APPOINTMENT TIME & DATE –_____
PLEASE BRING ALL MEDICINE BOTTLES TO EACH APPOITMENT
(FIRST VISIT NO SHOW WILL INCUR $100 CHARGES)

PATIENT INFORMATION & AUTHORIZATIONS -NEEL RAYA, M.D. INC.

LAST NAME FIRST NAME INITIAL TITLE

STREET ADDRESS CITY STATE ZIP CODE

HOME PHONE CELL PHONE SOCIAL SECURITY NUMBER

MALE/FEM MARR/SING/DIVORC/WIDOW DATE OF BIRTH **EMAIL ADDRESS REQUIRED**

SPOUSE'S NAME SPOUSE'S SOC.SECURITY NUMBER SPOUSE'S DATE-OF-BIRTH

****

AUTHORIZATION of INSURANCE PAYMENT

I Request That Payment Of AuthorizeD Benefits Be MaDe On My Behalf. I. If Applicable, May Assign The Benefits Payable For Services To The Physician Furnishing The Services AnD Authorize Such Physician To Submit A Claim To My Insurance Carrier Or MeDicare For Payment. I Authorize Any HolDer Of MeDical Or Other Information About Me To Release To Insurance Carriers Or The Health Care Financing ADministration AnD Its Agents Or The Social Security ADministration Or Its IntermeDiaries Or Any Agency, Group Or Person(S) Necessary To Secure Payment For Any Information NeeDeD For This Or RelateD Claims. For AnD In ConsiDeration Of Services RenDereD AnD To Recognizing The NeeD For Health Care Consents To The Above List MeDical ProviDer. I Hereby Guarantee Payment Of All Charges IncurreD For This Account. The Patient Or His/Her Representative Treatment, Laboratory ProceDures, X-Ray Examinations Or Other Services RenDereD UnDer The General AnD Specific Instructions Of The Physicians. I Certify That The Information Given By My In Applying For Payment Is Correct. I UnDerstanD That My MeDical Insurance Is A Contract Between The Insurance Carrier AnD Me AnD Not Between The Insurance Carrier AnD The Doctor, AnD That I Am Responsible For All MeDical Fees.

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives inDiviDuals the right to request a restriction on uses anD Disclosures of their protecteD health information (PHI). the inDiviDual is also proviDeD the right to request confiDential communications to that a communication of PHI be maDe by alternative means, such as senDing corresponDence to the inDiviDual's office insteaD of the inDiviDual's home.

. ..

I wish to be contacteD in the following manner. (**This is Dr.Raya's office StanDarD Policy**.)

Home/Cellphone/Workphone

Dr.Raya's office will leave a DetaileD message concerning your appointment (using our automatic appointment reminDer),test results are available to be revieweD on our portal, we Do call results back to patients if it is urgent anD results in recommenDations, an appointment may be requireD as a result. if this is not acceptable please inDicate what you woulD like us to Do here _____

.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presenteD with a copy of the Notice of Privacy Practices, Detailing how my health information may be useD anD DiscloseD as permitteD unDer feDeral anD state law, AnD outlining my rights regarDing my health information.

Patient/Legal Guardian SIGNATURE Name Date. Patient Birth Date

Dr. NEEL RAYA, MD

BoarD CertifieD Internal MeDicine

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

RECORDS REQUESTED FROM:

PROVIDER/FACILITY NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

I, _____, authorize the above provider or facility to furnish a copy of my medical records dating from _____ through _____ to Dr. Neel Raya as soon as possible. My date of birth is _____ and Social Security Number is _____. I hereby release this proviDer/facility from all legal responsibilities or liability that may arise from this authorization.

Patient Signature: _____ Date: _____

Printed Name: _____

PLEASE SEND RECORDS VIA:
FAX: 740-653-2791
OR
MAIL: 2658 N COLUMBUS ST. SUITE A. LANCASTER, OH 43130

NEEL RAYA MD

2658 N COLUMBUS ST. SUITE-A, LANCASTER, OH 43130

PH 740-6545496, FAX 740-6532791

Names of persons to whom my medical information can be released and their relationship to me:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature of patient : _____

Name : _____

Date of birth : _____

Date : _____

PATIENT HEALTH SURVEY

NAME PLATE

NAME _____ AGE_____ M_____ F_____ DATE_____

ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Have you had

Childhood:

☐ Measles ☐ Mumps ☐ Chicken Pox
☐ Congenital Abnormalities ☐ Rheumatic fever or heart disease

Adult:

☐ Asthma ☐ High Blood Pressure ☐ Cancer (Site_____)
☐ Diabetes ☐ Ulcer or Gastritis ☐ Thyroid Problems
☐ Tuberculosis ☐ Kidney Problem ☐ Liver Problems
☐ Blood Problem ☐ Venereal Disease ☐ Heart Failure
☐ Heart Attack ☐ Abnormal Heart Rhythm

Have you had any serious illness? No Yes
Have you ever had a transfusion? No Yes
Have you ever been hospitalized or been under medical care for very long? No Yes

If Yes, for what reason? _____

_____

Most recent immunizations:

Hepatitis B_____(date) Flu Vaccine_____(date)

Pneumovax_____(date) Tetanus_____(date)

OPERATIONS:

Have you ever had any surgery? No Yes

List: ☐ Appendectomy ☐ Hysterectomy (If so, reason_____)
☐ Ovaries Removed ☐ Joint Replacement
☐ Gallbladder ☐ Bypass (If so, what_____)
☐ Other _____

_____

_____

ALLERGIES:

_____

_____

_____

MEDICATIONS:

_____

_____

_____

_____

INJURIES:

Have you ever been seriously injured in a motor vehicle accident? No Yes
Have you had any head concussions or injuries? No Yes
Have you ever been knocked unconscious? No Yes

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed Significant Other

With whom do you live? _____

Recreational Drug Usage? No Yes
Do you have any problems with sexual function? No Yes

Foreign travel within last year_____

Coffee_____ Tea_____ Cola's_____ (per day)

Alcoholic Beverages: Never_____ < 1 per week_____
1-5 per week_____ Other_____

Tobacco: ☐ Never Smoked ☐ Quit _____years ago
☐ Years smoked_____ ☐ Packs per day_____

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SOCIAL HISTORY: (continued)

Are you employed? Full Time_____ Part Time_____

What is your job? _____

_____

_____

Are you exposed to fumes, dusts or solvents? _____

_____

How much time have you lost from work because of your health during the past?

Six Months_____ One Year_____ Five Years_____

Education: (Years)

Grade School_____ College_____ Postgraduate_____

Do you wear seatbelts? ☐ Always ☐ Sometimes ☐ Never

FAMILY HISTORY:	Age	Health	If Deceased, Age at Death	Cause of Death
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has either parent, sister, brother, child or grandparent ever had?

Stroke	No	Yes	Heart Trouble	No	Yes
Tuberculosis	No	Yes	High Blood Pressure	No	Yes
Diabetes	No	Yes			

Has any blood relative ever had?

Cancer	No	Yes	Bleeding Tendancy	No	Yes
Type:			Gout or other crippling arthritis		
Suicide	No	Yes		No	Yes
Mental Illness	No	Yes	Hereditary Defects	No	Yes

PATIENT HEALTH SURVEY

NAME PLATE

CIRCLE NO OR YES FOR THOSE THAT APPLY

SYSTEMIC REVIEW: Do you have any of the following?

General: Maximum weight_____ Minimum weight_____

Recent weight change? No Yes

Have you been in good general health most of your life? No Yes

Have you recently had?

☐ Weakness ☐ Fever ☐ Chills ☐ Night Sweats

☐ Fainting ☐ Problems Sleeping

Skin:

Skin Disease No Yes
Jaundice No Yes
Hives, eczema or rash No Yes

Head-Eyes-Ears-Nose-Throat (cont'd):

Dry eyes or mouth No Yes
Bleeding Gums - Frequent or Constant No Yes
Blurred Vision No Yes
Date of Last Eye Exam _____
Sneezing or runny nose No Yes
Nosebleeds - Frequent No Yes
Chronic sinus trouble No Yes
Ear disease No Yes
Impaired hearing No Yes
Dizziness or sensation of room spinning No Yes
Frequent or severe headaches No Yes

Respiratory:

Asthma or Wheezing No Yes
Difficulty breathing No Yes
Any trouble with lungs No Yes
Pleurisy or Pneumonia No Yes
Cough up Blood (ever) No Yes

Cardiovascular:

Chest pain, pressure, or tightness No Yes
Shortness of breath with walking or lying down No Yes
Difficulty walking two blocks No Yes
Palpitations No Yes
Swelling of hands, feet or ankles No Yes
Awakening in the nights smothering No Yes
Heart murmur No Yes

Gastrointestinal:

Vomiting blood or food No Yes
Gallbladder disease No Yes
Change in appetite No Yes
Hepatitis/Jaundice No Yes
Painful bowel movements No Yes
Bleeding with bowel movements No Yes
Black stools No Yes
Hemorrhoids or piles No Yes
Recent change in bowel habits No Yes
Frequent diarrhea No Yes
Heartburn or indigestion No Yes
Cramping or pain in the abdomen No Yes
Does food stick in throat No Yes

Endocrine:

Hormone therapy No Yes
Any change in hat or glove size No Yes
Any change in hair growth No Yes
Have you become colder than before - or skin become dryer No Yes

Neck:

Stiffness No Yes
Enlarged glands No Yes

Genitourinary:

Loss of urine No Yes
Blood in urine No Yes
Frequent urination No Yes
Burning or painfu No Yes
Night time urinating No Yes
Kidney trouble No Yes
Problem stopping/starting flow of urine No Yes
Testicular mass No Yes
Testicular pain No Yes
Prostate problem No Yes
Sexual Dysfunction No Yes
STD / AIDS Risk No Yes

Gynecological:

First day of last period _____
Age periods started _____
How long do periods last? _____ Days
Frequency of periods every _____ Days
Pain with periods No Yes
Number of pregnancies _____
Number of miscarriages _____
Date of last cancer smear and results _____
Breast Lump No Yes
Abnormal Vaginal Discharge No Yes
Breast Discharge No Yes
Pain with Intercourse No Yes
Skin change of Breast No Yes
Nipple retraction No Yes

Locomotor-Musculoskeletal:

Stiffness or pain in joints (check all that apply)

☐Finger ☐Hands ☐Wrist ☐Elbows ☐Shoulders ☐Neck ☐Back
☐Hip ☐Knee ☐Toes ☐Foot ☐Temporomandibular Joint

Weakness of muscles or joints No Yes
Any difficulty in walking No Yes
Any pain in calves or buttocks on walking relieved by rest No Yes

Neuro-Psychiatric:

☐Transient blindness ☐Tremor ☐Numbness in fingers ☐ Weakness

Have you ever had counselling for your mental health? No Yes
Have you ever been advised to see a psychiatrist? No Yes
Do you ever have, or have had, fainting spells? No Yes
Convulsions No Yes
Paralysis No Yes
Problem with coordination No Yes
Domestic violence No Yes
Depression Symptoms (difficulty sleeping, loss of appetite loss of interest in activities, feelings of hopelessness) No Yes

Hematologic:

Are you slow to heal after cuts? No Yes
Anemia No Yes
Phlebitis or Blood Clots in veins No Yes
Have you had difficulty with bleeding excessively after tooth extraction or surgery? No Yes
Have you had abnormal bruising or bleeding? No Yes

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Provider _____ Date _____ Signature of Patient _____