AAA MEDICAL GROUP
2477 County Rd 516 Unit 103, Old Bridge NJ, 08857
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Rizwana Khan, MD
Internal Medicine
Primary Care

Patient Information:

Name:_____Today's Date:_____

Last First Middle

Address:_____Home Phone:_____

City:_____State:_____Zip:_____Cell Phone:_____

Sex: ▢ M ▢ F Age:_____Birthdate:_____Social Security#_____

Check One:

Status: ▢ Married ▢ Widowed ▢ Single ▢ Minor ▢ Separated ▢ Divorce ▢ Partnered

Ethnicity: ▢ Hispanic or Latino ▢ Not Hispanic or Latino ▢ Refusal ▢ Other

Race: ▢ American Indian/Alaskan Native ▢ Asian ▢ Black/Native American ▢ Native Hawiian/Pacific Islander

Occupation:_____Email:_____

How did you hear about our practice?_____

In case of emergency, who should be notified?_____

Relation:_____Phone:_____

Preferred Pharmacy:_____

Address:_____

Medical History:

When was your last physical exam?_____

1) Are you currently taking any medications? ▢ Yes ▢ No

   Please Describe:_____

2) Do you have any allergies?

   Food:

   Seasonal:

   Drug Allergies:

   ▢ No Known Allergies

3) Do you smoke? ▢ Yes ▢ No ▢ In the Past

4) Do you use alcohol? ▢ Yes ▢ No ▢ In the Past

5) Do you use cocaine or other drugs? ▢ Yes ▢ No ▢ In the Past

Have you had any of the following:

Anemia (low blood count)----------▢ Yes ▢ No
Arthritis----------▢ Yes ▢ No
Asthma ----------▢ Yes ▢ No
Bleeding Tendency----------▢ Yes ▢ No
Blood Disease----------▢ Yes ▢ No
Cancer----------▢ Yes ▢ No
Chemical Dependency (addiction to drugs) ▢ Yes ▢ No
Congenital Heart Lesions----------▢ Yes ▢ No
Diabetes----------▢ Yes ▢ No
Emphysema----------▢ Yes ▢ No
Epilepsy ----------▢ Yes ▢ No
Glaucoma----------▢ Yes ▢ No

Heart Murmur----------▢ Yes ▢ No
Heart Disease----------▢ Yes ▢ No
Hepatitis Type ____----▢ Yes ▢ No
Herpes----------▢ Yes ▢ No
High Blood Pressure---▢ Yes ▢ No
HIV/AIDS----------▢ Yes ▢ No
Kidney Disease---------▢ Yes ▢ No
Latex Sensitivity-------▢ Yes ▢ No
Liver Disease----------▢ Yes ▢ No
Migraine Headaches---▢ Yes ▢ No
Multiple Sclerosis------▢ Yes ▢ No
Pacemaker----------▢ Yes ▢ No

Prostate Problem--------▢ Yes ▢ No
Respiratory Disease-----▢ Yes ▢ No
Rheumatic Fever--------▢ Yes ▢ No
Shortness of Breath-----▢ Yes ▢ No
Sinus Trouble----------▢ Yes ▢ No
Stroke----------▢ Yes ▢ No
Thyroid Problems-------▢ Yes ▢ No
Tuberculosis----------▢ Yes ▢ No
STDs --------▢ Yes ▢ No

Any other condition(s)?

_____
_____
_____
_____
_____
_____

Family History:

Mother:	▢ Hypertension	▢ Diabetes	▢ Cancer	▢ Other (specify):_____
Father :	▢ Hypertension	▢ Diabetes	▢ Cancer	▢ Other (specify):_____
Brother:	▢ Hypertension	▢ Diabetes	▢ Cancer	▢ Other (specify):_____
Sister :	▢ Hypertension	▢ Diabetes	▢ Cancer	▢ Other (specify):_____
Grandmother (M):	▢ Hypertension	▢ Diabetes	▢ Cancer	▢ Other (specify):_____
Grandmother (P):	▢ Hypertension	▢ Diabetes	▢ Cancer	▢ Other (specify):_____
Grandfather (M):	▢ Hypertension	▢ Diabetes	▢ Cancer	▢ Other (specify):_____
Grandfather (P) :	▢ Hypertension	▢ Diabetes	▢ Cancer	▢ Other (specify):_____

Other Information:

Date of Last Tetanus Shot:_____

Date of Last Menstrual Period:_____

Are you Pregnant? ▢ Yes ▢ No Are you Breastfeeding? ▢ Yes ▢ No

Is there anything else you would like to tell us about your health that would help us come up with the best care plan for you?

_____

_____

_____

I understand that if I do not give AAA Medical Group a 24 hour prior notice for any appointment cancellations I might be charged a $25 cancellation fee

Name: _____

Signature: _____

Date: _____

AAA MEDICAL GROUP

Release of Information and Assignment of Benefits:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize AAA MEDICAL GROUP or insurance companies to release any information required to process my claims. In addition, I acknowledge that I have been informed of the AAA MEDICAL Group's Notice of Privacy Practices. I understand AAA MEDICAL Group is a HIPAA compliant office. As a patient, I have the right to obtain a copy of the Notice of Privacy Practices at any time.

Payment Policy

Our mission at AAA MEDICAL Group is to deliver excellent and personal care that positively impacts people in a changing healthcare system. Our payment policy was created to reduce administrative costs in order to keep our fees as low as possible for our patients.
Payment is required at the time of service. Any applicable co-payments, co-insurance, negotiated payment plans and/or deductibles are due at the time of service. For patients with medical insurance benefits, we will bill your insurance. All charges incurred at AAA MEDICAL Group ultimately the responsibility of the patient, regardless of insurance benefits. We accept payment in the form of cash, check or credit card. At AAA MEDICAL Group we want to manage our time efficiently , so we can deliver excellent personal care to our patients. We request a 24 hour notice for all cancellations /reschedules. If you no-show for your appointment you will be charged $ 25 on the second occurrence . This fee is not covered by insurance and is the sole responsibility of the patient . Please understand this policy is to ensure efficient time management , so all patients get the time they need with our medical providers. A fee will be charged for any returned checks.

X_____/_____/_____

PARENT/GUARDIAN SIGNATURE DATE