Dr. Ali Abdul Wahid M.D

1108 Ward Ave. Bldg. A Ste. 1 Patterson, CA 95363 Ph: 209-892-1300 Fax 209-780-4141

Patient Demographics

PATIENT INFORMATION

Name:_____Middle:_____Last:_____ Age:_____

D.O.B:_____ Social Security #:_____ ☐ Female ☐ Male ☐

Address(Street)_____(City)_____(State)_____(Zip Code)_____

P.O. Box :_____ (City)_____(State)_____(Zip Code)_____

Home Ph:_____ Cell Ph:_____ Work Ph:_____ **Email**:_____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ **If a Minor** Parent/Legal Guardian:_____

Employer:_____Occupation:_____

Driver's License No.:_____ State:_____ Primary Language:_____

Race: ☐ African/ African American ☐ Asian ☐ Hawaiian /Pacific Islander ☐ Native American ☐ White ☐ Other Race

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Not Latino ☐ Unknown ☐ Declined

Emergency Information

Emergency Contact:_____ Relationship:_____

Home Ph:_____ Cell Ph:_____ Work Ph:_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance:_____ Group #:_____ I.D#:_____

Subscriber Name:_____ Subscriber D.O.B:_____ Relationship:_____

Social Security No.:_____ Employer:_____

SECONDARY INSURANCE

Insurance:_____ Group #:_____ I.D#:_____

Subscriber Name:_____ Subscriber D.O.B:_____ Relationship:_____

Social Security No.:_____ Employer:_____

CONSENT FOR TREATMENT / AUTHORIZATION / ASSIGNMENT / RESPONSIBILITY STATEMENT

I consent to have Ali A.Wahid, M.D., Physicians and Mid-level to treat me at Wahid Medical Corporation. I consent to have physical examination (2) Diagnostic procedures, (3) minor surgery and medical treatment, (4) Local anesthesia given to me if necessary and (5) the prescription of medication. I understand that I am financially responsible for all charges for services rendered to me, including the balance remaining after payment of possible insurance benefits.(6) If insurance does not cover my procedure / visit, I take responsibility of unpaid balance. I authorize payment of medical benefits for myself and/or Ali A. Wahid, M.D., and authorize the release of any medical information necessary to process this claim. If I am a Medicare patient, I authorize Medicare payments to be paid to Wahid Medical Corporation and/or Ali A. Wahid, M.D. and I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on any outstanding balances on my account. I understand that there are fees that apply for missed appointments, forms, and deposits required one week prior to procedures performed in the office.

Patient's Signature **Date** **Parent/Guardian Signature** **Date**

Revised 04/18/2013

Wahid Medical Corporation **Dr. Ali Wahid M.D.** Family Practice

Patient Name: _____ Sex: M☐ F☐ DOB:_____

Health History

Medical Problems:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgeries:	Type of Surgery	Year	Place
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Medications Currently Being Taken: **Pharmacy:_____**

Allergies: ☐ **No known allergies**	**Reaction:**

Date of last TB skin Test:_____ Last Tetanus shot:_____ Last Colonoscopy?_____
Do you smoke?_____ How Often?_____ Drink Alcohol?_____ How often?_____
Do you consider it a problem?_____ Do you consider your weight a problem?_____ What is your "ideal" weight?_____

For Women: How many Pregnancies?_____ Miscarriages?_____ Therapeutic Abortions?_____
Living children?_____ Last menstrual period began on:_____ First period at what age?_____
Are you presently using birth control?_____ Last Pap Smear done_____ Normal?_____
Last mammogram done? _____ Normal? _____

For Children: Birth weight:_____ Length:_____ Full Term Pregnancy?_____
Problems During Pregnancy:_____ During Delivery or just after:_____

Family History:	**Yes or No**	**Relative (Mother, Father, etc)**
Diabetes	☐ Y N	_____
Colon Cancer or Polyps	Y ☐ N	_____
Other Cancer	☐ Y ☐ N	_____
Heart Attack / Stroke	☐ Y ☐ N	_____
Other: _____	☐ Y ☐ N	_____

_____ _____
Signature / Parent or Guardian **Date**

Revised 04/12/2013

Dr. Ali Abdul Wahid M.D

Office Policy

- NO SHOW, NO CALL APPOINTMENTS ARE NOT TOLERATED.
- If you no show, no call for your appointments two or more time YOU WILL BE RELEASE FROM CARE. You will be given 30 days to be treated for emergency care only. Once you notify us of your new doctor you records can be forwarded by signing a records release form.
- We require 24 hour cancellation notice. We Reserve the right to charge for appointments cancelled or broken with 24 hours advance notice.
- Please be aware we have 24 hour surveillance cameras in our office.

Fee Acknowledgement

I understand that I will be charged a fee for the following:

- Missed/no-show appointments
- Returned checks patient will be responsible for the return check fee of $20.00 and amount owed
- Forms
- Deposits on all procedures performed in the office, due one week prior to procedure appointment.

Consent

Photo Consent: I _____herby grant permission to Wahid Medical to take
(Patient name / Minor name)
and use photo of myself for my electronic medical records.

EMAIL Consent: I _____herby grant permission to Wahid Medical to have
(Patient name / Minor name)
My email on file for any type of E-mail communications.

Email Address:_____

By signing below I accept
(Please check)

☐ **ALL**
☐ **Office Policy**
☐ **Fee Acknowledgement**
☐ **Consent**

Patient signature/ Guardian:_____

Date: _____

Wahid Medical Corporation

Notice of Privacy Practice

This form is used to confirm that individual has received our Notice of Privacy

Patient Name:_____ DOB:_____
(Print name)

I acknowledge that I have received a Notice of privacy practice. I have had full opportunity to read and consider the contents of the notice and privacy practices.

Signature Patient or Parent/ Guardian:_____ **Date:**_____

Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) and California law, practice may not use or disclose your health information except as provided in our Notice of Privacy Practices without your permission. Your completion of this form means that you are giving us permission for the uses and disclosure described below. You may revoke this authorization at any time by notifying Wahid Medical in writing. You have the right to a copy of this authorization. Please review and complete this form carefully. It may be invalid if not fully completed.

Authorizing Access

Please list those authorized to disclose your health information:

_____

(Name) (Relation to patient) (Phone)

_____

(Name) (Relation to patient) (Phone)

_____

(Name) (Relation to patient) (Phone)

☐ I agree Wahid Medical Corporation may disclose authorized health information at the request of the above listed individual

_____ **Initial** _____ **Date**

☐ **I do not want anyone access my health information.**

_____ **Initial** _____**Date**

Advance Directives

This form is used to confirm that individual has received our Advance directives.

Patient Name:_____ DOB:_____
(Print Name)

I acknowledge that I have received a copy of advance directives.

Signature:_____ **Date**:_____

☐ **Patient is a Minor no need for advance directives.**