☐ Shahbaz Ahmad, MD

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# Comprehensive ID Care, PA

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## NEW PATIENT REGISTRATION

**Name (First, Middle,** ______________________________________________

**Date of Birth MM/DD/YYYY:** _____________ **Age:** ______ **Social Security Number:** __________________

**Street Address:** ______________________________________________

**City:** _______________ **State:** ____________ **Zip Code:** _______________ **Sex:** ☐Male ☐Female

**Main Phone:** _______________________ **Alternative Phone:** _______________________

**Email:** ______________________________________________

**Reason for Visit:** ______________________________________________

**Primary Care Physician's Name:** ________________ **Primary Care Physician's Phone:** ______________

***Emergency Contact*** **Full Name:** ______________________________________________

**Relationship:** ______________ **Phone Number:** ____________________

***Marital Status (Optional)*** ☐Married ☐Single ☐Divorced ☐Widowed

**Ethnicity (Optional)** ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐White ☐Hispanic or Latino ☐Native Hawaiian or Other Pacific Islander

### *PRIMARY & Secondary Insurance*

***INSURANCE COVERAGE – PRIMARY***

**Company Name:** ________________ **Member ID:** ___________________ **Group No:** _________

**Name of Policy Holder:** _________________________ **Date of Birth:** _____________________

**Relationship to Insured:** ☐Self ☐Spouse ☐Child ☐Other ________________________________

***INSURANCE COVERAGE – SECONDARY***

**Company Name:** ________________ **Member ID:** ___________________ **Group No:** _________

**Name of Policy Holder:** _________________________ **Date of Birth:** _____________________

**Relationship to Insured:** ☐Self ☐Spouse ☐Child ☐Other ________________________________

### *PREFFERED PHARMACY*

**Pharmacy Name:** ____________________ **Pharmacy Phone Number:** ______________________

**Pharmacy Address/Location:** ______________________________________________

# Comprehensive ID Care, PA

## *HIPPA FORM*

**Please list the individuals with whom we may discuss your medical information with:**

Name: ______________________________________________ Relationship: ____________________________

Name: ______________________________________________ Relationship: ____________________________ *I*

*certify that by my signature below, I give* **Comprehensive ID Care, PA** *permission to discuss my medical information with the individuals listed above. This may be revoke anytime by my signature.*

_________________________________ ____________________________ ___________________

**Printed Name** **Signature** **Date**

## *TERMS OF TREATMENT*

*Please **initial** and **sign** where indicated to acknowledge your receipt and understanding of them.*

**______ Assignment of Benefits**: The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Comprehensive ID Care, PA and its related companies. I understand that I am financially responsible for any balance. I also authorize Comprehensive ID Care and its related companies, or insurance company to release medical information required to process claims.

**______ Consent for Communication:** I understand Comprehensive ID Care, PA will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders.

**______ Payments:** Payment is due at time of service, including copays, deductibles, co-insurance, and prior balance due. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents, less any amount paid by insurace to Comprehens ive ID Care & its r elated companies. If you have any questions regarding this, please call your insurance company.

______ **Annual/Physical Exams:** If you are here for physical exam and want to be seen for other health issues in addition to the Annual/Physical Exam, then we will bill your insurance for both sick and well visit. Your insurance might not pay for the combination visit; if this is the case then you are responsible in paying the complete balance due.

**______ Prescriptions**: Our doctor MUST SEE YOU prior to prescribing a new RX, refills on Antibiotics or Narcotics (Controlled medications) and changing your existing medication. NO controlled medication will be prescribed over the phone, out of State, after hours, or weekends. If you have not been seen the doctor within the past 3 months and need a refill, you must schedule an appointment to see doctor for your prescription refill.

**______ Referrals:** Obtaining a referral from your insurance can take up to 72 hours or more. Please do not call from the specialist's office at the time of your appointment for a referral. Please call our office and schedule an appointment to get a referral before seeing a specialist.

____________________________________ ____________________________ _______________

**Printed Name** **Signature** **Date**

# Comprehensive ID Care, PA

Name: ______________________________________ DOB: __________________ Age: ______

## *MEDICAL HISTORY*

***Please check off the following that apply to you.***

☐Heart Disease
☐Heart Murmur
☐Rheumatic Fever
☐Asthma
☐COPD
☐Pneumonia
☐High Blood Pressure
☐Stroke
☐Blood Clot in Vein
☐Rheumatological Disease
☐High Cholesterol
☐Sickle Cell Disease
☐Blood Transfusion

☐Diabetes
☐Cancer
If so, what kind? _________
☐Migraine
☐Congenital Disease
☐Seizures
☐Epilepsy
☐Liver Disease
☐Hepatitis
☐Mononucleosis
☐Gallbladder Disease
☐STD
☐Kidney Problems

☐Mood Disorders
☐Depression
☐Anxiety
☐Chronic Pain
☐Arthritis
☐Osteoporosis
☐Insomnia
☐Anemia
☐Sleep Apnea
☐Other ________________

***Surgical Procedures / Hospitalizations*** | ***Year***

_______________________________ ________
_______________________________ ________
_______________________________ ________

***Social History***

Do you smoke?☐Yes ☐No
If yes, how many times per day? ____________
Do you drink alcohol? ☐Yes ☐No
If yes, how many units per week? ___________
Have you taken illegal drugs? ☐Yes ☐No
If yes, which ones? _______________________

***Family History***

Do any of the following conditions run in your family? If so, please list their relationship to you.

| Condition | Relationship |
|---|---|
| ☐Stroke | |
| ☐Heart Attack/Disease | |
| ☐High Cholesterol | |
| ☐High Blood Pressure | |
| ☐Cancer | |
| What kind? | |
| ☐Diabetes | |
| ☐Genetic Condition | |
| ☐Breast Disease | |

***What date, if ever, did you last have the following?***

______ Cholesterol Check
______ Colonoscopy (50+)
______ EKG
______ Flu Vaccine

______ Prostate Screening (Men 50+)
______ Mammogram (Women 40+)
______ Pap Smear (Women 18+)
______ Bone Density Screen (65+)

______ Shingles Vaccine (50+)
______ Pneumonia Vaccine (65+)
______ Last Menstrual Cycle
______ Last Fall (65+)

| **MEDICATION LIST** | | |
|---|---|---|
| Name | Dose | Frequency |
| | | |
| | | |
| | | |
| | | |
| | | |

| **ALLERGIES** | |
|---|---|
| Food/Drug Name | Reaction |
| | |
| | |
| | |
| | |
| | |

## Comprehensive ID Care, PA

## Autherization for Treatment:

Any and all procedures will be thoroughly explained before they are performed. You or your family will
be given the opportunity to ask questions. I agree to cooperate fully and to participate in all agreed upon medical care procedures and to comply with a plan of care as it is established. I agree to follow the recommendations from the healthcare provider has given to me. Are you acknowledge that I have read
and received copies of authorization for treatment
and patience right and responsibilities.

Patient name: Date of Birth

Patient signature: Date:

Witness signature: Date: