stiffness
__Back pain
__Redness of joints
__Swelling of joints
__Trauma

Neurologic:
__Dizziness
__Fainting
__Seizures
__Weakness
__Numbness
__Tingling
__Tremor

Hematologic:
__Ease of bruising
__Ease of bleeding

Endocrine:
__Head or cold intolerance
__Sweating
__Frequent urination
__Thirst
__Change in appetite

Psychiatric:
__Nervousness
__Stress
__Depression

Rakesh Passi M.D., LLC

172 Summerhill Road, Suite 4, East Brunswick, NJ 08816 | Contact # 732-238-6440 | Fax # 732-651-1431

Internal Policy on E-mail—Communication Guidelines: e-mail correspondence will not be used for urgent matters, nor will it be used when the message is quite lengthy or when back-and-forth correspondence about an issue is required. Under each of those circumstances, patient shall be directed to seek medical treatment, rather immediately for urgent matters. Practice will also avoid including patients' social security numbers, credit card numbers, or other financial account numbers (unless the last four digits of the number are used) in e-mail correspondence. This safeguard will be observed in order to protect patients from potential identity theft and practices from liability for breaches of patients' PHI and financial data, should such e-mails be intercepted or misdirected. Rakessh Passi MD LLC would also consider what types of transactions (e.g., prescription refills, appointment scheduling or reminders, patient reporting of blood pressure or blood sugar levels) and what types of health information or conditions (e.g., lab test results, mental health information, communicable disease information) will be addressed in e-mail correspondence at its own discretion. Whereas e-mails containing information about appointment reminders, prescription refills, or side-effects generally may not be considered "sensitive" PHI, when the prescription is for treatment of a communicable disease or other condition deemed "sensitive," or if the e-mails otherwise allude to such conditions, Practices would consider whether they will communicate such information to patients through e-mail. Patients are advised not to contact the office or the physician through e-mail for any queries regarding health, billing, schedule appointments etc. Patients shall continue to use the office contact # 732-238-6440 or fax # 732-651-1431 for any office/medical related correspondence. Patients may request the office staff or the Physician to send their personal documents through email and only on receiving an oral or written request will the office involve in an e-mail correspondence to send patient related data to the requested/authorized entity.

Authorization to use e-mail for Health-Related Activities

I the undersigned have agreed to provide my personal email address and authorized Rakesh Passi MD LLC to share my personal medical documents through e-mail as future correspondence (should there be a need). I have been advised about the privacy and security limitations of e-mail correspondence and that it includes potential privacy or security risks to the information provided through e-mail. I understand that as per the HITECH Act which modifies the HIPAA Privacy and Security Rules; it contemplates that if patients request copies of their medical records by e-mail, it suggests that Providers/Physicians must agree to such requests where feasible. I am also made aware that Rakesh Passi MD LLC continues to be fully committed to protecting my medical records and personal information and that they would not be involved in any e-mail correspondence without an oral or written request.

Patient Name:_____ Signature:_____ _____

Last M First Date

Rakesh Passi M.D., LLC

172 Summerhill Road, Suite 4, East Brunswick, NJ 08816 | Contact # 732-238-6440 | Fax # 732-651-1431

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Rakesh Passi MD LLC's Notice Of Privacy Practices, and that Rakesh Passi MD LLC may use and disclose my Health Information as described in the Notice.

_____ _____

Print Name of Patient (or Personal Representative) Relationship of Personal Representative

_____ _____

Signature of Patient (or Personal Representative) Date (mm/dd/yyyy)

Rakesh Passi M.D., LLC

172 Summerhill Road, Suite 4, East Brunswick, NJ 08816 | Contact # 732-238-6440 | Fax # 732-651-1431

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____ _____

Print Patient Name Patient Signature Date

_____

Address

I hereby authorize Rakesh Passi MD LLC and its employees/agents to use/disclose my protected health information as described below:

1. I authorize the use and disclosure of the following protected health information

_____
_____
_____

2. I authorize the disclosure of the protected health information to the following persons and entities:

_____
_____
_____

3. I authorize the use and disclosure of the protected health information for the following purposes:

_____
_____
_____

4. This authorization expires on the following date or upon occurrence of the following even:

_____
_____

5. I understand that this authorization is voluntary and that Rakesh Passi MD LLC may not condition treatment to sign this authorization. _____
   Patients Initials

6. I understand that I may revoke this authorization at any time by notifying Rakesh Passi MD LLC in writing of such revocation, but the revocation will only apply to the extent that Rakesh Passi MD LLC has not made use of or disclosed the protected health information in reliance on this authorization. _____
   Patients Initials