M. Amar Chaudhry, M.D.
BOARD CERTIFIED INTERNAL MEDICINE
570-32ND ST. UNION CITY, NJ 07087
PHONE: 201-758-7250 FAX: 201-758-7251 / email: doctoramarc@gmail.com

PATIENT REGISTRATION

NAME: ______________________ LAST NAME: ______________________
DATE OF BIRTH: ______________________ GENDER: ______________________
ADDRESS: ______________________ CITY: ______________________
ZIP CODE: ______________ STATE: ________ SOCIAL SECURITY: ______________
PHONE: ______________ CELL PHONE: ______________________
EMAIL ADDRESS: ____
REFERRED BY: ____
MARITAL STATUS: ______________ SPOUSE'S NAME: ______________________
REASON OF THE VISIT: ______________ ALLERGIES: ______________________
OCUPATION: ______________ EMPLOYER'S NAME: ______________________
EMERGENCY CONTACT NAME: ______________ PHONE: ______________________
PREFERRED PHARMACY: ____
DO YOU HAVE ANY IMPAIRMENT (Visual, Hearing, Speech, Learning or Physical)? ______________
DO YOU HAVE ANY CULTURAL BARRIER? ______________________________
WHAT OTHER LANGUAGE DO YOU SPEAK, READ OR WRITE?: ______________________
DO YOU HAVE ANY RELIGIOUS OR CULTURE CUSTOMS THAT THE DOCTOR SHOULD KNOW ABOUT? ☐ YES ☐ NO
IF YES, PLEASE DESCRIBE: ____

ADVANCED DIRECTIVE

IN CASE OF AN EMERGENCY AND YOU ARE NOT ABLE TO ANY MEDICAL DECISIONS, WHO WOULD YOU ASSIGN TO BE YOUR HEALTHCARE REPRESENTATIVE?

- NAME: ____
- ADDRESS: ____
- PHONE: ____
- RELATION: ____

INSURANCE INFORMATION

INSURANCE NAME: ____
INSURED'S NAME: ____

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits.

Signature: ______________________________ Date: ______________________

Diligent Medical Care, PC
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Medical History

Name:_______________________________ **DOB:**______________ **Date:**______________________

Personal History	
Please list all medications you are taking (over the counter and presciption)	
Please list allergies you have (medications, foods, pets, seasonal, other)	
Please list any chronic you (asthma, diabetes, glaucoma, high blood pressure, other)	
Please list all major illness, injuries, surgeries, and/or hospitalizations whitin the last 10 years	

Family History

Has a blood relative ever had	Y	N
Anemia		
Arthritis		
Diabetes		
Glaucoma		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Thyroid Disease		

Please see Cancer History form attached

Social History

	Y	N	If yes, how often?
Tobacco			
Alcohol			
Recreational Drugs			

Preventive Screenings

In the past years, have you had?	Y	N
Blood pressure check		
Blood Test		
Flu shot		
Physical Exam		

Men Only

In the past 2 years, have you had?	Y	N
Colonoscopy		
Prostate Exam		
Testicular Exam		

Women Only

In the past 2 years, have you had?	Y	N
Colonoscopy		
Mammogram		
Pap Smear		

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Personal and Family History

Name: ______________________________ **Date:** ______________

Family history is the MOST important insight in how we can better manage YOU. Personalized care begins with knowing your risks. Please complete this thoroughly so you can get the best care possible from our medical staff.

Please describe any Cancer(s) you or your family have had below

The Following Relatives Should Be Considered: You, Mother, Father, Brother, Sister, Children, Paternal Aunt/Uncle, Maternal Aunt/Uncle, First Cousins, Nieces/Nephews, Maternal and Paternal Grandparents

History Description	Circle	Relative(s)	Paternal/ Maternal	Age(s) of Diagnosis
Colon Cancer before the age of 50 or two diagnosis of colon cancer on the same side of the family	YES - NO			
Uterine/Endometrial cancer before the age of 50	YES - NO			
One of the following cancers: Ovarian, pancreatic, or gastric cancer(s) in your family?	YES - NO			
One of the following cancers: small bowel, liver, kidney, or brain cancer(s) in your family?	YES - NO			
Breast Cancer diagnosed at or before the age of 50	YES - NO			
Ovarian Cancer diagnosed at any age	YES - NO			
Male Breast Cancer diagnosed at any age	YES - NO			
Three or more breast cancers on the same side of the family regardless of age	YES - NO			
A relative diagnosed with breast cancer twice	YES - NO			
Any diagnosis of pancreatic cancer with breast cancer in the same family member?	YES - NO			
Have you or any of your family members been tested for the BRCA gene? If no, why not?	YES - NO			
Please list any other cancers, what relative, and side of the family:				

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Depression and Alcohol

Patient Name: ______________________ **Date of Birth:** ______________ **Date:**____________________

How often during the past 2 weeks were you bothered by....	Not at all	Several Days	More than half the days	Nearly every day
1.- Little interest or pressure in doing things	0	1	2	3
2.- Feeling down, depressed or hopeless	0	1	2	3
3.- Trouble falling or staying asleep too much	0	1	2	3
4.- Feeling tired or having little energy	0	1	2	3
5.- Poor apetite or overeating	0	1	2	3
6.- Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	0	1	2	3
7.- Trouble concentrating on things, so as reading the newspaper or watching TV	0	1	2	3
8.- Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.- Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Total Score: ____________

CAGE-AID Questionnaire		
1.- Have you ever felt that you ought to cut down on your drinking or drug use?	**Yes**	**No**
2.- Have people annoyed you by criticizing your drinking or drug use?	**Yes**	**No**
3.- Have you ever felt bad or guilty about your drinking or drug use?	**Yes**	**No**
4.- Have you ever had a drinking or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	**Yes**	**No**

Screening i: Positive / Negative

Agreement between Doctor and Patient

As your primary care physician, my goal is to provide you with the best care possible, however; in order to do that I need your cooperation as a patient this is why I ask that you read and sign this document and by doing so; you will confirm that you agree with its content.

1. I will follow all the instructions given by Dr. Mohammad A. Chaudhry and associates pertinent to my treatment, exams, diets, etc., and will attend all the appointments necessary to discuss my results.
2. If I have any questions regarding such instructions, I will ask Dr. Chaudhry and associates an explanation. I understand that if I don't follow his instructions, I will be responsible of the possible consequences, which will also be explained to me by Dr. Chaudhry and associates.
3. I understand that if Dr. Chaudhry and associates refers me to a different provider, I will follow his instructions. Failure to follow these instructions and miss appointments with the referred specialists will be my responsibility.
4. I understand that in the case that a medication prescribed by Dr. Chaudhry and associates is not covered by my insurance, I will contact the doctor prior to making any changes. Any changes in medications without the authorization of Dr. Chaudhry and associates will be my responsibility.
5. I will communicate Dr. Chaudhry and associates about any treatment, diagnostic or procedures that have been ordered by another provider and I understand that this information will help assist Dr. Chaudhry and associates with future treatment.
6. I understand that my medical insurance might need a referral from Dr. Chaudhry and associates prior to seeing other specialist and/or to get any procedures. If I do not have these referrals, I understand that I will be responsible for this.
7. I will inform to Dr. Chaudhry and associates and his staff about any changes in my address, phone number, medical insurance or any relevant changes in my demographics.
8. I will inform Dr. Chaudhry and associates about my preferences in medical care in the case I am not able to make medical decisions for myself as well as my preference for artificial respirators, resuscitation, etc.
9. I will behave in a respectful manner with the staff and with Dr. Chaudhry and associates and I will not cause any disturbance or threats to anyone in the office.

Understanding and contributing to the previous statements I will help me provide you with better medical care. By signing this, you agree to follow these rules.

Sincerely,

Mohammad A. Chaudhry M.D.

I ___________________________________, have read the previous agreement between the doctor and patient and I understand the importance of following this rules.

Signature ___________________________Date: _____________________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, is kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used.

At DILIGENT MIEDICAL CARE PC, we are committed to protecting the privacy of our patients personal and health information. All of our employees are required to sign confidentiality policies.

As required by "HIPAA" we have prepared this explanation of how we maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records, only for each of the following purposes:

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care profession for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Practice Operations. Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as require by law. For example, we are required to report certain communicable disease to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Diligent Medical Care Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. Mohammad Amar Chaudhry
Diligent Medical Care, PC
570 - 32nd St.
Union City, NJ, 07087

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address or to the Department of Health and Human Services.

You will not be penalized or otherwise retaliated against for filing a complaint.

This notice is effective as of September 26, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

The undersigned acknowledges that he/she has received a copy of this notice of privacy practices:

____________________ ____________________

Patient/Guardian Date

Bill of Rights

1. Understand and use these rights. If for any reason you do not understand or you need help, the office MUST provide assistance, including an interpreter.
2. Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment, or age.
3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. Receive emergency care if you need it.
5. Be informed of the name and position of the doctor who will be in charge of your care in the medical office.
6. Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.
7. Receive complete information about your diagnosis, treatment and prognosis.
8. Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
9. Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so.
10. Refuse treatment and be told what effect this may have on your health.
11. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
12. Privacy while in the medical office and confidentiality of all information and records regarding your care.
13. Participate in all decisions about your treatment.
14. Review your medical record without charge. Obtain a copy of your medical record for which the office can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
15. Receive an itemized bill and explanation of all charges.
16. Complain without fear of reprisals about the care and services you are receiving.