PINNACLE CARE
Internal Medicine

Sick Today, Seen Today.

NAME: _____ DATE OF BIRTH: _____

GENDER: ☐MALE ☐ FEMALE SOCIAL SECURITY NO. _____

HOME ADDRESS: _____

STREET **CITY** **STATE** **ZIP**

PREFERRED PHONE NO: _____ SECONDARY: _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐WIDOWED ☐ OTHER

ETHNICITY: ☐HISPANIC OR LATINO ☐NOT HISPANIC OR LATINO

RACE: ☐ AMERICAN INDIAN ☐ ASIAN ☐ BLACK ☐ CAUCASIAN ☐ HISPANIC ☐ REFUSED

PREFERRED LANGUAGE: ☐ ENGLISH ☐SPANISH ☐FRENCH ☐CHINESE ☐OTHER: _____

EMAIL ADDRESS: _____

BEST WAY TO CONTACT YOU: _____

MAY WE LEAVE MESSAGES/TEXT REGARDING OFFICE AND TESTING APPOINTMENTS ON YOUR VOICEMAIL? ☐ YES ☐ NO

PHARMACY NAME: _____

CROSS STREETS PHONE NUMBER

PATIENT EMPLOYMENT INFORMATION

PATIENT EMPLOYER: _____ OCCUPATION: _____
EMPLOYER PHONE NUMBER: _____

PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID#:_____
SUBSCRIBER NAME:_____ DOB:_____
RELATIONSHIP TO SUBSCRIBER: _____GROUP #: _____
SECONDARY INSURANCE: _____ ID #:_____
SUBSCRIBER NAME:_____DOB:_____
RELATIONSHIP TO SUBSCRIBER: _____GROUP #: _____

DO YOU HAVE A LIVING WILL? ☐YES ☐ NO IF YES, PLEASE PROVIDE A COPY FOR OUR RECORDS
DO YOU HAVE A DNR? ☐ YES ☐ NO IF YES, PLEASE PROVIDE A COPY FOR OUR RECORDS

AUTHORIZATION, ASSIGNMENT, AND RELEASE

I authorize Pinnacle Care Internal Medicine to perform, evaluate and treat, as they deem necessary. I further authorize my insurance company_____ to pay Pinnacle Care Internal Medicine all medical benefits. I understand that ultimately, I am responsible for all charges not covered by my insurance as well as all deductibles; co-insurance and co pay amounts as determined by my insurance company. I understand that all balances not paid within 30 days of statement due date will accrue an interest charge in the amount of 1.5% per month/18% per annum. I understand that I will be responsible for all collection fees and all legal fees, if my account is placed with an outside collection agency. I hereby authorize Pinnacle Care Internal Medicine to release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

PATIENT SIGNATURE: _____**DATE**:_____

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EMERGENCY CONTACT AND

RELEASE OF PROTECTED HEALTH INFORMATION CONSENT

Patient Name: _____ Date of birth: _____

Preferred Phone No.: _____Cell Phone No.: _____

May we leave a message? ☐ Yes ☐ No Select preference for voice message: ☐ Home ☐Cell Phone

Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

BESIDES THE PERSON LISTED AS MY EMERGENCY CONTACT, I AUTHORIZE THE FOLLOWING ADDITIONAL PEOPLE WHO MAY RECEIVE MY PROTECTED HEALTH INFORMATION**. I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY GIVING WRITTEN NOTIFICATION TO THIS OFFICE.**

Name	Relationship	Phone

Patient Signature: _____ **Date:** _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION;

ABOUT YOU MAY BE USED AND DISCLOED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

Protected health information, about you, is obtained as a record of your contacts or visits for healthcare services with Pinnacle Care Internal Medicine. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services. Pinnacle Care Internal Medicine is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law. If you have any questions about this notice, please contact our Privacy Manager at 623-249-2100.

YOUR RIGHTS UNDER THE PRIVACY RULE

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this Notice Privacy Practices- We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at the time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time for your next appointment.

You have the right to authorize other use and disclosure- This means you have the right to authorize or deny any other use or disclosure of protected health information. You may revoke an authorization, at anytime, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative- This means you may designate a person with the delegated authority to consent to , or authorize the use or disclosure of protected health information. You have the right to inspect and copy your protected health information- This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record.

You have the right to request a restriction of your protected health information-This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

You may have the right to have us amend your protected health information- This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request a disclosure accountability-This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our office.

Complaints- You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

How We May Use or Disclose Protected Health Information

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive but do describe the types of uses and disclosures that may be made by our office.

For Treatment- We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results for exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. And, we may contact you to provide information about health-related benefits and services offered by our office.

For Payment- Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations- We may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes Education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identification information

Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To Others Involved in Your Healthcare-Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, **that you identify**, your protected health information that directly relates to that person's involvement in your health care. If you are to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law- We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

For Public Health- We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

For Communicable Diseases- We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight- We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Case of Abuse or Neglect- We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health

information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

To The Food and Drug Administration- We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products: to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.

For Legal Proceedings- We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

To Law Enforcement- we may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

To Coroners, Funeral Directors, and Organ Donation- We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

In Cases of Criminal Activity- consistent with applicable federal and state laws, we may disclose protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

For Military Activity and National Security-When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities: (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or: (3) to foreign military authority if you are a member of that foreign military services.

For Worker's Compensation- Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally-established programs

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This Acknowledgement of Receipt of Notice of Privacy Practices applies to, Pinnacle Care Internal Medicine/Surraj Medical Associates, PLLC.

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my providers participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice of Privacy Practices. You may refuse to sign this acknowledgement, if you wish. Thank you.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE PINNACLE CARE INTERNAL MEDICINE NOTICE OF PRIVACY PRACTICES.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because.

☐ The patient refused to sign.

☐ We wereunable to communicate with the patient.

☐ Other (Please provide specific details) _____

Employee Name (print): _____ Initials: _____

Date: _____

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Internal Medicine

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OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS

Thank you for choosing Pinnacle Care Internal Medicine. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. The team at Pinnacle Care strives to exceed expectations in care and service in order to make your experience with us as comfortable and stress-free as possible. Our goal is to provide quality medical care in a timely manner. In order to do so we have implemented office policies and procedures to allow us to operate in the most efficient and organized way possible. Please feel free to contact our office if you have any questions regarding our policies or procedures.

OFFICE HOURS

Our office can be reached at 623-249-2100, Monday-Friday 8:00am 12:00pm and 1:00pm to 4:00pm, as well as Saturday's from 8:00am to 12:00pm. Our Physicians are available after hours 24 hours per day/365 days per year by calling our phone number and following the prompts for our on-call services. If you need an appointment, prescription refill or test results, please call during regular business hours as these requests will NOT be handled after hours.

WALK IN POLICY

We have a convenient WALK IN urgent care available for our patients. This service is available Monday-Friday 8:00am-3:45pm and Saturday from 8:00am to 11:45pm. Our goal is to provide medical care for urgent acute illnesses or injuries and we will NOT accept walk in patients for medication refills or for medical concerns which can be addressed within a regularly scheduled appointment. Please be advised that walk in patients will be worked in around our regularly scheduled patients thus there may be a longer wait time for walk in patients. All walk in patients are seen by our Physician extenders in respect to our Physician's schedules.

APPOINTMENTS

Pinnacle Care is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance of follow-up due dates. When calling for an appointment, please provide your name, telephone number, chief complaint/reason for visit, as well as any updated contact or insurance information. While we strive to schedule appointments appropriately, emergencies can and do occur in Primary Care thus same day or walk in appointments are available with our Physician Assistant or Nurse Practitioner. To ensure quality care, Pinnacle Care, does not treat patients we have not seen (i.e., we will not call in prescriptions or offer medical advice for patients prior to their initial visit or who are not present in the office for evaluation). Follow up may be required to be scheduled after testing has been completed, so that results may be reviewed together and an effective and appropriate plan for your healthcare can be determined. We encourage you to schedule appointments for preventative health visits, physicals, well women exams, chronic medical conditions, prescription renewals and sick visits.

PHYSICIAN EXTENDERS

We strive to give all of our patients the time that they require and deserve. For this reason, we use our team of licensed and qualified Physician extenders, Physician Assistants & Nurse Practioner's, to provide care to our patients. Each of these extenders works under the direct supervision of our Physicians and consults with our Physicians on every patient case to ensure quality care. The use of extenders allows our Physicians to maintain their patient population while

continuing to give individualized attention to their scheduled appointments. All same day and walk in appointments are scheduled with our Physician extenders to avoid over booking our Physician schedules which ensures that each patient receives the individualized attention they deserve. If you wish to only see a Physician, we ask that you schedule your appointments in advance to guarantee your appointment with a Physician.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of the medical needs of our patients please be courteous and call Pinnacle Care Internal Medicine promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. This is how we can best serve the needs of our patients. If it is necessary to cancel your scheduled appointment we require that you call one (1) working day in advance. Appointments are in high demand, and your early cancellation will give another person the ability to have access to timely medical care. If an appointment is not cancelled within the 1 day period, you will be assessed a $35 fee which will be due prior to rescheduling. This policy and fee are also applicable to same day cancellations.

NO SHOW POLICY

A “no show” is someone who misses an appointment without canceling it within one (1) business day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a “no show”. An administrative fee of $50.00 will be billed to your account. You will be sent a letter alerting you to the fact that you failed to show for a scheduled appointment and did not cancel the appointment within one (1) business day in advance along with the bill for the administrative fee. A copy of the letter will be placed in your medical record. Three (3) “no-shows” within one (1) calendar year will result in a formal discharge from our practice. *Please note that No-Show charges are patient responsibility and will not be billed to your insurance company.*

INSURANCE POLICY

Pinnacle Care accepts most insurance plans. If you have specific questions regarding your insurance, please contact our billing department at 623-249-2100 option 4. It is patient responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment and services will be billed to the patient. Patients are responsible for co-pays at time of service. No exceptions are made in this policy as the waiving of co-pays or adjustments of co-pays are a direct violation of our contractual agreement with your insurance carrier. If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department.

PAYMENTS

Pinnacle Care accepts cash, personal checks, MasterCard, Discover, Visa and American Express. Checks can be made out to Pinnacle Care Internal Medicine. It is the policy of Pinnacle Care Internal Medicine to make all reasonable attempts to collect outstanding balances’ should they accrue, including, convenient payment arrangements. Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection. Furthermore, all balances not paid in full within 30 days of the bill date will be assessed a 1.5% interest fee to cover the costs associated to handling such balances. This interest is also applicable to patient accounts which have been placed on payment plans to cover the costs/resources associated to handling such accounts on a monthly basis.

FORMS/LETTERS POLICY

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Pinnacle Care will be happy to complete forms and write medical letters as necessary upon your request. However, because this can be time consuming, there are fees associated to such requests. Fees for these forms/letters are as follows and are due at the time of request prior to completion of such requests:

- **FMLA/DISABILITY FORMS/PHYSICAL ATTESTATION: $60.00**
- **MENTAL/PHYSICAL CAPACITY ATTESTATIONS/LETTERS: $40.00**
- **LETTERS REQUESTING JURY EXCUSAL/WORK EXCUSAL/FLIGHT EXCUSAL: $20.00**

Due to the time involved in such requests, please allow 7-10 days for completion of all of these forms/letters.
To avoid this fee, an appointment can be scheduled with our Providers to have these documents completed at the time of service and the documents MUST be present, with all patient information portions completed, at the visit to avoid an additional charge.

MEDICAL RECORDS POLICY

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials. All patients can request a copy of their medical records one time, free of charge. Additional copies may be requested at a cost of $0.75 per page or in an electronic format for $15.00. The law allows Medical Offices 30 days to complete requests for records. However, our medical records department puts forth every effort to respond to these requests in a timely manner.

PRESCRIPTION REFILLS & PHARMACY INFORMATION

Please inform Pinnacle Care Internal Medicine of which Pharmacy you use and update us if this should change. Please allow one to two business days for refill requests. We encourage our patients to review their medications prior to their office appointments and to request refills at that time, if needed. Please note that we do not fill Narcotic Medications or order Antibiotics over the phone. Our Practice does NOT order Narcotic Pain Medicine or controlled medications by phone; an appointment MUST be scheduled for these types of medications.

CONTROLLED SUBSTANCE MEDICATION POLICY

In compliance with federal and state guidelines, our practice has changed our policy related to the prescribing of controlled substances. Patients must schedule a separate appointment specific to obtaining refills or for any initial requests for any controlled substance medication. Refills of these medications require an office visit every 30 days to evaluate the necessity and the therapeutic benefits of the medication. Patients will be required to sign our controlled substance agreement as well as complete urine toxicology screenings every 30 days. Same day and walk in appointments cannot be scheduled to request controlled substances. We do not make exceptions to this policy under any circumstance.

CIVILITY POLICY

The team at Pinnacle Care Internal Medicine strive to provide quality, comprehensive and attentive care to every patient we treat. All employees are held to a standard of civility and respect to reflect the organizations reputation of compassion, respect and professionalism. If this is ever violated by any of our staff, please report the incident to Administration immediately as this is policy is strictly enforced amongst our organization. However, this standard is also expected of our patients to allow our team to work in a safe and respectful environment. As such, any abusive or demeaning behavior, which threatens the safety and privacy of our employees, will result in a formal discharge and withdraw from a patient's medical care.

REFERRALS/PRIOR AUTHORIZATIONS POLICY

As Primary Care Providers, our practice is responsible for the submission of referrals to specialists as required by insurance guidelines and as directed by our Providers. Due to insurance guidelines, many of these requests must be submitted via electronic portals for review and approval by the individual carrier. As such, we ask that you allow 5-7 business days for completion of referral submissions/approvals. Our office will contact you once these requests are

completed to advise you of their completion and to provide you with the contact information of the specialist you have been referred to. Similarly, our office is also responsible for submission of prior authorization requests for services which may require authorization or written approval from your carrier for coverage. These requests can be submitted verbally or via electronic portals in adherence with each individual carrier's guidelines. Again, we kindly ask that you allow 5-7 business days for these requests to be submitted/reviewed/approved. Our office will contact you to schedule or to provide you with an update once your insurance carrier has made a decision on the request.

CHRONIC CARE MANAGEMENT

Pinnacle Care Internal Medicine participates in the CMS approved Chronic Care Management program and offers this service to all of our Medicare Part B patients as a beneficial service in managing chronic conditions. The intention of this program is to improve medication compliance, reduce hospital admissions and to create a formal plan of care in partnership with your provider and the Chronic Care team. This program is a monthly call in which our Chronic Care team will review any and all medical concerns with the patient to keep our providers up to date on the patient's condition and monitor a patient's adherence to the plan of care. Per Medicare guidelines, this is a billable service and if a patient is not enrolled in a supplemental plan, there is a cost estimation of $9.00 per month which is billable to the patient.

TRIAGE PROCEDURES

Pinnacle Care Internal Medicine Triage Coordinators act as liaisons between our provider team and our patients to handle patient concerns related including but not limited to medication clarification, care plan coordination, radiology/laboratory orders/results, Patient forms/letters and DME requests. Our Patient Triage Coordination team is not qualified to diagnose or provide treatment by phone. Each patient concern will be assessed, and a recommendation will be given under the office policies and providers guidance. All calls/messages are returned the same day while all requests are completed within a 48 hour period to give our Triage team the necessary time to consult with the provider team, compile documentation and coordinate completion of each request.

Ashish Sachdeva, MD, Namita Sachdeva, MD
Dien Do, ACNP, Dominque Brown, PA-C
9401 W Thunderbird Rd., Ste 155
Peoria, AZ 85381
O: 623-249-2100 F: 623-476-7305

ACKNOWLEDGEMENT OF OFFICE POLICIES AND PROCEDURES

By signing below, I acknowledge that I have received a copy of Pinnacle Care Internal Medicines policies and procedures, and that I will read and follow these policies.

My signature also indicates that I am aware that if, at any time, I have questions regarding the policies and procedures of Pinnacle Care Internal Medicine, I have the right to direct my questions to the Administration of the practice.

I also understand that by signing below, I am acknowledging my receipt of these policies and procedures and I am agreeing to abide by these policies and procedures as a patient of Pinnacle Care Internal Medicine.

I am also aware that Pinnacle Care Internal Medicine, at any time, may on reasonable notice; make changes to the practice policies and procedures and this is acknowledged by my signature below.

_____ _____

Patient Printed Name Date

_____ _____

Patient Signature Date

PINNACLE CARE
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NEW PATIENT INTAKE FORM

NAME: _____ DATE OF BIRTH: _____

FAMILY HISTORY

FATHER IS: ❑ LIVING ❑DECEASED CAUSE OF DEATH: _____AGE OF DEATH: _____

Health problems: ❑ DIABETES ❑ HYPERTENSION ❑ HEART DISEASE ❑STROKE ❑MENTAL
❑CANCER ❑OTHER: _____

MOTHER IS: ❑ LIVING ❑DECEASED CAUSE OF DEATH: _____AGE OF DEATH: _____

Health problems: ❑ DIABETES ❑ HYPERTENSION ❑ HEART DISEASE ❑STROKE ❑MENTAL
❑CANCER ❑OTHER: _____

Any history of other health problems in SIBILINGS and/or BLOOD RELATIVES:
_____

HISTORY OF EXPOSURES

HAVE YOU EVER SMOKED CIGARETTES? ❑ YES ❑ NO HOW LONG? _____ HOW MUCH A DAY? _____
IF YOU QUIT, HOW LONG AGO WAS THAT? _____

HOW MUCH ALCOHOL PER DAY DO YOU USE? _____ WHAT KIND OF ALCOHOL? _____
IF YOU QUIT, HOW LONG AGO WAS THAT? _____ HOW LONG DID YOU DRINK? _____

HAVE YOU EVER USED ANY RECREATIONAL DRUGS? ❑ YES ❑NO WHICH ONE(S)? _____

DO YOU WORK? ❑ YES ❑NO WHAT WAS/IS YOUR OCCUPATION? _____

ANY EXPOSURES AT WORK? ❑ YES ❑ NO IF SO, WHAT TYPE OF EXPOSURE? _____

ADVANCED DIRECTIVES

MEDICAL POWER OF ATTORNEY (IF APPLICABLE): _____
RELATIONSHIP: _____
IS THERE DOCUMENTATION DESIGNATING THE MEDICAL POA? ❑ YES ❑ NO WHERE? _____
DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)? ❑ YES ❑ NO CODE STATUS: ❑ FULL CODE ❑DNR

SPIRITUAL HISTORY

DO YOU HAVE A RELIGIOUS OR SPIRITUAL PRACTICE? ❑ YES ❑ NO PLEASE DESCRIBE: _____
IF YES, DO YOU HAVE A RELIGIOUS PREFERENCE? _____
HOW DOES YOUR RELGIOUS/SPIRITUAL PRACTICE RELATE TO YOUR HEALTH? _____
IS THRE ANY OTHER COMMUNIY OR AFFLATION THAT PROVIDES SUPPORT FOR YOU? _____

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CHIEF COMPLAINT (S)

_____
_____
_____
_____

MEDICATIONS
*(PLEASE INCLUDE ALL DAILY MEDICATIONS AND THEIR DOSES, INCLUDING SUPPLEMENTS **OR** ATTACH LIST)*

	NAME OF DRUG	**DOSE**	**FREQUENCY**	**INDICATION**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

HAVE YOU EVER BEEN ADMITTED TO THE HOSPTIAL WITHIN THE LAST 6 MONTHS? ❑ YES ❑ NO

IF SO, WHAT HOSPTIAL? _____

DATE OF ADMISSION? _____

WHAT WERE YOU TREATED FOR? _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑ YES ❑ NO

IF YES, PLEASE SPECIFY:

	MEDICATION	**ALLERGIC REACTION**
1.		
2.		
3.		
4.		
5.		

NON-MEDICAL ALLERGIES:

_____
_____

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MEDICAL HISTORY

- ❑ ACID REFLUX
- ❑ ALCOHOLISM
- ❑ ALLERGIES
- ❑ ALS
- ❑ ALZHEIMER'S DISEASE
- ❑ ANEMIA
- ❑ ANXIETY DISORDER
- ❑ ARRHYTHMIA
- ❑ ASBESTOS EXPOSURE
- ❑ ASTHMA
- ❑ ATERIAL FIBRILLATION
- ❑ BIPOLAR DISORER
- ❑ BLOOD DISORDER
- ❑ BRONCHIETASIS
- ❑ CANCER: _____ _____
- ❑ CANDIDIASIS
- ❑ CATARACTS
- ❑ CELIAC DISEASE
- ❑ CLAUDICATION
- ❑ CIRRHOSIS
- ❑ CHRONIC BRONCHITIS
- ❑ CHRONIC PAIN SYNDROME
- ❑ CROHN'S DISEASE
- ❑ CONGESTIVE HEART FAILURE
- ❑ COPD
- ❑ CORNOARY ARTERY DISEASE
- ❑ DVT
- ❑ DEMENTIA_____
- ❑ DEPRESSIVE DISORDER
- ❑ DIABETES: (circle one) TYPE I / TYPE II
- ❑ DIALYSIS
- ❑ DIVERTICULAR DISEASE
- ❑ EATING DISORDER
- ❑ EMPHYSEMN
- ❑ ERECTILE DYSFUNCTION
- ❑ FIBROMYALGIA
- ❑ GLAUCOMA
- ❑ GOUT
- ❑ HEART ATTACK/MI
- ❑ HEPATITIS A/B/C
- ❑ HIGH BLOOD PRESSURE
- ❑ HIGH CHOLESTEROL
- ❑ HIV/AIDS
- ❑ INSOMNIA
- ❑ IRRITABLE BOWEL SYNDROME
- ❑ LIVER DISEASE
- ❑ LUPUS
- ❑ MENINGITIS
- ❑ MIGRAINE
- ❑ MITRAL VALVE PROLAPSE
- ❑ MURMURS
- ❑ NARCOLEPSY
- ❑ OPEN HEART SURGERY
- ❑ OSTEOARTHRITIS
- ❑ OSTEOPOROSIS
- ❑ PACEMAKER
- ❑ PARKINSON'S DISEASE
- ❑ POPTIC ULCERS
- ❑ PERIPHERAL VASCULAR DISEASE
- ❑ PNEUMONIA
- ❑ POLYCYSTIC OVARIAN SYNDROME
- ❑ POSITIVE TB SKIN TEST
- ❑ PTSD
- ❑ PULMONARY EMBOLISM
- ❑ PULMONARY HYPERTENSION
- ❑ RENAL FAILURE
- ❑ RESTLESS LEG SYNDROME
- ❑ RHEUMATOID ARTHRITIS
- ❑ SARCOLDOSIS
- ❑ SCHIZOPHRENIA
- ❑ SELERODERMA
- ❑ SEIZURE DISORDER
- ❑ SINUS PROBLEMS
- ❑ SKIN DISORDERS
- ❑ SLEEP APNEA
- ❑ STROKE OR TIA
- ❑ THYROID PROBLEMS
- ❑ TUBERCULOSIS
- ❑ ULCERATIVE COLLITIS
- ❑ UTI
- ❑ VALLEY FEVER

❑ OTHER CONDITIONS (OR COMMENTS ON ABOVE CONDITIONS):

_____

_____

_____

HAVE YOU EVER BEEN PREGNANT? ❑ YES ❑ NO HOW MANY TIMES? _____ HOW MANY LIVE BIRTHS? _____
HOW MANY PRETERM BIRTHS? _____

PAST SURGICAL HISTORY: Please list any surgeries you have had with approximate date(s) below:

_____

_____

_____

_____

_____

GENERAL / CONSTITUTIONAL	YES	NO
INSOMNIA/TROUBLE SLEEPING	❑	❑
CHANGE IN APPETITE	❑	❑
HEADACHES	❑	❑
WEIGHT GAIN/LOSS	❑	❑

EYES

BLURRY VISION	❑	❑
EYE PAIN	❑	❑

ARE YOU DIABETIC?

- DATE OF LAST EYE EXAM?

_____

- WHERE?

_____

ENT		
DECEASED HEARING	❑	❑
RINGING IN EARS	❑	❑
FREQUENT INFECTIONS	❑	❑
PAIN	❑	❑
FREQUENT CANKER SORES	❑	❑
SNORING	❑	❑
MOUTH BREATHING AT NIGHT	❑	❑
MASSES OR SWOLLEN GLANDS	❑	❑

ENDOCRINE/HORMONES		
ACNE	❑	❑
EXCESSIVE THRIST	❑	❑
EXCESSIVE HUNGER	❑	❑
COLD OR HEAT INTOLERANCE	❑	❑

RESPIRATORY/LUNGS		
ASTHMA	❑	❑
COUGH	❑	❑
BREATHING PROBLEMS	❑	❑

BREAST		
NIPPLE DISCHARGE	❑	❑
BREAST BIOPSIES	❑	❑
BREAST LUMPS	❑	❑
HISTORY OF BREAST CANCER?	❑	❑
DO YOU HAVE RELATIVES W/BREAST CANCER?	❑	❑

WHEN WAS YOUR LAST MAMMOGRAM?

_____

WHERE? _____

GASTROINTESTIONAL		
ABDOMINAL PAIN	❑	❑
BLOOD IN STOOL	❑	❑
CONSTIPATION	❑	❑
DIARRHEA	❑	❑
NAUSEA/VOMITTING	❑	❑
STOMACH PROBLEMS	❑	❑

HEMATOLOGY/BLOOD	YES	NO
ANEMIA	❑	❑
EASY BRUISING	❑	❑
RECENT TRANSFUSION	❑	❑

WOMEN ONLY		
BREAST LUMP	❑	❑
IRREGULAR MENSES	❑	❑
PAINFUL INTERCOURSE	❑	❑
VAGINAL DISCHARGE	❑	❑

MEN ONLY		
DIFFICULTY INITIATING STREAM	❑	❑
DRIBBLING AFTER URINATION	❑	❑
HARD TESTICLE	❑	❑
HERNIA	❑	❑

GENITOURINARY		
BLOOD IN URINE	❑	❑
DIFFICULTY URINATING	❑	❑
FREQUENT URINATION	❑	❑

MUSCOSKELETAL		
ARTHRITIS	❑	❑
BACK PROBLEMS	❑	❑
CARPARL TUNNEL	❑	❑
HISTORY OF GOUT	❑	❑
SCIATICA	❑	❑
PAINFUL JOINTS	❑	❑
TRAUMA TO LIMBS?	❑	❑

WHICH? _____

PERIPHREAL VASCULAR		
COLD EXTREMITIES	❑	❑
DECREASED SENSATIONS	❑	❑
PAIN OR CRAMPING OF LEGS	❑	❑
ULCERATION OF THE FEET	❑	❑

SKIN		
APPLIES SUNSCREEN DAILY	❑	❑
DISCOLORATION	❑	❑
ECZEMA	❑	❑
HAIR CHANGES	❑	❑
MOLES	❑	❑
SKIN CANCER	❑	❑

NEUROLOGIC		
BALANCE DIFFICULTY	❑	❑
GAIT ABNORMALITY	❑	❑
MEMORY LOSS	❑	❑
STROKE	❑	❑
SEIZURES	❑	❑

PSYCHIATRIC		
ANXIETY	❑	❑
HALLUCINATIONS	❑	❑
DEPRESSED MOOD	❑	❑
SUBSTANCE ABUSE	❑	❑
SUICIDAL THOUGHTS	❑	❑

PINNACLE CARE
Internal Medicine

Sick Today, Seen Today.

ALLERGY INTAKE FORM

DATE___/____/____

NAME_____**PHONE NUMBER**_____**DOB**____/___/_____

1) **DO YOU SUFFER FROM ALLERGIES?** YES NO
   If yes, which seasons: SPRING SUMMER WINTER FALL

2) **WHAT ARE SOME OF THE SYMPTOMS DO YOU TYPICALLY HAVE?**
   Sneezing Itchy and / or watery eyes soar/ scratchy throat hives
   Fatigue/ Runny/ Stuffy Nose/Congestion Headaches

3) **WHEN DO YOUR SYMPOTMSOCCUR THE MOST?** Morning Afternoon Night All Day

4) **HOW LONG HAVE YOU HAD THESE SYMPTOMS**? _____

5) **DO YOU SUFFER FROM CHRONIC SINUS INFECTIONS AND / OR COLDS?**YES NO

6) **HAVE YOU BEEN DIAGNOSED WITH ASTHMA?** YES NO **IS IT CONTROLLED**? YES NO

7) **DO YOU TAKE ANY ANTIHISTAMINE MEDICATION?** YES NO
   If yes, please list them and last date taken.

8) **ARE YOU PREGNANT?** YES NO

9) **DO YOU TAKE BETA BLOCKER MEDICATIONS**? YES NO
   If yes, please list. _____

10) **HAVE YOU EVER BEEN ALLERGY TESTED?**YES NO
    IF yes, when? _____ **HAVE YOU EVER DONE IMMUNOTHERAPY?** YES NO

11) **HAVE YOU EVER HAD A LIFE-THREATENING ALLERGIC REACTION**? YES NO
    If yes, when and to what: _____

12) **DO YOU WANT TO GET ALLERGY TESTED?** YES NO

PATIENT SIGNATURE_____ **DATE**____/____/_____