# RAJIV PARIKH, M.D. Board Certified Family Physician 1964 E. Baseline Rd., Suite 103 Tempe, AZ 85283 Telephone: (480) 897-1725

Fax: (480) 897-1737

## PATIENT HISTORY QUESTIONNAIRE

Name			Age	Birthdate_		Today's Date	
Address				Ph	ıone		
Email			Ethnic	Background		Religion	
Occupation					Occupation		
List other doctors treating y					-		
Is it OKAY to leave message			achine?	Who re	ferred you to thi	s office?	
List all medicines that you a					-		
<u>Medicine</u>	•	<u>Dose</u>	, 0	<u>Frequency</u>		For what illness?	
Are you allergic to any medic	ines or foods?	☐ Yes ☐ No	o If so, list: _				
List all past operations and so Operation or Illness			Month a	and Year	City, State	<u>Outcome</u>	
Have you ever been advised  Do you have a Living Will(Adv  Do you smoke cigarettes?	anced Medical	Directive)? □ How much?_	Yes □ No 1	f no, would you lik	ke information reg When d	garding living Wills? 🗆 Yes	
Do you drink alcohol?	JVos □ No	How much?	ioi o stoppini	Б:	When did you		
Do you utilik alcollor:	1103 1110	How much h	efore stonni	 nσ?	vviicii did yo		
Have you ever used any stree	t drugs or illici						
How physically active are you							
FAMILY HISTORY:							
	State of	f Health		Age at Death		Cause of Death	
Father:							
Mother:							
Brother/Sister(circle one)							
Brother/Sister(circle one)							
Brother/Sister <sub>(circle one)</sub> Has any blood relative ever h					Dolotius		
mas any biood relative ever in	ad: Cancer Tubercul	Incie		□ Yes □ No □ Yes □ No	Relative:		
	Diabetes			□ Yes □ No	Relative:		
	Heart Tr			□ Yes □ No	Relative:		
		od Pressure		□ Yes □ No	Relative:		
	Stroke			□ Yes □ No	Kelative:		
	Epilepsy			□ Yes □ No	KGISTING:		

HAVE YOU EVER HAD:		Blood Clots	□No □Yes
Heart attack	□No □Yes	Gonorrhea or syphilis	□No □Yes
Heart murmur	□No □Yes	Nephritis	
Leaky Heart	□No □Yes	Jaundice- Hepatitis	□No □Yes
Enlarged Heart	□No □Yes	Gallbladder disease	□No □Yes
High Blood Pressure	□No □Yes	Anemia	□No □Yes
Rheumatic fever	□No □Yes	Childhood diseases	
Tuberculosis	□No □Yes	Scarlet fever	□No □Yes
Valley Fever	□No □Yes	Blood Transfusion	□No □Yes
Diabetes		Stroke	□No □Yes
Asthma		Any others not listed?	
Cancer			
DO YOU HAVE OR HAVE YOU HAD WITHIN THE PAST	TW0(2)	Swelling of any joints	⊓No ⊓Vos
YEARS:	1110(2)	Had X-ray(s) of stomach or colon in the last 10 year	
Chest pain		Had X-ray(s) of gallbladder in the last 10 years	
Pain in arms or throat		Discoloration of fingers when exposed to cold	
Wake up due to chest pain		Discoloration of milders when exposed to cold	
		FOR WOMEN ONLY:	
How many pillows do you sleep on? #Palpitations or very rapid heart rate	□No □Vos	Data of look Dam	
Skipped heart beats		Age at onset of menstruation:	
High blood pressure		Onest data of last pariod	
Leg cramps when walking		Onset date of last period:Number of days between periods:	
Leg cramps when lying down		Number of days of flow:Heavy?	)
Varicose veins		Method of birth control	
Swelling of ankles		Age at appat of intercourse	
Heartburn		Age at manageure	
Recurrent nosebleeds		Age at menopause	
		Abnormal Paps?	
Fainting spells		PREGNANCIES	
Light-headedness on standing up Double vision			
		Total number of pregnancies	
Severe headaches		Number of live births	
Coughed up phlegm		Number of prematuresStillbi	
Coughed up bloodPersistent hoarseness			
Recurrent skin rashes		Number of living children	
Numbness or tingling of hands or feet,		Any complications?	
Changes in hair texture		CHECK ANY OF THE FOLLOWING YOU HAVE HAD:	
Changes in weight			dono
Nausea or vomiting	□NU □ YES	Breast Biopsy	done
Vomited blood or "coffee-ground material"			done
Black bowel movements		Mammogram □No □YesYear	done
Blood in bowel movements		Breast Surgery □No □YesYear	done
Abdominal cramping			done
Colitis		,	done
Pain on urinating		Has a <u>blood relative</u> had breast cancer?□No □Yes	
How often do you get up at night to urinate?# of times_		Relationship:	
Difficulty in starting urination	□NO □YES	Date of last mammogram:	
Blood in urine		Do you perform breast self-exam? □No □Yes	
Lose urine on coughing or sneezing Discharge from penis	DNO 🗆 Yes	Other important information:	

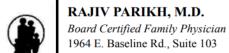


#### RAJIV PARIKH, M.D.

Board Certified Family Physician 1964 E. Baseline Rd., Suite 103 Tempe, AZ 85283

Telephone: (480) 897-1725 Fax: (480) 897-1737

	Patient Information
NAME	
ADDRESS	
CITYSTATEZIF	Smoker? If yes, how many per day?
HOME PHONE	DRIVERS LICENSE #State
SOCIAL SECURITY #	PERMANENT ADDRESS
EMPLOYER	
ADDRESS	HOME PHONE #
CITY/ST/ZIP	
PHONE #	EMAIL
	Miscellaneous
Drug allergies?	
Effect (Nausea, rash, etc.)	
In case of emergency, notify	Relation to Patient
Home phone	Work Phone
	Primary Insurance
INSURANCE CO	POLICYHOLDER'S NAME
ADDRESS:	POLICYHOLDER SSNDOB
CITY/ST/ZIP	
PHONE #	GROUP #
Effective Datesthrough	
PLAN NAMECOPAY \$	
	Secondary Insurance
INSURANCE CO	
ADDRESS:	
CITY/ST/ZIP	
PHONE #	GROUP #
Effective Datesthrough	
PLAN NAMECOPAY \$	
The patient acknowledges that all of the above inform the patient is liable for all services rendered and that I reasonable attorney's fee collection should be necessar necessary. I herby authorize and request that payment me. I also authorize the release of any information recand/or AIDS.  I hereby consent to the administration of all diagnosti	Assignment and Release nation is true and correct and that it has been furnished to this office with full knowledge the he/she is contractually bound to pay for said services, including all costs of collection and a lary. Patient hereby waives his/her confidentiality rights should collection action become to under my insurance plan be made directly to Rajiv Parik, MD for any services furnished equired to process insurance claims including any information relating to alcohol, drug abuse the procedures and/or treatments which in the judgement of my physician may be considered nation prior to any testing, procedure, or referral and that I have the option to decline such
(If patient is a minor- signature of parent/s	



Tempe, AZ 85283 Telephone: (480) 897-1725 Fax: (480) 897-1737

Patient Name:	Date:
Patient's Date of Birth	<u> </u>
Authorization, Assignment of Benefits & Re	elease
furnished to this office with full knowledge that the contractually bound to pay for said services, includ collection become necessary. Patient hereby waives necessary. I hereby authorize and request that paym M.D. for any services furnished to me. I hereby consent to the administration and performating pudgement of Dr.Parikh may be considered necessatesting, procedure, or referral and that I have the operations are the constant of the procedure.	patient registration form is true and correct and that it has been expatient is liable for all said services rendered and that he/she is ling all costs of collection and a reasonable attorney's fee should as his/her confidentiality rights should collection action become ments under my insurance plans be made directly to Rajiv Parikh, ance of all diagnostic procedures and/or treatments which in the ary and advisable. I am entitled to a full explanation prior to any otion to decline such treatment or seek further information. Aired to process insurance claims including any information will the control of the control
Financial Arrangements	
the plans with which we participate, payment is exp	vide range of insurance plans. If you are not covered under one of pected at the time of service. Please check the option which you cial arrangements or need special arrangements, please ask for
☐ Bill my insurance (A copy of you ☐ Cash	ir insurance card is required)
Personal check w/valid driver's l	
☐ Credit Card ☐ Visa ☐ Mast Card #	erCard Expiration Date
Acknowledgement of Receipt of Privacy No	tice
	M.D.'s "Notice of Privacy Policies", detailing how my d under federal and state law. I understand the contents of the acerning my personal medical information:
This authorization may be revoked in writing by m	e at any time.
Signed:D	Date:

\_ Date:\_

(if patient is a minor- signature of parent/guardian)



## **NOTICE OF NO SHOW FEE**

Please be advised that our office requires 24 hours notice to cancel or reschedule your appointment. Missing an appointment hinders our ability to care for you as well as others, because we lose a time slot that could have been used to help another patient. For this reason, you will be responsible for a \$45.00 no show fee each time you do not show for your scheduled appointment.

If a patient fails to show up for more than three appointments within 6 month without giving proper notice, he/she may be dismissed from the practice for failure to follow physician's recommendations. We very much want to serve you, so we urge you to make every effort to keep all of your appointments.

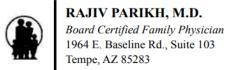
understand that if i do not show		
for my scheduled appointment, cancel or r hours before that scheduled time, I will be		
Print Name	Date	
Signature	_	



Telephone: (480) 897-1725 Fax: (480) 897-1737

### CONSENT TO DISCLOSE MEDICAL INFORMATION

[ <u>,</u>	give
(1	Name of Patient)
Permis	sion to Rajiv Parikh, M.D. to disclose medical information
to	
	(name of Authorized party)
I agree	that the above named person can also:
	_ receive results
(Initials)	
	_ make/ change appointments
(Initials)	nielz un deauments
(Initials)	_ pick up documents
I under	stand that a record of this consent will be kept in my file and can
	acted with written consent stating otherwise.
Signatu	re of Patient
Date	



Telephone: (480) 897-1725 Fax: (480) 897-1737

"I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider."

Patient Name:	Today's Date
Patient Signature	