New Patient Questionaire

Dr. Aruna Koney MD

1151 N. Buckner Blvd. Suite 103
Dallas, TX 75218
(214)-390-5047

Date ___________________ E-Mail Address _____________________________________

First Name _____________________________ Last name ______________________________

Race: ______________ Ethnicity: _______________ Language: __________________

Home Address: ____

City ________________________________ State ________ Zip _______________________

Home Phone (   ) ________________________ Cell (   ) __________________________

Birth Date __________________ Current Age _________ S.S.N. ____________________

Marital Status: ____________________ Number of Children ________________________

Spouse Name ___________________________ Spouse DOB____________________________

Your occupation ____

Patient's Employer ______________________________ Wk# ____________________________

In case of emergency, contact ____

Phone: _____________________________ Relationship: ______________________________

Primary Insurance Company ____

Name of Insured ___________________________________ Date of Birth: _________________

Policy No ______________________________ Group No ______________________________

Medicare No __________________________

I clearly understand and agree that all services rendered to me are charged directly to my insurance (with the exception of copay or coinsurance) and any and all charges not covered or paid, I will be directly responsible for payment. I also understand that if I suspend or terminate my care and/or treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature ____________________________________ Date ___________________

Please list your main reason for making appointment:
(Present illness or complaint – illness duration)

____

Events preceding onset: ____

____

Please list your current medical problems: (list the conditions you are currently being treated for)

____

____

Please list any other doctors who are currently treating you:

____

Allergies or Drug Reactions (list drug and reaction):

____

Pharmacy Name: _________________________ Ph#: _______________________

Location: _________________________ Cross Street: _________________________

Please list how you would like to be contacted, for test results:

Phone number: ____________________________ home work cell

May we leave results on voice mail? YES NO

Past medical history: Please list all hospitalizations, major illnesses and surgeries:

____

____

Previous PCP: ____
Phone No _______________________

Date of last Physical Exam ____

Abnormal Findings ____

Date of Last Pap Smear ___________ (normal) _________ (abnormal) __________

Date of last Mammogram ____________ (normal) ________ (abnormal) _________
Location: ______________________________ Phone# __________________________

Date of last Colonoscopy ___________ (normal) _________ (abnormal) __________

Date of last Eye Exam ______________ (normal) __________ (abnormal) __________
Location: ______________________________ Phone# __________________________

Have you received travel immunizations? __________ if so, please list ________

____

Personal habits:

Do you smoke cigarettes? _____ how many packs per day? ________ at what

age did you start? ____________ have you ever smoked? __________

When and how did you quit? _________________________

Do you consume alcohol? _________ frequency _________________________

How much caffeine do you drink/eat per day?

Tea ________ Coffee _________ Sodas ________ Chocolate __________

Do you have difficulty falling asleep? Y N

Do you take a sleep aid? _________ what type? ________________

Have you lost or gained 10 pounds in the last year? Y N

Are you currently on a diet or weight-loss program? ________ If so, please list

program ______________________ how many pounds have you lost? _____lbs.

Personal History:

Please List any medications you are currently taking (including non/prescription drugs, vitamins or natural supplements)

Blood pressure pills _______________ Thyroid medication _______________
Hormones, estrogen _______________ Diuretic (water pill) ________________
Diabetic medication ________________ Insulin __________________________
Iron _____________ Blood thinners __________ Barbiturates ______________
Cortisone, prednisone (steroids) _______________________________________

Dilantin ______________________ Phenobarbital ________________________

Laxatives _____________________ Injections _______________________

Please list any other medications you are currently taking:
____
____

Have you ever had a frequent or prolonged use of the following drugs, if so, provide your age at the time and duration you took them:

Antibiotics _______________________________________ age _________

Antihistamines ___________________________________ age __________

Cortisone _______________________________________ age __________

Prednisone ______________________________________ age _________

Steroids ____ age _________

Do you now or have you ever had a problem with drugs? ____________________

If yes, describe: ____

Do you exercise? ______ How often __________ What type _______________

Do you wear seat belts? ____________ Do you wear a bike helmet? _________

Do you use drugs (marijuana, cocaine, crack etc.)? _________________________

Have you or do you currently work with chemicals, plants, asbestos or other

hazardous materials? ________ Explain ________________________________

Would you describe your stress level as low, moderate or high? _______________

What emotional or stress-related factors are of concern to you currently?
____

What Lifestyle/dietary changes can you make to improve your health and help you feel better?
____
____

Describe how you feel about these issues (G=Great / O=Okay / P= Problem)

Spouse ________ Significant other _______ Children _______ Work ________

Sex Life _________ Finances ________

Describe how you feel about your life in general: __________________________

____

For the following illnesses, check the box if you have now or have had them, and include description, now vs. prior, treatment/action taken and date:

□ Cancer ____

□ AIDS/HIV ____

□ High Blood Pressure ____

□ Elevated Cholesterol ____

□ Diabetes ____

□ Peptic ulcers ____

□ Major Dental Problems ____

□ Rheumatoid Arthritis ____

□ Lupus/Auto-Immune illness ____

□ Multiple Sclerosis ____

□ Hepatitis/ Liver Disease ____

□ Gall Stones ____

□ Kidney Stones ____

□ Heart problems ____

□ Migraine ____

□ Food/Environmental Allergies ____

□ Anemia ____

□ Asthma ____

□ Lung Problems ____

□ Vascular problems ____

□ Excessive Fatigue ____

□ Abdominal pain ____

□ Gonorrhea/ Syphilis /Chlamydia ____

□ Herpes ____

□ Shingles ____

□ Ulcerative Colitis / Crohn’s Disease _______________________________________

□ Depression / Nervous Breakdown ____

□ Insomnia ____

□ Pneumonia ____

□ Thyroid Disease ____

Family History

Father (if living) age ______ and current health _________________________

or age at death _______ and cause of death ______________________________

Mother (if living) age ______ current health ______________________________

or age at death _______ and cause of death ______________________________

Siblings: Please circle sex and give current health status

Age _______ M F health is fair __________ good _________excellent _________

Age _______ M F health is fair __________ good _________excellent _________

Age _______ M F health is fair __________ good _________excellent _________

Age _______ M F health is fair __________ good _________excellent _________

Age _______ M F health is fair __________ good _________excellent _________

Do you have any blood relatives who have or have had any of the following?

Stroke	Y N	relationship ______________
Hypertension	Y N	relationship ______________
Heart disease	Y N	relationship ______________
Cancer	Y N	relationship ______________
(What type) ____		
Diabetes	Y N	relationship ______________
Arthritis	Y N	relationship ______________
Seizures	Y N	relationship ______________
Migraine	Y N	relationship ______________
Asthma	Y N	relationship ______________
Glaucoma	Y N	relationship ______________
Tuberculosis	Y N	relationship ______________
Leukemia	Y N	relationship ______________
Thyroid problems	Y N	relationship ______________
Congenital heart	Y N	relationship ______________
Colitis or bowel problems	Y N	relationship ______________
Drug or alcohol addiction	Y N	relationship ______________
Mental illness	Y N	relationship ______________

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

To: ____

Address: ____

Ph# __________________________________Fax# ________________________

►► Patient Name: ______________________________ DOB: ________________

SSN: _______________________________

Date(s) of Service: ____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient.

Patient Information is needed for: Continuing Medical Care

Information to be released or accessed:

___ History & Physical ___ Consultation report ___ ER records

___ Operative reports ___ Discharge summary ___ Face Sheet

___ Lab/Pathology reports ___ X-Ray/Imaging reports ___ all records

The above information may be released to:

Aruna Koney, MD
1151 N. Buckner Blvd. Suite 103
Dallas, TX 75218

Phone: 214-320-1200 Fax: 214-320-9400

I understand my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand the specified information to be released may include Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Date: ____________________

►► Signature: ____
Patient or legally authorized representative

____
Printed name of patient or legally authorized representative

____
Relationship to patient

Patient preference regarding communication of Health Information

I. WHO TO CONTACT

I hereby give permission to Dr. Aruna Koney and/or her office staff to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close friend(s).

____ ____________________
Name/Relationship Phone #

____ ____________________
Name/Relationship Phone #

____ ____________________
Name/Relationship Phone #

__________ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

II. HOW TO CONTACT

I wish to be contacted in the following manner:

Home/Cell Phone: ________________________ Work Telephone: ________________________

( ) OK to leave message with detailed information ( ) OK to leave message with detailed information

( ) Leave message with call back number only ( ) Leave message with call back number only

Written Communication:
( ) OK to mail to my home address: ____

____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that for medical information from persons not listed will require a specific authorization prior to the disclosure of any medical information. I have reviewed Notice of Privacy Practices for this office which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Name: ____

____ ____________________
Signature of Patient or Legal Representative Date

Aruna Koney, M.D.
Board Certified in Internal Medicine

Dear Patient,
Our office is pleased to have the opportunity to serve you. Our primary mission is to provide you with quality, cost effective, medical care. Together, we (patient and physician) are trying to adapt to the changing way that healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps required by your insurance or managed care plan.
PAYMENT GUIDELINES:

- You must pay any copay, co-insurance and/or deductible at the time of service, unless other arrangements have been made in advance with our office.
- We accept cash, check, money order or credit cards as form of payment
- The remainder of your bill will be sent to your insurance company for payment to our office.
- If payment should be sent to you from your insurance company, please forward Payment and all correspondence sent to you. PLEASE DO NOT SEND PAYMENT BACK TO YOUR INSURANCE COMPANY.

When to Present Insurance Card:
Please present your insurance card at EACH VISIT; it is the patient's responsibility to inform us of any changes (new card, policy or group number) since your last visit. If you fail to inform us of any changes this could delay your claim being processed correctly and possibly denied for timely filing. If your claim is denied for this reason you will be responsible for the amount due. Our office will file your secondary insurance as a courtesy, however if we have not received payment from your secondary insurance in a timely manner the balance will become your responsibility.
Insurance Payment Denials:

Your insurance company may deny your claim for some of the following reasons:

1. Pre-existing illness or condition that they will not cover
2. Deductible has not been met for full calendar year
3. The type of medical services rendered are not covered under your plan
4. Insurance policy not in effect at time services were rendered
5. You may have another insurance policy that is primary (or must be filed first)
6. Maximum dollar/visit amount has been met

If your insurance company denies your claim for any of the above reasons or reasons not listed, the charges will become your responsibility and full payment will be expected.

We value you as a patient and are eager to serve you; our first priority is to provide you with the best possible care. If you would like to contact our billing assistant, you may reach them at 214-320-1200.

Sincerely,
Aruna Koney, MD

I have read and understand my financial obligation to this office; I understand that this office will file an insurance claim on my behalf. Both the doctor and I will receive and explanation of benefits (EOB) from my insurance company that will detail all payments, deductions and/or adjustments made per my plan's guidelines.

I understand that I am financially responsible for payment of any and all medical services denied by my insurance company, as applicable by state and/or federal law.

_______________________________________ ____________________

PATIENT SIGNATURE DATE

ARUNA KONEY, M.D, P.A.

Consent for Treatment

I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of Aruna Koney, M.D., P.A., her assistants or her designee as is necessary in her judgment.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination by Aruna Koney, M.D., P.A.

Patient Signature: ____

Date: ____

If patient is unable to sign:

Signature: ____

Relationship to Patient: ____
Date: ____