AZ INTERNAL MEDICINE
Dr. Nandini Raman Dr. Anupa Ashar
Board Certified in Internal Medicine

NEW PATIENT INFORMATION

PLEASE PRINT

Rendering Provider (PCP): ☐ Dr. Raman ☐ Dr. Ashar **Today's Date: ________________**

Patient Information:

LAST NAME ______________________________ FIRST NAME __________________________ MI ______

Date of Birth __ __/__ __/__ __ __ __ (mm/dd/yyyy) Social Security No. _______________ Sex: ☐ Male ☐ Female

Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed
☐ Legally Separated ☐ Partner ☐ Unknown

Address ____

City ______________________________ State _______________ Zip __________

Home Phone No. _______________________ Cell Phone No. ____________________

Work Phone No. _______________________ Ext. _________

Billing Address (if different from mailing):

Address ____

City _____________________________ State _______________ Zip _____________

☐ **OK to leave message at home** ☐ **OK to leave message on cell phone**

Previous PCP: ______________________________ Tel. #: _________________ Fax #: _______________

E-mail ____________________ Language ___________________ Race (optional) ________________

Responsible Party Information: (statements will be addressed to the responsible party)

Name ____

Address ____

City, State, Zip ____

Home Phone No. ___________________________ Work Phone No. __________________

Date of Birth: _ _/_ _/_ _ _ _ Social Security No.: _________________________

Sex: ☐ Male ☐ Female ☐ OK to leave message

Advance Directive (Living Will):

☐ HAS – has one will bring it at next office visit
☐ INP – in the process of making one
☐ WM – will make one

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Insurance Information: (Primary Insurance)

Insurance Name: ____

Address: ____

Phone No.: ______________________

Subscriber's Name: ____

Subscriber ID No.: ______________________ Group No.: ______________________

Patient relationship to Subscriber (check one): ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Subscriber's Date of Birth : _ _ / _ _ / _ _ _ _ Co-Payment Amount: ______________________

Insurance Information: (Secondary Insurance)

Insurance Name: ____

Address: ____

Phone No.: ______________________

Subscriber's Name : ____

Subscriber ID No.: ______________________ Group No. ______________________

Patient relationship to Subscriber (check one): ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Subscriber's Date of Birth: _ _ / _ _ / _ _ _ _ Co-Payment Amount : ______________________

Responsible Party's Employer Information:

Company: ____

Address ______________________ City ______________________

State ____________ Zip ________ Phone No. ______________________

Emergency Contact #1

Name: ______________________
Phone: ______________________
Address: ______________________
____
Relationship: ______________________

Emergency Contact #2

Name: ______________________
Phone: ______________________
Address: ______________________
____
Relationship: ______________________

Pharmacies: (Retail)

Name: ______________________
Cross Streets: ______________________
Phone No.: ______________________
Fax No.: ______________________
Plan Type: ______________________

(Mail Order)

Name: ______________________
Address: ______________________
Phone No.: ______________________
Fax No.: ______________________
Plan Type: ______________________

A Z INTERNAL MEDICINE

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HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I) ☐ Male ☐ Female DOB:

Date of last physical : **Date:**

Your Medical History

☐ Hay fever (allergies)
☐ Hearing loss
☐ Cataracts
☐ Other eye diseases ____________________

LUNGS

☐ Asthma
☐ COPD
☐ Lung nodule
☐ Other lung diseases ____________________

HEART

☐ HTN (high BP pressure)
☐ Heart attack (MI)
☐ Heart Failure
☐ Heart arrythmias
☐ Atrial Fibrillation
☐ High cholesterol or triglycerides
☐ Other heart disease ____________________

GASTRIC

☐ Acid Reflux
☐ Crohn's disease
☐ Ulcerative Colitis
☐ IBS
☐ Hepatitis

BONE/MUSCULAR

☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Fibromyalgia
☐ Lupus
☐ Osteoporosis
☐ Osteopenia
☐ Other rheumatoid disorders _______________

ENDOCRINE

☐ Diabetes
☐ PreDiabetes
☐ Menopause
☐ Polycystic Ovarian Disorder
☐ Hypothyroidsm(low thyroid)
☐ Other Endocrine disorders _________________

KIDNEYS

☐ Kidney diease
☐ Kidney stones
☐ Enlarged Prostate
☐ Frequent Urinary infections
☐ Other Kidney diseases ____________________

NEUROLOGICAL

☐ Stroke/TIA (ministroke)
☐ Migraine Headaches
☐ Other headaches
☐ Seizures
☐ Dementia
☐ Parkinson's
☐ Other Neurological issues _________________

SKIN

☐ Skin cancer
☐ Eczema
☐ Other skin issues

BLOOD

☐ Anemia
☐ Leukemia
☐ Lymphoma
☐ Blood clot
☐ Other blood disorders ____________________

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I)

ANY CANCER

____

____

PSYCHIATRIC

- ☐ Depression
- ☐ Anxiety
- ☐ ADD
- ☐ Bipolar
- ☐ Eating disorders
- ☐ Other Psych issues

____

____

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I)

Immunizations

Immunization	Date	Immunization	Date
☐ Influenza		☐ Pneumovax	
☐ Shingles (zotavax)		☐ Gardisil	
☐ Hepatitis B		☐ Tetanus	
☐ Hepatitis A		☐ dTap	
☐ MMR		☐ Any other Vaccines	

Screening Male and Female	Date		
☐ Stool Cards		☐ Normal	☐ Abnormal
☐ Colonoscopy		☐ Normal	☐ Abnormal
☐ Bone Density		☐ Normal	☐ Abnormal
Which imaging center: ________________________________			

Screening Male	Date		
☐ PSA		☐ Normal	☐ Abnormal
☐ Testicular Exam		☐ Normal	☐ Abnormal

Screening Female	Date		
☐ Pap Smear		☐ Normal	☐ Abnormal
☐ Mammogram		☐ Normal	☐ Abnormal
Which imaging center: ________________________________			

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I)

List all your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of the Drug	Strength	Frequency Taken

Allergies to medications

Name of the Drug	Reaction you had

Allergies to all other agents including food

Name of agent or food	Reaction you had

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HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I)

Health Habits and Personal Safety

Exercise
- ☐ Sedentary (No Exercise)
- ☐ Mild exercise (climbing stairs, walk, golf)
- ☐ Occasional vigorous (i.e. work or recreation, less than 4x/week for 30 mins.)
- ☐ Regular vigorous (i.e. work or recreation, 4x/week for 30 mins)

Diet

Are you dieting? ☐ Yes ☐ No

If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No

Number of meals you eat in an average day? _____________

Rank salt intake ☐ High ☐ Medium ☐ Low

Rank fat intake ☐ High ☐ Medium ☐ Low

Caffeine ☐ None ☐ Coffee ☐ Cola ☐ Tea

Number of cups/cans per day? ___________

Alcohol

Do you drink alcohol? ☐ Yes ☐ No

If yes, what kind? ___________________________________

How many drinks per week? __________

Are you concerned about the amount you drink? ☐ Yes ☐ No

Have you considered stopping? ☐ Yes ☐ No

Have you ever experienced black outs? ☐ Yes ☐ No

Are you prone to "binge" drinking? ☐ Yes ☐ No

Do you drive after drinking? ☐ Yes ☐ No

Tobacco

Do you use tobacco? ☐ Yes ☐ No

☐ Cigarettes-pks/day ☐ Chew #/day __________

☐ Pipe #/day ☐ Cigars #/day __________

☐ Number of years __________ ☐ Or year you quit ____________

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I)

Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used: ____		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Would you like to speak with your provider about your risks of HIV/AIDS	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an advanced directive or living will?	☐ Yes	☐ No
	Would you like information for the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

Family Health History

	Age	Significant Health Problems		Age	Significant Health Problems
Father			**Children**		
			☐ Male ☐ Female		
Mother			☐ Male ☐ Female		
Siblings					
☐ Male ☐ Female			☐ Male ☐ Female		
☐ Male ☐ Female			☐ Male ☐ Female		
☐ Male ☐ Female			**Maternal**		
			Grandmother		
			Grandfather		
☐ Male ☐ Female			**Paternal**		
☐ Male ☐ Female			Grandmother		
			Grandfather		

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I)

Mental Health

Question	Yes	No
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

PATIENT CONSENT FORM

I consent to the use or disclosure of my protected health information by AZ Internal Medicine, PLLC for the purpose of my diagnosis, treatment, payment, or to conduct health care operations.

I understand the following:

- Diagnosis or treatment of me by Dr. Nandini Raman, M.D. / Dr. Anupa Ashar, M.D., may be conditioned upon my consent as evidenced by my signature on this consent.
- I have the right to request a restriction on the uses of my protected health information; the physician's practice may not agree with the restrictions. However, if they do agree, the restriction is binding.
- I have the right to revoke this Consent, in writing, at any time; all future disclosures will subsequently cease. Any disclosures previously made from my prior consent, will not be affected by this revocation.
- Prior to signing this consent, I have the right to review AZ Internal Medicine, PLLC Notice of Privacy Practices & Financial Policy, which have been provided to me.

My "protected health information" means health information, including my demographics information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

AZ Internal Medicine, PLLC has a Notice of Privacy Practices. The Notice of Privacy Practices describes how we may use and disclose protected health information about you. The Notice of Privacy Practices also describes patient rights under the law.

At any time, AZ Internal Medicine, PLLC may change the privacy practices as described in the Notice of Privacy Practices. I may contact the office to receive a revised copy.

This document is provided in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a courtesy to our patients, we will file up to 2 insurance companies. Because we are Medicare Providers, we must first file to the insurance companies of all Medicare patients.

Medical Information Release-Direct Physician Payment Release

By Signing below, I authorize the release of all medical information necessary for filing my insurance claims. I also authorize my insurance company to make direct payment to my physician. A copy of this release may be used in place of the original. I understand that I am responsible for any balance due on my account after my insurance carriers(s) have paid, including my yearly deductibles, co-payments and coinsurance. I also understand that any overpayment will be refunded if authorized by my insurance company.

FINANCIAL POLICY

It is your responsibility to be aware of your benefits. If you are unsure of your insurance benefits, you will need to contact your insurance carrier for clarification of your benefits.

This office will not change or re-code claims once they have been billed. This constitutes fraud and will not be done.

This office bills only for services performed by our providers. The laboratory and radiology will bill you or your insurance company for all labs and imaging studies performed. If you have any questions regarding your lab or radiology bill please contact the laboratory/radiology directly or your insurance carrier.

All insurance information, including prior authorizations, referrals, and claim forms when necessary, must be provided at the time of service.

All co-pays, deductibles, and payments are due at the time of service, with co-pays being collected prior to you seeing the doctors. We accept cash, Visa, MasterCard, American Express and most debit cards displaying the Visa or MasterCard logo as forms of payments.

Any account left unpaid after 90 days will be turned over to an outside collection agency. Any collection fees necessary to collect this debt will be added to the outstanding balance. Please keep in mind that should your account go to our collection agency, any arrangements/payments will need to be made directly with/to the collection agency. In addition, once an account has been turned over to the collection agency, the patient may receive a letter of discharge from our practice.

We understand that situations arise that you must cancel your appointment. We do request a 24 hour notice of such cancellations. A fee of $25.00 will be charged to your account for three consecutive no shows.

Although we require you to fill out "update" on your first appointment of each New Year, it is your responsibility to notify our office immediately of any change of name, address, phone number, or insurance coverage.

I have read the above Financial Policy, and understand and agree to these terms.

Patient/Guardian Signature _______________________________ Date ______________________

Relationship to Patient ___________________________________

AZ INTERNAL MEDICINE, PLLC

3920 S. Alma School Rd., Ste. 8, Chandler, AZ 85248

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: ____

DATE OF BIRTH: ____/____/________ **SOCIAL SECURITY NO:** ___________________________

ADDRESS ____

CITY, STATE, ZIP ____

PHONE (HOME) _____________________________ **(WORK)** ______________________________

I hereby authorize ____

Tel. No.______________________ Fax No. __________________

to send/release photocopies of my medical records to:

AZ INTERNAL MEDICINE, PLLC
DR. NANDINI RAMAN / DR. ANUPA ASHAR
3920 S. ALMA SCHOOL RD., STE. 8
CHANDLER, AZ 85248
Phone: (480) 855-8700
Fax : (480) 855–8701

NOTE: WE PREFER THAT MEDICAL RECORDS BE ON A CD (except for hospitals).

For the purpose of: ____

I authorize the release of photocopies of the following records in the possession or control of ____, its employees and/or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" AND "X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S SECTION 36-611), CONFIDENTIAL ALCHOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2 ET SEQ.) AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

REQUESTED DATE(S): From _____________________ To _______________________

___ Complete Medical Records
___ Hospital Records
___ Consultation Reports
___ Laboratory Reports
___ Imaging Studies
___ Other ______________________________________

This consent will expire one (1) year after the signed date below. I have given my consent freely and voluntarily. I may revoke this authorization at any time provided I notify my PCP in writing to that effect. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

______________________________ ______________________

Patient Signature **Date**

______________________________ ______________________

Parent/Legally Authorized Representative **Relationship to Patient**