Patient Information and Medical History

It is important to complete this form as accurately as possible, to assist us in providing you with the highest quality medical care.

PATIENT INFORMATION

Patient Name:			☐Male ☐Female
Race/Ethnicity: ☐Caucasian/White ☐Black/African American ☐Hispanic ☐Asian ☐American Indian/Alaskan Native ☐Native Hawaiian/Other Pacific Islander ☐Asian Pacific American ☐Other:_____ ☐Decline to state			
Date of Birth:	Soc Sec No:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed	
Mailing Address:		Apt No:	
City:		State:	Zip:
Cell Phone:	Home Phone:	May we leave you a voicemail on these numbers? ☐Yes ☐No	
Please provide us with your E-Mail (will allow us to send you appointment reminders)			

RESPONSIBLE PARTY

Name of Person Responsible:		Relationship to Patient:	
Date of Birth:	Phone:	Soc Sec No:	
Mailing Address:		Apt No:	
City:		State:	Zip
Employer/School Name:		Phone:	
Employer Address:			
City:		State:	Zip:

EMERGENCY CONTACT(S)

(1)Name:	(1)Relationship to Patient:
(1)Cell Phone:	(1)May we release medical information to this person? ☐Yes ☐No
(2)Name:	(2)Relationship to Patient:
(2)Cell Phone:	(2)May we release medical information to this person? ☐Yes ☐No

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PATIENT LABEL

EMPLOYMENT INFORMATION

Patient Employment Status: ☐Working Fulltime ☐Working Part-Time ☐Unemployed ☐Student ☐Retired – Date of Retirement: _____		
Employer/School Name:		
Patient Occupation:	Employer Phone:	
Employer Address:		
City:	State:	Zip:

PRIMARY INSURANCE INFORMATION

Insurance Plan:		Phone:	
Policy No:	Group No:	Claims Phone:	
Name of Insured:	Patient's relationship to Insured:		
Mailing Address:		Apt No:	
City:		State:	Zip:
Insured's Date of Birth:	Insured's Soc Sec No:		

AUTHORIZATION TO VERIFY BENEFITS & BILL INSURANCE

I hereby authorize, Nirav Naik, MD, FACS or his medical staff to contact my insurance carrier (shown below) in order to determine eligibility for medical services. I understand that my insurance will be billed for services rendered by Nirav Naik, MD, FACS, and/or his medical staff providing treatment(s) [including any weight loss seminar I attend] under his supervision.

I understand that my insurance carrier may require an Authorization/Precertification and/or referral. Without this documentation, I understand that my insurance carrier may deny my benefits. If my insurance denies payment for services rendered by Nirav Naik, MD, FACS, and/or his medical staff providing treatment(s) under his supervision, I agree to be responsible for payment.

I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered by Nirav Naik, MD, FACS, and/or his medical staff providing treatment(s) under his supervision, I will **within five days of receipt** of this check make payment in the amount of said check to or sign over the original check to Nirav Naik, MD, FACS.

I understand that I am responsible for any charges not covered by my insurance carrier such as, but not limited to, Deductibles, Co-pays and/or Co-Insurance Amount(s).

The following also applies to the use of my insurance to cover the cost of services rendered:

1. **Authorization to Release Medical Information for Billing:**
   - I hereby authorize the release of any information regarding services by the Physician and/or the Facility to process insurance claims and allow to retain my **signature on file** for insurance claims.

2. **Assignment of Insurance Benefit:**
   - I hereby authorize assignment of payment for my benefits due to me for the services rendered by the physician and the facility to be made directly to the Physician and/or the Facility.

Patient Signature for "On File":	Date:
Subscriber Signature (**if other than patient**) for "On File":	Date:

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ADDITIONAL INFORMATION

Preferred Name to be called by:	
How did you hear about us or which doctor referred you to us?	Who is your Primary Care Physician?

Have you or any family members, friends, or acquaintances previously been treated by Dr. Naik? ☐Yes ☐No **If YES, please provide↓**

Name:	Procedure:	Date of Procedure:

REASON FOR VISIT

Please describe in your own words the reason for this visit: _____

When did this problem begin? _____

Have you had this problem previously in the past? ☐Yes ☐No **If Yes, when was the first time?** _____

Is your problem currently getting better or worse? _____

What makes your problem better/worse? _____

Have you had any prior treatment for this problem? _____

PAST MEDICAL HISTORY

Diabetes? ☐Yes ☐No	**If YES How long?** _____	**On insulin?** ☐Yes ☐No	
Glucose intolerance/pre-diabetes? ☐Yes ☐No			
High Blood Pressure? ☐Yes ☐No	**How long?**_____	**Heart Failure?** ☐Yes ☐No	
History of heart attack? ☐Yes ☐No	**When?** _____	**Heart stent or surgery?** ☐Yes ☐No	
Atrial fibrillation (irregular heartbeat)? ☐Yes ☐No	**When?** _____	**Pacemaker/Defibrillator?** ☐Yes ☐No	
History of stroke? ☐Yes ☐No	**When?** _____	**History of mini-strokes?** ☐Yes ☐No	
Asthma/Emphysema/COPD? ☐Yes ☐No		**On oxygen at home?** ☐Yes ☐No	
Sleep Apnea? ☐Yes ☐No		**Are you using a CPAP or BiPAP?** ☐Yes ☐No	
Hiatal Hernia? ☐Yes ☐No **Heartburn?** ☐Yes ☐No		**On any medications for heartburn?** ☐Yes ☐No	
High Cholesterol? ☐Yes ☐No			
Hepatitis B or C? ☐Yes ☐No		**Cirrhosis, or other liver problems?** ☐Yes ☐No	
Varicose (spider) veins? ☐Yes ☐No		**Any leg discomfort/swelling?** ☐Yes ☐No	
History of blood clot (legs, lungs)? ☐Yes ☐No		**On any blood thinners, or have had IVC filter?** ☐Yes ☐No	
Back pain? ☐Yes ☐No **Joint pain?** ☐Yes ☐No		**On any pain medications?** ☐Yes ☐No	
History of Gout? ☐Yes ☐No		**On medications currently?** ☐Yes ☐No	
Low thyroid? ☐Yes ☐No		**High thyroid?** ☐Yes ☐No	

Any other medical problems? _____

_____

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PRIOR SURGERIES

☐**NO PRIOR SURGERIES**

PROCEDURE	DATE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

MEDICATIONS (Please list dosage, how often, and what it is for; or please attach a list if available)

☐**NO CURRENT MEDICATIONS**

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

ALLERGIES

☐**NO KNOWN ALLERGIES**

Latex: ☐Yes ☐No	Tape: ☐Yes ☐No	Iodine: ☐Yes ☐No

Medication	Reaction
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
Other:	

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REVIEW OF SYSTEMS

Please mark all that apply. If you do not understand a term, please let us know so that we may assist you.

General ☐No Symptoms

☐Fever	☐Fatigue
☐Chills	☐Recent involuntary weight loss
☐Night Sweats	☐Loss of appetite

Neuro-Psycho-Social ☐No Symptoms

☐Severe headaches	☐Alcohol or Drug Abuse
☐Dizziness	☐Obsessive-compulsive disorder
☐Fainting	☐Bipolar disorder
☐Convulsions or seizures	☐Eating disorder (bulimia, etc.)
☐Psychiatric illness	☐Tremors
☐Depression or Anxiety Disorder	☐Numbness in arms or legs
☐Suicide attempts	☐Weakness in arms or legs
☐History of Emotional or Physical Abuse	☐Pseudotumor Cerebri

Eyes, Nose, Ears, Throat ☐No Symptoms

☐Seeing double	☐Sinus pain
☐Blurry vision	☐Recurrent sore throat
☐Eye pain	☐Hoarseness or weak voice
☐Ringing in the ears	☐Swollen glands in the neck

Respiratory System ☐No Symptoms

☐Asthma (Wheezing)	☐Shortness of breath
☐Chronic cough	☐Pneumonia
☐Coughing up blood	☐Tuberculosis
☐Snoring/gasping at night (waking you)	☐Valley Fever (coccidioidomycosis)
☐Periods of not breathing while sleeping (Sleep Apnea)	Using: ☐CPAP ☐BIPAP ☐Home Oxygen

Cardiovascular ☐No Symptoms

☐Chest Pain or discomfort	☐Leg pains below the knee
☐Heart Murmur	☐Skin problems on legs or feet
☐Prior blood transfusions	☐Varicose veins
☐Bleeding or bruising problems	☐Leg swelling/ulcers
☐Blood clot problems	☐Compression stockings

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Endocrine/Metabolic ☐No Symptoms

☐Iron Deficiency Anemia	☐Thyroid problems
☐Vitamin Deficiency	☐Cannot stand heat or cold
☐Abnormal fasting glucose	☐Excessive thirst
☐Lactose Intolerance	☐Hair changes

Gastrointestinal ☐No Symptoms

☐Heartburn (GERD)	☐Hemorrhoid Problems
☐Regurgitation (Food/Acid comes up when lying flat)	☐Change in bowel habits
☐Difficulty swallowing	☐Red blood in stool
☐Nausea or vomiting	☐Black or tarry stools
☐Abdominal pain	☐Excessive gas
☐Bloating	☐Trouble holding ☐gas or ☐stool
☐Stomach ulcers	☐Colon or rectal problems
☐Diarrhea	☐Yellow skin or eyes (jaundice)
☐Constipation	☐Abnormal liver tests
☐Irritable bowel syndrome	☐History of pancreatitis

Genitourinary (Urinary) ☐No Symptoms

☐Loss of bladder control ☐With sudden movements such as coughing, sneezing, or laughing.	☐Urinary stream is smaller
	☐Increased urinary frequency
	☐Blood in urine
☐Burning with urination	☐Kidney failure
☐Pain with urination	☐Kidney Stones
☐Difficulty starting to urinate	☐Getting up at night to urinate? How many times_____

Musculoskeletal ☐No Symptoms

☐Joint Pain	☐Problems walking
☐Back Pain	☐Using a walker or a cane
☐Bone Pain	☐Unable to walk 200 ft (1/2 block)
☐Muscles decreasing in size	☐Using a wheelchair
☐Arthritis (formal diagnosis)	☐Difficulty getting up without help

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Skin ☐No Symptoms

☐Dry Skin	☐Prior skin infections
☐Itching	☐MRSA – Methicillin-resistant Staphylococcus aureus Infection
☐Current Skin Rash	
☐Extra Skin (Hanging)	☐VRE – Vancomycin-resistant Enterococcus Infection
☐with difficulty grooming	☐History of Skin Surgery When? _____
☐with difficulty walking	

Men's Health ☐No Symptoms ☐Not-Applicable

☐Prostate problems	☐Erectile dysfunction On medication? ☐Yes ☐No

Women's Health ☐No Symptoms ☐Not-Applicable

☐No periods for more than 6 months	Date of last PAP test:
☐Menopause	Date of last mammogram:
☐Irregular cycles	Number of pregnancies:
☐Polycystic ovarian syndrome	Number of live births:
	☐Did you breast feed your children?

FAMILY HISTORY

☐Adopted (Don't Know)	☐Difficulty with Anesthesia	☐Heart Disease	☐Obesity
☐Cancer	☐Gallstones	☐Hernias	☐Stroke
☐Diabetes	☐Heartburn	☐High Blood Pressure	☐Other (Please list below↓)

SOCIAL HISTORY

Smoking: ☐Yes ☐Quit ☐Never	How much?	Date Quit:
Marijuana/CBD: ☐Yes ☐Quit ☐Never	How often?	Date Quit:
Alcohol: ☐Yes ☐Quit ☐Never	How much?	Date Quit:
Drugs: ☐Yes ☐Quit ☐Never	Type?	Date Quit:
Caffeine: ☐Yes ☐Quit ☐Never	Type?	Date Quit:

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NOTIFICATION TO PATIENTS

Initials _____ **All Payments, Co-Payments, Co-Insurance, and/or visit deductibles are due at the time of your appointment prior to us rendering service(s).**

Initials _____ **Due to growing trend toward high deductible plans, please be aware that we may collect an estimated payment for our services rendered.**

Initials _____ **As of January 1, 2016, there will be a $35.00 fee for missed appointments/cancellations within less than 24 hours and will be marked on your chart as a NO-SHOW. Insurances DO NOT cover this fee.**

Initials _____ **If you have an open balance or owe any NO-SHOW Fees this must be paid prior to scheduling your next visit.**

Initials _____ **If you have more than three (3) NO-SHOW appointments, or consecutive rescheduling of appointments you may be discharged from Dr. Naik's medical care.**

Initials _____ **As of January 1, 2019, there will be a $300.00 fee for surgery cancellations made within less than 7 business days.**

Initials _____ **All fees associated with your surgery must be paid 48 hours prior to your surgery. If no payment is made and we need to reschedule, you may be subject to the Surgery Cancellation Fee.**

Initials _____ **If I choose to have Robotic Surgery, I understand I AM RESPONSIBLE for all charges not covered by my insurance; this may also include the $500.00 surcharge for the Robotic use.**

Initials _____ **There is a 3% convenience fee applied to all payments made with a Debit or Credit Card. We accept Cash or Check(s) as other means of payment; a $50.00 fee applies for each bank returned Check.**

PHOTOGRAPHS

Initials _____ I consent to and authorize this office and the attending physician and/or medical staff to take photographs of me before, during and after treatment; I agree that these photographs become property of the doctor, to be used as he deems fit. This may include publication in a journal, article, social media, or book. My permission is granted to show these photographs to any other physician, patient or persons.
Personal information WILL NOT be shared including name, date of birth, address or phone number.

CONSENT FOR INFORMATION EXCHANGE

Initials _____ I agree to allow the office to obtain External Prescription History provided by Surescripts.
This information will help our office better manage your care and prescriptions.

Initials _____ I agree to allow the office to share clinical and demographic information electronically with other healthcare providers (such as hospitals, your primary care physician and other physician as needed to facilitate your medical care).

The information reported on this questionnaire is true to the best of my knowledge.
I also agree to and understand all statements disclosed on this form.

_____
PRINT your name

_____ _____
SIGN your name Date