# INFECTIOUS DISEASE ASSOCIATES

380R Merrimack St • Suite 2B • Methuen, MA 01844
Ph: (978) 689-2510 • Fx: (978) 689-3510
Venugopal Saddi, MD • Nicole Sleiman, MD • Tanya Markos, NP


## NEW APPOINTMENT PAPERWORK

### WELCOME TO OUR CLINIC!

We're grateful for you taking the time to join us for your healthcare needs. The enclosed forms will give us a great head start on your care. You'll find three forms that we are required by law to have you fill out:

1. **CARE COORDINATION AND TREATMENT CONSENT FORM**. This form collects some of your basic personal information, the contact information for your emergency contact, and the location of your pharmacy where any prescriptions you may need can be sent. Signing this form acknowledges that you have been made aware of your HIPAA compliant privacy rights, and that you give your consent for our providers and associates to treat you and attain the necessary information relevant to your treatment.

2. **INSURANCE & BILLING CONSENT FORM**. This form lays out the conditions in which you and your health insurance plan are billed for the services rendered with our providers during the course of your treatment.

3. **PERSONAL HISTORY SELF-REPORTING QUESTIONNAIRE FORM**. This form allows you to report your own relevant social and medical history to our providers. We understand that discussing certain parts of your personal history can be difficult, but we ask that you complete this form to the best of your ability. Doing so helps us ensure that everything pertinent to your care is taken into consideration when our providers plan your treatment with you, and allows us to ensure that you're receiving the best care possible.

We appreciate having the opportunity to provide your care. When you have filled these forms out to the best of your ability and signed all three, you can bring in a printed copy when you attend your appointment, or send the electronic form to our HIPAA secured email address that safely goes directly to our practice manager:

office@infectiousdisease.clinic

These forms are part of your check-in process, so finishing them ahead of time can greatly reduce your wait! We look forward to giving you the care you deserve.

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## CARE COORDINATION AND TREATMENT CONSENT FORM

### SECTION I: PATIENT INFORMATION

**Patient Name:** _____ **DOB:** _____ **Sex:**_____

**Street Address:** _____

**City:** _____ **State:** _____ **ZIP:** _____

**Phone:** (_____) _____-_____ **Alt:** (_____) _____-_____

**Email Address:** _____

I would like access to the healow Patient Portal using the email address I have provided. ☐ Yes ☐ No

### SECTION II: EMERGENCY CONTACT INFORMATION

**Contact Name:** _____ **Relation:** _____

**Street Address:** _____ ☐ Same as Patient

**City:** _____ **State:** _____ **ZIP:** _____

**Phone:** (_____) _____-_____ **Alt:** (_____) _____-_____

I authorize **IDAPC** to share details related to my case with my emergency contact. ☐ Yes ☐ No

### SECTION III: CARE TEAM AND PHARMACY INFORMATION

**Primary Care Provider:** _____ **City:** _____

**Referring Provider:** _____ ☐ Same as Primary Care Provider

**Pharmacy:** _____ **Street:** _____ **City:** _____

**By signing below, I hereby attest to the following:**

- I consent to be treated by the healthcare providers practicing with **INFECTIOUS DISEASES ASSOCIATES, PC**, and understand that I have the right to revoke this consent at any point during the course of my treatment, except on actions already taken by these healthcare providers and their associated clinical personnel.
- I authorize **INFECTIOUS DISEASES ASSOCIATES, PC** to release and receive any information necessary in the course of my examination or treatment, including health and medication history, to/from my health insurance carriers, primary care provider, referring clinicians, and any other clinicians, practices, or facilities to/from whom I may be referred in the course of this treatment.
- I have received a copy of the **HIPAA** Notice of Privacy Practices from **INFECTIOUS DISEASES ASSOCIATES, PC**, which is attached to this intake paperwork for me to read and keep a copy of, and is also posted beside the reception desk.

X_____ _____

Patient Signature (or signature of other authorized representative) Date Signed

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## INSURANCE & BILLING CONSENT FORM

- I, _____, understand that my health insurance coverage is a contract between myself and my health insurance carrier, and that payment for services rendered by the health care providers at **INFECTIOUS DISEASES ASSOCIATES, PC**, **across all dates of service**, is ultimately my responsibility.

- I understand that, if my health insurance plan requires a referral, it is ultimately my responsibility to ensure that my primary care/referring provider provides one to **INFECTIOUS DISEASES ASSOCIATES, PC** in a timely manner, and that failure to do so may result in denial of coverage by my health insurance carrier. I understand that payment for all services rendered by providers at **INFECTIOUS DISEASES ASSOCIATES, PC**, **across all dates of service**, will then become my responsibility.

- I understand that some expenses are not covered by my health insurance carrier. I agree to pay all copay, coinsurance, and deductible amounts in full in a timely manner.

- I understand that certain visit types and procedures may not necessarily be covered by my health insurance carrier, and agree to pay for all associated expenses incurred **across all dates of service** in that event, except for those services in which billing a patient is prohibited by law.

- I understand that certain expenses may not be assigned to my personal responsibility by my health insurance carrier before the end of my care with **INFECTIOUS DISEASES ASSOCIATES, PC**. In such events, I agree to have a bill for any outstanding balance **discretely** sent to my address on file, or that I have arranged alternate/electronic invoicing methods with the office staff at **INFECTIOUS DISEASES ASSOCIATES, PC**.

- I understand that failure to ensure all billed charges are covered and/or paid may result in my account being transferred to a collections agency.

- I understand that any questions I may have regarding a bill can be directed toward the billing staff of **INFECTIOUS DISEASES ASSOCIATES, PC**, and that I am entitled to an explanation of charges upon receiving a bill for an outstanding balance of any amount.

**By signing this document, I am attesting that I have read the information above, and agree to abide by all terms listed.**

X_____ _____
Patient Signature (or signature of other authorized representative) Date Signed

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## PERSONAL HISTORY SELF-REPORTING QUESTIONNAIRE FORM

### SECTION I: PERSONAL INFORMATION

**Patient Name:** _____ **DOB:** _____

**Preferred Name:** _____ **Preferred Pronouns:** _____ ☐ Prefer to Not Answer

**Primary Language**: _____ ☐ Translator Needed **Race:** _____ ☐ Prefer to Not Answer

**Ethnicity:** _____ ☐ Prefer to Not Answer **Nation of Origin:** _____ ☐ Prefer to Not Answer

### SECTION II: MEDICAL HISTORY

*Please indicate with a ✓ if any of the following apply to your medical history.*

| CONDITION | CURRENT | PAST | NOTES |
|---|---|---|---|
| Bone Infections | ☐ | ☐ | |
| Cancer | ☐ | ☐ | |
| Congestive Heart Failure | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | |
| Frequent Urinary Tract Infections | ☐ | ☐ | |
| Hepatitis | ☐ | ☐ | |
| High Blood Pressure/Hypertension | ☐ | ☐ | |
| HIV/AIDS | ☐ | ☐ | |
| Kidney Failure | ☐ | ☐ | |
| MRSA/Staph Infections | ☐ | ☐ | |
| Pneumonia | ☐ | ☐ | |
| Skin Infections | ☐ | ☐ | |
| Tuberculosis | ☐ | ☐ | |
| Other | ☐ | ☐ | |
| | ☐ | ☐ | |
| | ☐ | ☐ | |

### SECTION III: MEDICATIONS

*Please list all medications you are currently taking, including prescriptions and over-the-counter.* ☐ Separate List Attached

| MEDICATION NAME | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Section IV: Allergies

*Please list all known allergies, including allergies to any medications.* ☐ No Known Allergies

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## Section V: Procedures & Testing

*Please list all recent procedures, including CAT scans, MRIs, blood tests, urine tests, and x-rays.*

| Procedure | Date | Location |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Section VI: Hospitalizations

*Please list all recent inpatient hospital admissions, regardless of length of stay.*

| Reason for Admission | Date | Location |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Section VII: Surgeries

*Please list all surgeries you have undergone, including emergency, reparative, cosmetic, and transplants.*

| Surgery | Date | Location |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Section VIII: Family History

*Please indicate with a ✓if any members of your immediate family have suffered from any of the below.*

| ✓ All That Apply | Mother | Father | Sibling | Child | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather |
|---|---|---|---|---|---|---|---|---|
| Anxiety | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Autoimmune Disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bleeding Disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| HIV / AIDS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Seizure Disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Please Specify | | | | | | | | |

## Section IX: Social History

*Please indicate with a ✓to any of the following that apply.*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Marital Status | ☐ Single | ☐ Married | ☐ Separated | ☐ Divorced | ☐ Widowed | | |
| Employment Status | ☐ Unemployed | ☐ Full-Time | ☐ Part-Time | ☐ Contract | ☐ Student | ☐ Retired | ☐ Disability |
| Occupation | | | | | | | |
| IV Drug Use | ☐ Yes | ☐ No | ☐ Former | Specify: | | | |
| Recreational Drug Use | ☐ Yes | ☐ No | ☐ Former | Specify: | | | |
| Marijuana Use | ☐ Yes | ☐ No | ☐ Former | Specify: | | | |
| Tobacco Use | ☐ Yes | ☐ No | ☐ Former | Specify: | | | |
| Alcohol Use | ☐ Yes | ☐ No | ☐ Former | Specify: | | | |
| Have you recently been in contact with children? | ☐ Yes | | ☐ No | | | | |
| If yes, were any of the children sick? | ☐ Yes | ☐ No | ☐ Unknown | ☐ N/A | | | |
| How many people live in your home? | ☐ 1 | ☐ 2-4 | ☐ 5-8 | ☐ 9+ | | | |
| Please list any places you have travelled to | | | | ☐ N/A | | | |
| Do you spend time outdoors? | ☐ Yes | | ☐ No | | | | |
| Have you noticed any recent bite marks or attached insects? | ☐ Yes | | ☐ No | | | | |
| Have you recently experienced any physical trauma or lacerations? | ☐ Yes | | ☐ No | | | | |
| Please list your recreational hobbies | | | | | | | |

## Section X: Review of Systems

*Please indicate with a ✓ if any of the following apply to you.*

| Constitution | | | | |
|---|---|---|---|---|
| ☐ Fever | ☐ Chills | ☐ Night Sweats | ☐ Weight Loss | ☐ Swollen Lymph Nodes |

| Eyes | | | |
|---|---|---|---|
| ☐ Visual Changes | ☐ Pain Behind Right Eye | ☐ Pain Behind Left Eye | ☐ Pain Behind Both Eyes |

| Ears | | | |
|---|---|---|---|
| ☐ Decreased Hearing | ☐ Ringing | ☐ Pain | ☐ Drainage |

| Nose | | |
|---|---|---|
| ☐ Sinus Troubles | ☐ Hay Fever | ☐ Seasonal Allergies |

| Mouth & Throat | | | |
|---|---|---|---|
| ☐ Sore Throat | ☐ Thrush | ☐ Oral Ulcers | ☐ Recent Dental Work |

| Cardiac | | | | |
|---|---|---|---|---|
| ☐ Chest Pain | ☐ Palpitations | ☐ Heart Murmur | ☐ Pacemaker | ☐ Artificial Valve |

| Pulmonary | | |
|---|---|---|
| ☐ Coughing | ☐ Shortness of Breath | ☐ Emphysema |

| Gastrointestinal | | | | |
|---|---|---|---|---|
| ☐ Nausea | ☐ Vomiting | ☐ Abdominal Pain | ☐ Diarrhea | ☐ Decreased Appetite |

| Gastrourinary | | | | | |
|---|---|---|---|---|---|
| ☐ Urinary Pain | ☐ Blood in Urine | ☐ Frequent UTIs | ☐ Discharge | ☐ Urinary Frequency | ☐ History of STDs |

| Back | | |
|---|---|---|
| ☐ New Back Pain | ☐ History of Back Pain | ☐ Chronic Back Pain |

| Musculoskeletal | | | |
|---|---|---|---|
| ☐ Joint Pain | ☐ Joint Swelling | ☐ Muscle Weakness | ☐ Muscle Pain |

| Hematology | | | |
|---|---|---|---|
| ☐ Easily Bruised | ☐ Unexplained Bruises | ☐ Bleeding Disorder | ☐ History of Blood Transfusions |

| Skin | | | | |
|---|---|---|---|---|
| ☐ Psoriasis | ☐ Itching | ☐ Rashes | ☐ Recent Tattoos | ☐ Recent Piercings |

| Psychology | | | |
|---|---|---|---|
| ☐ Depression | ☐ Anxiety | ☐ Suicidal Ideation | ☐ Suicidal Actions |

| Endochrine | | |
|---|---|---|
| ☐ Diabetes | ☐ Hypothyroidism | ☐ Hyperthyroidism |

| Neurology | | | |
|---|---|---|---|
| ☐ History of Seizure Disorder(s) | ☐ History of Stroke(s) | ☐ Dizziness or Vertigo | |
| ☐ Lightheadedness | ☐ Numbness or Tingling | ☐ Leg Weakness | ☐ Headaches or Migraines |

Please take a moment to review your answers to ensure everything is accurate, and that the questionnaire has been filled out in its entirety. Your self-reported answers about your personal, social, and medical history are critical to your providers in formulating your plan of care.

**By signing and dating below, I attest that the information I have provided in this form is both complete and accurate to the best of my knowledge.**

X_____ _____

Patient Signature (or signature of other authorized representative) Date Signed