PATIENT INFORMATION

[redacted]

[redacted]

[redacted]

Add:
- Driver's License ID
- ID expiration
- Height
- Eye color

FULL NAME: *GREEN FIELDS = OCR, require 2nd verification

First Name | Middle Name | Last Name

PREFFERED NAME:

SEX:

DOB:

MM-DD-YYYY

Date

AGE: *Calculate

MAIDEN NAME:

SOCIAL SECURITY#:

MARITAL STATUS:

- SINGLE
- MARRIED
- WIDOWED
- DIVORCED
- SEPARATED
- PARTNER

HOME ADDRESS:

Street Address

City

State / Province

Postal / Zip Code

[redacted]

PHONE: Cell:

[redacted]

(000) 000-0000

Please enter a valid phone number.

[redacted]

EMAIL ADDRESS:

[redacted]

example@example.com

OCCUPATION:

EMPLOYER:

DRUG ALLERGIES:

PHARMACY:

LOCATION:

PHARMACY PHONE#:

(000) 000-0000

Please enter a valid phone number.

WHO MAY WE THANK FOR THIS REFERRAL

OTHER FAMILY MEMBERS SEEN HERE:

INSURANCE INFORMATION:

PRIMARY INSURANCE:

Card #:

SECONDARY INSURANCE:

Card #:

POLICY HOLDER:

- SELF
- SPOUSE
- PARENT
- LEGAL GUARDIAN

[redacted]

***NAME ONLY (relationship doesn't matter much, according to pVerify)**

NAME:

DOB:

MM-DD-YYYY

Date

RELATIONSHIP:

PHONE:

(000) 000-0000

Please enter a valid phone number.

[redacted]

EMERGENCY CONTACT INFORMATION:

Add friend / Invite to create profile?

NAME:

RELATIONSHIP:

[redacted]

MOBILE PHONE:

(000) 000-0000

Please enter a valid phone number.

[redacted]

[redacted]

Submit

HIPAA COMPLIANCE

FINANCIAL INFORMATION FOR ALL PARTIES

PLEASE MAKE SURE ALL INFORMATION HAS BEEN FILLED OUT CORRECTLY, IT IS YOUR RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES, ESPECIALLY IF YOU ARE CHANGING INSURANCE CARRIERS BETWEEN VISITS.

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSMENT FOR PATIENT FEES PAID TO THE PROVIDER AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES, AND OTHERS PAY ONLY A PERCENTAGE OF THIS ALLOWANCE. IT IS THEREFORE A GOOD IDEA TO FULLY UNDERSTAND WHAT IS COVERED UNDER YOUR POLICY AND WHAT IS NOT COVERED UNDER YOUR POLICY.

IF YOU BELONG TO AN HMO OR OTHER MANAGED CARE MEDICAL PLAN, PLEASE CHECK TO SEE THAT WE ARE A PARTICIPATING PROVIDER UNDER THAT PLAN. IF SO, REMEMBER TO GET NECESSARY REFERRALS FROM YOUR PCP TO COVER ANY VISISTS AND/OR SURGERY. YOU UNDERSTAND THAT YOU ARE RESPONSIBLE FOR ANY CLAIMS DENIED FOR MISSING REFERRALS.

THERE IS A THIRTY-FIVE DOLLAR CHARGE FOR RETURNED CHECKS.

TO THE EXTENT NECESSARY TO DETERMINE LIABILITY FOR PAYMENT, TO OBTAIN REIMBURSEMENT AND/OR ABIDE BY MY INSURANCE COMPANY’S LEGAL REQUEST, I AUTHORIZE DISCLOSURE OF PORTIONS OF MY MEDICAL RECORDS

TO MY INSURANCE COMPANY, INCLUDING MEDICARE, MEDICAID, PRIVATE INSURANCE AND OTHER HEALTH PLANS.

I HEREBY ASSIGN ALL MEDICAL AND SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, MEDICAID, PRIVATE INSURANCE AND OTHER HEALTH INSURANCE PLANS TO ANIKET CHAKRABARTI, M.D P.C. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING. A PHOTOCOPY OF THIS STATEMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND I AM FINACIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID ASSIGNEES TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

SIGNED: *Signed > digital signature

Sign Here

Clear

DATE: *Should be automatic

MM-DD-YYYY

Date

RESPONSIBLE PARTY:

DATE:

MM-DD-YYYY

Date

FOR MEDICARE PATIENTS ONLY:

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR RELATED MEDICARE CLAIM. I PERMIT

A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND IT IS MANDITORY TO NOTIFIY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT, (SECTION 11288, SOCIAL SECURTITY ACT PROVIDES PENALTIES FOR WITHHOLDING THIS INFORMATION). REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.

SIGNED:

Sign Here

Clear

DATE:

MM-DD-YYYY

Date

Submit

HIPAA COMPLIANCE

Health History Questionnaire

All questions contained in this questionnaire are strictly confidentialand will become part of your medical record.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Previous Doctor(s):

Date of Last Physical Exam:

MM-DD-YYYY

Date

[redacted]

PERSONAL HEALTH HISTORY

Childhood Illness:

- [ ] Measles
- [ ] Mumps
- [ ] Rubella
- [ ] Chickenpox
- [ ] Rheumatic Fever
- [ ] Polio

Immunizations and Dates: if known

	Immunizations	Dates:
Tetanus	☐	
Hepatitis	☐	
Chickenpox	☐	
Influenza	☐	
Pneumonia	☐	
MMR	☐	

List Any Medical Problems That Other Doctors Have Diagnosed:

Type here...

Any Past Operations or Surgeries:

Year	Reason	Hospital

Year	Reason	Hospital

Year	Reason	Hospital

+

Other Hospitalizations:

Year	Reason	Hospital

Year	Reason	Hospital

Year	Reason	Hospital

+

Emergency room Visits:

Year	Reason	Hospital

Year	Reason	Hospital

Year	Reason	Hospital

+

Have you ever had a blood transfusion?

- ◯ Yes
- ◯ No

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name the Drug	Strength	Frequency Taken

Name the Drug	Strength	Frequency Taken

Name the Drug	Strength	Frequency Taken

Name the Drug	Strength	Frequency Taken

Name the Drug	Strength	Frequency Taken

+

Allergies to Medications:

Name the Drug | Reaction You Had

Name the Drug | Reaction You Had

Name the Drug | Reaction You Had

Name the Drug | Reaction You Had

Name the Drug | Reaction You Had

+

FAMILY HEALTH HISTORY

Age | Age at Death

Significant Health Problems or Cause of Death

	Age	Age at Death	Significant Health Problems or Cause of Death
Father			
Mother			

	Gender	Age	Age at Death	Significant Health Problems or Cause of Death
Children 1				
Children 2				
Children 3				
Children 4				
Children 5				

Brothers and Sisters

	Sibling	Gender	Age	Age at Death	Significant Health Problems or Cause of Death
1					
2					
3					
4					
5					

Grandparents (Mother's Side)

	Age	Age at Death	Significant Health Problems or Cause of Death
Male			
Female			

Grandparents (Father's Side)

	Age	Age at Death	Significant Health Problems or Cause of Death
Male			
Female			

HEALTH HABITS AND PERSONAL SAFETY

Exercise:

Exercise:

- [ ] Sedentary (No exercise)
- [ ] Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
- [ ] Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)
- [ ] Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet:

Are you dieting?

- ◯ Yes
- ◯ No

Of meals you eat in an average day?

Rank Salt Intake

- ☐ Hi
- ☐ Med
- ☐ Low Rank

Rank Fat Intake

- ☐ Hi
- ☐ Med
- ☐ Low Rank

Caffeine:

Caffeine:

- ☐ None
- ☐ Coffee
- ☐ Tea
- ☐ Cola

# of Cups/Cans Per Day?

Alcohol:

Do you drink alcohol?

- Yes
- No

Are you concerned about the amount you drink?

- Yes
- No

Have you considered stopping?

- Yes
- No

Have you ever experienced blackouts?

- Yes
- No

Are you prone to “binge” drinking?

- Yes
- No

Do you drive after drinking?

- Yes
- No

Tobacco:

Do you use tobacco?

- Yes
- No

- [ ] Cigarettes
- [ ] Chew
- [ ] Pipe
- [ ] Cigars

# of Years

or Year Quit

Drugs:

Do you currently use recreational or street drugs?

- Yes
- No

Have you ever given yourself street drugs with a needle?

- Yes
- No

Sex

Are you sexually active?

- Yes
- No

Any discomfort with intercourse?

- Yes
- No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with us about your risk of this illness?

- Yes
- No

Personal Safety:

Do you live alone?

- Yes
- No

Do you have frequent falls?

- Yes
- No

Do you have vision or hearing loss?

- Yes
- No

Do you have an Advance Directive and/or Living Will?

- Yes
- No

Would you like information on the preparation of these?

- Yes
- No

Physical and/or mental abuse has become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with us?

- Yes
- No

MENTAL HEALTH:

Is stress a major problem for you?

- Yes
- No

Do you feel depressed?

- Yes
- No

Do you panic when stressed?

- Yes
- No

Do you have problems with eating or your appetite?

- Yes
- No

Do you cry frequently?

- Yes
- No

Have you ever attempted suicide?

- Yes
- No

Have you ever seriously thought about hurting yourself?

- Yes
- No

Do you have trouble sleeping?

- Yes
- No

Have you ever been to a counselor?

- Yes
- No

Would you like to discuss this issue with us?

- Yes
- No

WOMEN ONLY

Age at onset of menstruation:

Date of last menstruation:

MM-DD-YYYY

Date

Period every ____ days.

Heavy periods, irregularity, spotting, pain or discharge?

- Yes
- No

Number of pregnancies

Number of live births

Are you pregnant or breastfeeding?

- Yes
- No

Have you had a D&C, hysterectomy or cesarean? .

- Yes
- No

Any blood in your urine?

Yes No

Any urinary tract, bladder or kidney infections within the last year?

Yes No

Any problems with control of urination?

Yes No

Any hot flashes or sweating at night?

Yes No

Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of period?

Yes No

Experienced any recent breast tenderness, lumps or nipple discharge?

Yes No

Date of last pap and rectal exam?

MM-DD-YYYY

Date

MEN ONLY

Do you usually get up to urinate during the night?

Yes No

Do you feel pain or burning with urination?

Any blood in your urine?

Yes No Yes No

Do you feel burning discharge from penis?

Yes No

Has the force of your urination decreased?

Yes No

Have you had any kidney, bladder or prostate infections within the last 12 months?

Yes No

Do you have any problems emptying your bladder completely?

Yes No

Any difficulty with erection or ejaculation?

Yes No

Any testicle pain or swelling?

Yes No

Date of last prostate and rectal exam?

MM-DD-YYYY

Date

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

- [ ] Skin
- [ ] Head/Neck
- [ ] Ears
- [ ] Nose
- [ ] Throat
- [ ] Lungs
- [ ] Chest/Heart
- [ ] Back
- [ ] Intestinal
- [ ] Bladder
- [ ] Bowel
- [ ] Circulation

Recent Changes In:

Weight

Energy Level

Ability to Sleep

Other Pain/Discomfort:

Type here...

Please read and remember that the following recommendations are very important to maintaining your health.

- When in a car, wear your safety belt at all times.
- While riding a motorcycle or bicycle, wear a helmet.
- Always have functional smoke detectors and fire extinguishers in your home.
- If you own a firearm, make sure that it is accessible only to you.
- Take every precaution to ensure that children do not have access to a loaded firearm.
- Keep the firearm and ammunition in separate locations.

Thank You

Submit

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

WE ARE REQUIRED TO PROVIED YOU WITH A COPY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH STATES HOW WE MAY USE AND OR DISCLOSE YOUR HEALTH INFORMATION. PLEASE SIGN THIS FORM TO ACKNOWLEDGE RECEIPT OF THE NOTICE. ALSO PLEASE FILL OUT THE BOTTOM OF THE FORM WITH THE NAME/S OF THE PEOPLE YOU GIVE US PERMISSION TO RELEASE ANY HEALTH INFORMATION TO.

I ACKNOWLEDGE THAT I HAVE RECEIVED AND UNDERSTAND THE OFFICE'S NOTICE OF PRIVACY PRACTICES.

SIGNED:

Sign Here

Clear

DATE:

MM-DD-YYYY

Date

I AUTHORIZE ANIKET CHAKRABARTI, M.D. P.C. AND STAFF TO RELEASE MY MEDICAL INFORMATION TO THE FOLLOWING:

NAME:

RELATIONSHIP:

NAME: RELATIONSHIP:

NAME: RELATIONSHIP:

*Add / Invite friends/family

Submit

HIPAA COMPLIANCE