Anil R. Shah, MD FACS

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Patient Information

Name (Last, First, MI)				Today's Date
Street Address		Email:		
City	State	Zip	Age	Date of Birth
Social Security #	Cellular Phone ( ) -		Home Phone ( ) -	
Occupation	Employer	Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated		

Emergency Contact

Name	Relationship to Patient
Daytime Phone ( ) -	Evening Phone ( ) -

Referral Info

Referring Physician's Name (if applicable)	Physician Phone/Fax (if known) ( ) - / -
Physician Address (if known)	

Insurance Information

Primary Insurance Company	Policy #		Group #	
Claims Address	City	State	Zip	Phone ( ) -
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________	Name of Subscriber (if other than patient)			
Subscriber's Social Security #	Gender ☐ Male ☐ Female		Date of Birth	
Secondary Insurance Company	Policy #		Group #	
Claims Address	City	State	Zip	Phone ( ) -
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________	Name of Subscriber (if Other Than Patient)			
Subscriber's Social Security #	Gender ☐ Male ☐ Female		Date of Birth	

Assignment and Release

Please read the following and sign below:

Assignment of Benefits and Release of Information
I hereby authorize my insurance benefits to be paid directly to the undersigned physician. I understand that I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

Medicare Patients
I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine benefits for this or a related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or to the party who accepts assignment.

Notice of Privacy Practices Acknowledgment
By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Signature: ____ Date: ____/____/______.___

What brings you to the doctor's office today? ________________________________
____

What PRESCRIPTION medications do you take?

MEDICATION	MEDICATION

Do you have any allergies to medications? Please list the names and type of reaction:

ALLERGIC TO	REACTION	ALLERGIC TO	REACTION

What Other non-prescription (over the counter herbal or homeopathic) medications do you take?___________________
____

Please list any prior surgeries: ____
____

SOCIAL HISTORY:

Do you smoke? ☐NO ☐YES *How Much?* ______*packs per day*. *How Long?* ____years. Quit? _______*years ago.*

Do you drink: Caffeinated beverages? ☐NO ☐YES ____ *Cups per day?* Alcohol? ☐NO ☐YES *How much?* __________

FOR CHILDREN:

Was the mother's pregnancy normal? ☐Yes ☐No Birth weight? ________________________

Were there any problems at delivery? ☐Yes ☐No ( ) Vaginal ( ) C-Section? Explain? ________________________

Did the child reach his/her milestones (seating, walking, talking, etc) on time? ____

Walked at _______age. Speech & language at ________age.

FAMILY HISTORY: Do any of your blood relatives have problems with the following. Check any that apply.

☐Asthma ☐Diabetes ☐Tuberculosis ☐High blood pressure ☐Stroke ☐Headaches
☐Hearing Loss ☐Heart Disease ☐Allergies ☐Thyroid Disease ☐Cancer ☐Bleeding Problems
☐Problems with Anesthesia ☐Autoimmune Disease ☐Brain Tumor

PAST MEDICAL HISTORY:

Have you ever been diagnosed with cancer? ☐NO ☐YES Please give details ______________________________

____

DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING? PLEASE CHECK (✓) THOSE THAT APPLY

GENERAL	NO	( )Fever ( )Weight Change ( )Fatigue
EYES	NO	( )Visual Loss ( )Glaucoma ( )Cataracts ( )Itchy Eyes ( )Tearing ( )Blurred Vision
EARS	NO	( )Vertigo ( )Dizziness ( )Ringing Noises ( )Hearing Loss ( )Hearing Aid ( )Infections
NOSE	NO	( )Discharge ( )clear ( )colored ( )thick ( )thin ( )Post nasal drip ( )Obstruction ( )Bleeding ( )Sneezing
MOUTH	NO	( )Lumps ( )Dental Problems ( )Tonsillitis ( )Mouth Sores
THROAT	NO	( )Hoarseness ( )Voice Change ( )Problem Swallowing ( )Pain
NECK	NO	( )Pain ( )Lumps ( )Thyroid nodules ( )Swollen Glands
SKIN	NO	( )Breast Lumps ( )Psoriasis ( )Skin Growths ( )Rash ( )Itching
LUNGS	NO	( )Wheezing ( )Asthma ( )COPD ( )Bronchitis ( )Emphysema ( )Coughing up Blood ( )Chronic Cough ( )Pneumonia ( )Positive TB Test ( )Shortness of Breath
SLEEPING	NO	( )Snoring ( )Apnea ( )Insomnia ( )Waking up tired ( )Daytime Tiredness
HEART	NO	( )High Blood Pressure ( )Coronary Artery Disease ( )Myocardial Infarction ( )Chest Pain ( )Mitral Valve Prolapse ( )Congestive Heart Failure ( )Heart Valve Disease ( )Angina ( )Murmurs ( )Rheumatic Fever
GASTROINTESTINAL	NO	( )Hiatal Hernia ( )Heartburn ( )Reflux ( )Rectal Bleeding ( )Ulcers ( ) Hepatitis Type___ ( )Jaundice ( )Nausea ( )Vomiting ( )Colitis
GENITO-URINARY	NO	( )Frequent Urination ( )Pain ( )Discharge ( )Incontinence ( )Bloody Urine **MEN**: ( )Prostate Problems ( )Hernias **WOMEN** ( )Abnormal Periods ( ) Menopause ( )Are you Pregnant? L ( )Yes ( )No
MUSCLE/JOINTS	NO	( )Muscle Pain ( )Back Pain ( )Joint Pain ( )Arthritis ( )Lupus ( ) Gout
NEUROLOGICAL	NO	( )Headaches ( )Migrane headaches ( )Imbalance ( )Alzheimer's Disease ( )Loss of Consciousness ( ) Parkinson's Disease ( )Head Trauma ( )Tremors ( )Fainting ( )Seizures ( )TIA's ( )Stroke
PSYCHIATRIC	NO	( )Nervousness ( )Anxiety ( )Depression ( )Mood Swings
ENDOCRINE	NO	( )Thyroid Disease ( )Diabetes ( )Glandular/Hormonal Problems
HEMATOLOGIC	NO	( )Slow to Heal After Cuts ( )Easy Bruising or Bleeding ( )Immunocompromised Status ( )Transfusions ( )Phlebitis ( )Anemia

If this form is filled out by another other than the patient, please write the name and relationship.

Name ______________________________________Relationship to Patient___________________

I certify that this information is true and correct to the best of my knowledge.
I will notify you if any changes occur.

SIGNATURE: ____Date _________________

I have reviewed the above information with the patient: **MD SIGNATURE** ________________________