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

____

LAST NAME FIRST NAME INITIAL TITLE

____

STREET ADDRESS CITY STATE ZIP CODE

____

HOME PHONE WORK PHONE SOCIAL SECURITY NUMBER

____

MALE/FEM MARR/SING/DIVORC/WIDOW DATE OF BIRTH EMPLOYER FROM WHEN EMPLOYED

____

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

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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.

DATE--_____________**SIGNATURE-Patient**(Parent/Guardian IF MINOR) ___________________________

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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 Telephone & Answer Machine

Dr.Raya's office will leave a detailed message concerning your appointment (using our automatic appointment reminder - housecalls) , & test results (if unable to talk to you personally), if this is not acceptable please indicate what you would like us to do here ____

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Mailing/Faxing Reports:

Dr.Raya's office does not generally mail test results to patients. At patient's specific request, Dr.Raya's office may fax results to a number indicated by patient on that specific occasion. Please write the fax number here__________________________

Work Telephone

If Dr.Raya's office is unable to contact the patient at home or leave a message on the answering machine, <u>and it is very important to contact</u> the patient, Dr.Raya's office may call the patient at their work place and leave a brief message to call back. If this is unacceptable please indicate here (and do not give your work number to us) how you wish us to reach you.____ .

____

Patient/Legal Guardian SIGNATURE Name Date. Patient Birth Date

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.

DATE--_____________**SIGNATURE-Patient**(Parent/Guardian IF MINOR) _____________________________

If patients or representative refuses to sign acknowledgement STAFF please document below and sign.

Presented on (dale and time)-____________________________

By Dr.Raya Office Staff (name and title)- ______________________Signature-___________________________________

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute all adequate record. NOTE – Uses & disclosures for TPO may be permitted without prior consent in an emergency.

DATE	DISCLOSED TO WHOM	PURPOSE OF DISCLOSURE	BY WHOM

NAME PLATE

PATIENT HEALTH SURVEY

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______

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

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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