Lefferts Medical Associates PC

Inderpal Chhabra MD, FACP
Dalbir Chhabra MD
266-19 Union Turnpike
New Hyde Park, NY 11040
(718) 347-0434
Fax (718) 347-0517
www.LeffertsMedical.com

Welcome!

We are pleased you have chosen to become part of the Lefferts Medical Associates PC family.

Lefferts Medical Associates PC provides state of the art Medical treatment of various diseases of men, and women , such as Diabetes, Hypertension, Pulmonary, Headaches, Cardiac care, Cholesterol and many more. Our patients come to us with a variety of medical complaints, from simple colds to complex cardiovascular and cancer related problems. Our aim is to provide the same level of expertise regardless of your problem or insurance coverage. We have always provided quality, compassionate care in a friendly atmosphere in the treatment of medical diseases, which has earned us our outstanding reputation.

The physicians in the group utilize a team approach in treating our patients. Although each physician sees his own patients, the physicians are associates, which assures that a Physician is always available should an emergency arise. All Physicians are Board Certified in Internal Medicine, which assures you the highest quality of Medical Care. We provide 24 hour coverage for any emergencies arising after hours. Just call any of our offices to get the number for emergencies.

As a Primary Care Physician, our role is to provide outstanding care and treatment for your medical needs. Should the need for a specialist arise, we refer and coordinate care with various Specialists who share our vision and compassion in taking care of your problems.

We perform a variety of procedures in our offices, such as E.K.G., Spirometry, Echocardiogram, Carotid Doppler, 24 hour Holter monitoring, and Blood tests such as Glucose and Lipid (Cholesterol) tests. We have carefully chosen our personnel, office procedures and medical equipment to provide quality services in a pleasant, efficient, and friendly atmosphere.

If you have any suggestions, complaints or comments regarding our services, please inform us so that we may better serve you.

Thank you and welcome,

Lefferts Medical Associates PC

What to bring on the first appointment:

- Forms sent to you in this package
- Your insurance card
- Please call your insurance to make sure we are the primary physician
- A picture ID

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Lefferts Medical Associates PC** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Lefferts Medical Associates PC**. I understand that diagnosis or treatment of me by **Inderpal Chhabra M.D./ Dalbir Chhabra M.D.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Lefferts Medical Associates PC** is not required to agree to the restrictions that I may request. However, if **Lefferts Medical Associates PC** agrees to a restriction that I request, the restriction is binding on **Lefferts Medical Associates PC** and **Inderpal Chhabra M.D./ Dalbir Chhabra M.D.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Inderpal Chhabra M.D./ Dalbir Chhabra M.D.** or **Lefferts Medical Associates PC** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Lefferts Medical Associates PC**'s Notice of Privacy Practices prior to signing this document. The **Lefferts Medical Associates PC**'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Lefferts Medical Associates PC**. The Notice of Privacy Practices for **Lefferts Medical Associates PC** is also provided **at the waiting area** and on the website at www.indchhabra.com. This Notice of Privacy Practices also describes my rights and the **Lefferts Medical Associates PC**'s duties with respect to my protected health information.

Lefferts Medical Associates PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the **Lefferts Medical Associates PC**'s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative/ Date Signed

_____
Name of Patient or Personal Representative

Lefferts MD Medical Associates PC

PATIENT REGISTRATIO

Name _____ SS# _____

GENERAL MEDICAL INFORMATION

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

Present medications: _____

Allergies to medications: _____

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

Other physicians currently treating you: _____

Previous or other medical problems: _____

List any previous surgeries or hospitalizations (include number of miscarriages and live births): _____

Females only: Are you pregnant, planning a pregnancy or nursing a child? ❑ Yes ❑ No

Do you smoke? ❑ No ❑ Yes ❑ Cigarettes ❑ Pipe ❑ Cigars No. of years _____ How much? _____

Interested in stopping? ❑ Yes ❑ No

Do you regularly drink alcohol? ❑ Yes ❑ No How many ounces/beers per day? _____

Do you regularly drink coffee? ❑ Yes ❑ No How many cups per day? _____

Are you under a lot of pressure at work? ❑ Yes ❑ No Please describe: _____

PERSONAL MEDICAL HISTORY

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

❑ Chest pain/pressure/tightening _____	❑ Asthma _____	❑ Kidney disease _____
❑ Hypertension _____	❑ Dizzy spells _____	❑ Shortness of breath _____
❑ Heart attack _____	❑ Cancer _____	❑ TB/Lung disorder _____
❑ Stroke _____	❑ Diabetes _____	❑ Ulcers _____
❑ Headaches _____	❑ Arthritis _____	❑ Skin disorders _____
❑ Glaucoma _____	❑ Difficulty hearing _____	❑ Hepatitis _____
❑ Allergies or Eczema _____	❑ Glaucoma _____	❑ Cataracts _____
❑ Depression _____	❑ Memory loss _____	❑ Digestive problems _____
❑ Blood in stool _____	❑ Hemorrhoids _____	❑ Frequent urinary infections _____

Hepatitis C risk factor

❑ Blood transfusion prior to 1992	❑ Contact with blood/bodily fluid	❑ Shared razor/toothbrush
❑ IV drug use (1+ times)	❑ Tattoos	❑ Body piercing

IMMUNIZATIONS

(Year last received, if known)

Smallpox _____

Tetanus _____

Typhoid _____

Polio _____

Influenza _____

Pneumonia _____

Rubella _____

Hepatitis _____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	C	Ire
HIGH BLOOD PRESSURE	❑	❑	❑	❑	❑		I
EPILEPSY	❑	❑	❑	❑	❑		I
CANCER	❑	❑	❑	❑	❑		I
ECZEMA / PSORIASIS	❑	❑	❑	❑	❑		I
HEART ATTACK / STROKE	❑	❑	❑	❑	❑		I
DIABETES	❑	❑	❑	❑	❑		I
ASTHMA	❑	❑	❑	❑	❑		I
HAY FEVER	❑	❑	❑	❑	❑		I

Name

Lefferts Medical Associates PC

Patient Registration

Name _____ SS# _____

Street Address _____ Date of birth_____ Marital status: S M W Sep D

City _____ State _____ Zip_____

Telephone: Home_____ Office _____

Referred by _____

Spouse's name _____

Spouse's employer / address _____

Emergency contact _____ Tel# _____ Relationship _____

Patient Employer Information

Employer name _____ Tel# _____

Employer street address _____ City / State _____ Zip_____

Patients occupation_____

Insured Person (if not patient)

Name _____ Tel# _____

Street Address _____ City / State _____ Zip_____

Relationship to patient _____

Insurance

Medicaid # (if applicable)_____ Medicare # (if applicable) _____

Primary Insurance Company Name_____

ID #_____ Group # _____ Tel.# _____

Secondary Insurance Company Name _____

ID #_____ Group # _____ Tel.# _____

Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date _____ Signature _____

I hereby authorize Dr. _____ to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Dr. _____ (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ Signature _____
(Patient, parent, or guardian)

Name