Anoop K. Reddy, MD

# NEW PATIENT INFORMATION

## PERSONAL INFORMATION

NAME: _____ DATE: __/__/____

DATE OF BIRTH: ____/_____/_____ AGE: _____

SEX: ☐ MALE ☐ FEMALE SOCIAL SECURITY: _____

CURRENT ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: (_____) _____ CELL #: (_____) _____

IS THE ABOVE YOUR PERMANENT/MAILING ADDRESS? ☐ YES ☐ NO
IF NO, PLEASE LIST YOUR PERMANENT/MAILING ADDRESS: _____

EMAIL ADDRESS _____

DO YOU HAVE A LIVING WILL? ☐ YES ☐NO

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ LIFE-PARTNER

RACE: ☐ **WHITE** ☐ **BLACK/AFRICAN AMERICAN** ☐ **HISPANIC** ☐ **ASIAN** ☐ **OTHER** ☐ **I DO NOT WISH TO PROVIDE**
ETHNICITY: ☐ **HISPANIC OR LATIN** ☐ **NON-HISPANIC** ☐ **I DO NOT WISH TO PROVIDE**
PRIMARY LANGUAGE: ☐ **ENGLISH** ☐ **SPANISH** ☐ **INDIAN** ☐ **RUSSIAN** ☐ **OTHER**

PHARMACY NAME: _____ PHONE: _____
LOCATION: _____

EMPLOYER: _____ OCCUPATION: _____

NEXT OF KIN: _____ RELATIONSHIP: _____

HOME # (_____) _____ ALTERNATE #: (_____) _____

IN CASE OF EMERGENCY WHO SHOULD WE CONTACT OTHER THAN SPOUSE?

NAME: _____ RELATIONSHIP_____
PHONE # (_____) _____

PRIMARY CARE PHYSICIAN: _____

WHO REFERRED YOU TO OUR PRACTICE? _____

## OFFICE FINANCIAL POLICY

Our goal is to deliver the highest quality medical care as efficiently and effectively as possible. To maintain this standard of medical care, we must operate an efficient office from a business perspective. The following information will provide you with some of the financial guidelines of our office:

**OFFICE CHARGES:** Unless you are a patient with Medicare, an HMO, or PPO, payment is due at the time of service and may be made by cash, check, Visa, or MasterCard. Timely payments help us hold down the high cost of health care. An itemized statement will be given to you that you may attach to your insurance company's claim form for your reimbursement. Checks returned **for any reason**, will be assessed a $25.00 non refundable service charge. Past due accounts will be assessed any collection costs which may include attorney in addition to the balance owed.

If you are a member of an HMO or PPO, you will be required to make your necessary co-payment at the time of your visit. **It is your responsibility to arrange with your primary care physician to bring your referral with you for visits and diagnostic testing**. We are required by our HMO/PPO contracts to **reschedule any non-emergency appointment** until the proper authorization is granted.

You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at A.K. Reddy, M.D. P.A. and you have not obtained such authorization or referral;(ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at A.K. Reddy, M.D. P.A. are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at A.K. Reddy, M.D. P.A.; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

If you have **MEDICARE**, we accept assignment for Medicare claims. If you have a supplemental policy, that directly crosses over from Medicare, we will file this for you as well. If you do not have one of these supplemental insurances, or have not met your yearly Medicare deductible, we ask that you pay your co-payment amount at the time of service.

**APPOINTMENTS NOT CANCELLED WITHIN 48 BUSINESS HOUR ADVANCED NOTICE ARE SUBJECT TO CHARGES TO THE PATIENT'S PERSONAL ACCOUNT. (PLEASE SEE CANCELLATION POLICY)**

Should you have any questions regarding our policies or a special circumstance that you would like to discuss we invite you to speak with our office staff prior to your visit.

**INSURANCE INFORMATION**

*PLEASE PROVIDE ALL INSURANCE CARDS TO FRONT OFFICE STAFF SO THAT PHOTO COPIES CAN BE MADE!*

ONLY FILL OUT THE FOLLOWING IF YOU ARE **NOT** THE PRIMARY SUBSCRIBER TO THE INSURANCE:

PRIMARY INSURANCE: _____

SUBCRIBER NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____

SUPPLEMENTAL INSURANCE: _____

SUBCRIBER NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____

## AUTHORIZATION

I authorize the release of any medical information acquired in the course of my examination or treatment to process an insurance claim and that I have read and understand the office financial policy. I certify that all of the information given is true and correct to the best of my knowledge. I also request that payment of authorized services be made on my behalf to the physician rendering services for any balance not paid directly by myself. I authorize you to give me reasonable and proper medical care by today's standards of care. I have read and/or received a copy of the practice's notice of privacy practices.

Medicare patients: I certify that the information given to me in the applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release it to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized benefits be made on my behalf to the physician furnishing the services or authorize such physician to submit a claim to Medicare for payment to me.

SIGNATURE: _____ DATE: _____

**Note:** be sure to provide ALL insurance cards and a photo I.D. to front office staff so a copy can be made and placed in your record.

Anoop K. Reddy, M.D., P.A.

# HEALTH HISTORY

Name: _____ Date: _____

Reason for visit: _____

**SYMPTOMS:** Please check (✓) symptoms you currently have or may have had:

| | | |
|---|---|---|
| □ Depression | □ Blurred vision | □ Fainting or black-out spells |
| □ Numbness or tingling | □ Sudden loss of vision in one eye | |

**PAST MEDICAL HISTORY:** Please check (✓) conditions you have or had in the past: (ROS: )

| | | | |
|---|---|---|---|
| □ AIDS/HIV positive | □ Glaucoma | □ Kidney disease | □ Polio |
| □ Asthma | □ Gout | □ Migraine headaches | □ Prostate disease |
| □ Cataract/surgery | □ Heart disease | □ Multiple sclerosis | □ Psychiatric care |
| □ Cancer: (Type) _____ | | □ Hepatitis/liver disease | □ Osteoarthritis |
| □ Stroke | □Osteoporosis | □ Thyroid disease | □ Epilepsy/Seizures |
| □ Diabetes/high blood sugar | | □ High cholesterol | □ Tuberculosis |
| □ High blood pressure | □Low back pain | □ Neck pain | □ Ulcers |
| □ Pacemaker implant | □ COPD | | |

**ANY OTHER SERIOUS ILLNESS/INJURIES/OTHER MEDICAL PROBLEMS:**

**MEDICATIONS:** Please list all medications you are currently taking and dosage information.

Name of Medication:

**ALLERGIES:** Please list any medications that cause you to breakout in hives/rash/itching, etc...

Name of Medication Specific reaction

**Please Fill Out the Other Side**

## DRUG REACTIONS/ADVERSE REACTIONS: List any medications that you have encountered difficulty taking, such as nausea, etc...

| Name of Medication | Type of reaction |
|---|---|
| | |

## SURGERIES: Please list any and all procedures

| Year | Procedure | Location performed |
|---|---|---|
| | | |

## FAMILY HISTORY: Please in health information about your immediate family:

| Relation | Age | State of health | Age at Death | Cause of death | Check (✓) if blood relatives had any of the following: | |
|---|---|---|---|---|---|---|
| Father | | | | | Cancer | |
| Mother | | | | | Dependency/ psychiatric illness | |
| Sibling (M/F) | | | | | | |
| Sibling (M/F) | | | | | Diabetes | |
| Sibling (M/F) | | | | | Epilepsy/Seizures | |
| Sibling (M/F) | | | | | Heart Disease | |
| Sibling (M/F) | | | | | High Blood Pressure | |
| Sibling (M/F) | | | | | Kidney Disease | |
| Sibling (M/F) | | | | | Stroke | |
| Sibling (M/F) | | | | | Tuberculosis | |

## HEALTH HABITS: Please check (✓) which substance you use and describe how often/much use

| Check (✓) if you use item: | Substance: | Usage per day: | Length of time used: | When did you quit: |
|---|---|---|---|---|
| □ | Cigarettes | _____ packs per day | | |
| □ | Alcohol | _____ oz of wine/liquor daily<br>_____ bottles/cans of beer daily | | |
| □ | Other (please explain) | | | |
| □ | No Substance, Alcohol or Tobacco Abuse | | | |

What hand do you sign with? □ Right □ Left

Occupation: _____

Are you married? □ Yes, how long? _____ □ No

I certify that the above information is correct to the best of my knowledge.

Patient signature: _____ Date: _____

□ Reviewed with patient _____

**Anoop K. Reddy, M.D., P.A.**
***Diplomate of the American Board of Psychiatry and Neurology***
**4446 E Fletcher Avenue, Suite E, Tampa, FL 33613**
**Phone: (813) 558-8878**

# Cancellation Policy

Appointments are commitments between the patient and doctor to share a given time. Appointments that are not kept waste not only the doctor's time, but office staff and leave those patients with urgent healthcare needs waiting.

We are willing to work with our patients who are willing to work with us. We understand that there are some circumstances that cannot be avoided. If you have to cancel/reschedule your appointment it is appreciated if it is done as soon a possible. **Patients who do not cancel within 48 business hours prior to the scheduled time will be automatically billed for the visit that is missed**. _____(initial) This will be charged to the personal patient account and is not covered by insurance.

By signing this form you agree that you have been notified and understand the cancellation policy of the practice.

Patients Name: _____

Signature: _____

Date signed: ____/____/_____

**Anoop K. Reddy, M.D.**
***4446 E. Fletcher Ave. Ste E.Tampa, FL 33613***
**Ph: (813) 558-8878 Fax: (813) 558-0259**

# Authorization for Release of information

I hereby give my permission to Anoop K. Reddy, M.D. PA to request any medical records required for treatment from my primary care physician, referring physician, or any other physician involved in my treatment.

## PATIENT INFORMATION:

_____
Full Name

_____
Date of Birth

_____
Signature of Patient or Authorized Representative*

Date of signature: _____

Relationship to patient: _____

*If legal guardian, administrator or executor of estate, legal proof of this status must accompany this authorization.

Please fax records to number listed above, unless otherwise specified.

This authorization will expire automatically one year after the date signed. You may revoke this authorization at any time by notifying the office of Anoop K. Reddy, MD in writing to the address above. The written revocation will not affect any information already disclosed to the office of Anoop K. Reddy, MD prior to revocation.