Patient Name: ____ **Birthdate:** ____________________

Social Security #: ______________________ **Marital Status:** _________ **Age:** ________ **Sex:** _______

Address:____

City:_______________________________________ **State:**_______ **Zip Code:**___________________

Home Phone: ____________________ **Cell Phone:** ________________________

Email:____

Preferred Contact Method: ____________________ **Allow Text Message Alerts: Yes / No**

Allow Email Message Reminders & Alerts: Yes / No

Do You Request Access to Your Patient Portal (email address is required): Yes / No

Primary Care Physician: ____

Who referred you to our office? ____

Place of Employment: ____

Allergies:____

Emergency Contact: _____________________________________ **Phone:** _______________________

Preferred Pharmacy:____

Primary Insurance:____

Primary Insurance Subscriber's Date of Birth: _____/_____/_____

Secondary Insurance: ____

I understand that I am financially responsible for all charges for services related to my visit including the balance remaining after insurance has been applied.

<u>Assignment of Benefits:</u>

I authorize payment of Medicare and/or insurance benefits be made on my behalf to Shoaib Chowdhury, MD.

Signature: ____ **Date:**_________________

<u>Release of Information:</u>

I authorize any holder of medical information about me to release to the Health Care Financing Administration or its intermediaries/carriers, any information needed to determine benefits for this or any related claim. I permit a copy of this authorization to be used in place of the original and understand that charges not covered by my insurance plan are my responsibility.

Signature:____ **Date:** ________________

Medication List

Name:____ **Date of Birth:**__________________

Allergies:____

____

Medication	Dose	Frequency

Name:____ DOB:__________________________

Review of Symptoms (Check all that Apply)

Yes/No	Cardiac	Yes/No	Respiratory
	Chest Pain		Shortness of Breath
	Heart Rhythm		Cough/Sputum/Phlegm
	Fainting/Blackouts		Wheezing
	Heart Murmur		Chronic Lung Disease
	Swelling		**HEENT**
	Leg/Buttock Pain		Serious Eye Problems
	Constitutional		Hearing Problems
	Trouble Sleeping		Wear Glasses
	Lack of Energy		**Hematologic**
	Appetite/Weight Changes		Bleeding Disorders
	Thyroid Problems		Anemia
	Fevers/Freq. Infections		Blood Clots
	Gastrointestinal		**Genito-Urinary**
	Nausea/Vomiting		Frequent Urination at Night
	Heartburn		Difficult Urination
	Constipation		Prostate Problems
	Blood in Stool		Blood in Urine
	Diarrhea		Loss of Bladder Control
	Swallowing Difficulties		**Neurologic**
	Abdominal Pain		Numbness/Tingling
	Musculoskeletal		Dizziness
	Difficulty Walking		Weakness
	Joint Pain/Swelling		Seizures
	Psychological		**Skin**
	Depression/Anxiety		Non-Healing Sores

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Acknowledgement of Notice Delivery

Acknowledgement:

I acknowledge that I have received the attached Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Notice of Privacy Practices.

____ ________________________

Patient or Personal Representative Signature **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.

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