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_____Phone_____
Email_____Ethnic Background_____Religion_____
Occupation_____Previous Occupation_____
List other doctors treating you_____
Is it OKAY to leave messages on your home answering machine?_____Who referred you to this office?_____
List all medicines that you are currently taking: (Use another page if necessary)

Medicine	Dose	Frequency	For what illness?

Are you allergic to any medicines or foods? ☐ Yes ☐ No If so, list: _____
_____
List all past operations and serious illnesses:

Operation or Illness or Hospitalization	Month and Year	City, State	Outcome

Have you ever been advised to have any surgical operation which has not been done? ☐ Yes ☐ No If yes, explain:
_____
Do you have a Living Will(Advanced Medical Directive)? ☐ Yes ☐ No If no, would you like information regarding living Wills? ☐ Yes ☐ No
Do you smoke cigarettes? ☐ Yes ☐ No How much?_____When did you stop?_____
How much before stopping?_____
Do you drink alcohol? ☐ Yes ☐ No How much?_____When did you stop?_____
How much before stopping?_____
Have you ever used any street drugs or illicit drugs?_____
How physically active are you?_____
FAMILY HISTORY:

	Age	State of Health	Age at Death	Cause of Death
Father:				
Mother:				
Brother/Sister(circle one)				
Brother/Sister(circle one)				
Brother/Sister(circle one)				

Has any blood relative ever had:			
	Cancer	☐ Yes ☐ No	Relative:_____
	Tuberculosis	☐ Yes ☐ No	Relative:_____
	Diabetes	☐ Yes ☐ No	Relative:_____
	Heart Trouble	☐ Yes ☐ No	Relative:_____
	High Blood Pressure	☐ Yes ☐ No	Relative:_____
	Stroke	☐ Yes ☐ No	Relative:_____
	Epilepsy	☐ Yes ☐ No	Relative:_____

HAVE YOU EVER HAD:

Heart attack.....□No □Yes
Heart murmur.....□No □Yes
Leaky Heart.....□No □Yes
Enlarged Heart.....□No □Yes
High Blood Pressure.....□No □Yes
Rheumatic fever.....□No □Yes
Tuberculosis.....□No □Yes
Valley Fever.....□No □Yes
Diabetes.....□No □Yes
Asthma.....□No □Yes
Cancer.....□No □Yes

DO YOU HAVE OR HAVE YOU HAD WITHIN THE PAST TWO(2) YEARS:

Chest pain.....□No □Yes
Pain in arms or throat.....□No □Yes
Wake up due to chest pain.....□No □Yes
How many pillows do you sleep on? #_____
Palpitations or very rapid heart rate.....□No □Yes
Skipped heart beats.....□No □Yes
High blood pressure.....□No □Yes
Leg cramps when walking.....□No □Yes
Leg cramps when lying down.....□No □Yes
Varicose veins.....□No □Yes
Swelling of ankles.....□No □Yes
Heartburn.....□No □Yes
Recurrent nosebleeds.....□No □Yes
Fainting spells.....□No □Yes
Light-headedness on standing up.....□No □Yes
Double vision.....□No □Yes
Severe headaches.....□No □Yes
Coughed up phlegm.....□No □Yes
Coughed up blood.....□No □Yes
Persistent hoarseness.....□No □Yes
Recurrent skin rashes.....□No □Yes
Numbness or tingling of hands or feet,.....□No □Yes
Changes in hair texture.....□No □Yes
Changes in weight.....□No □Yes
Nausea or vomiting.....□No □Yes
Vomited blood or "coffee-ground material".....□No □Yes
Black bowel movements.....□No □Yes
Blood in bowel movements.....□No □Yes
Abdominal cramping.....□No □Yes
Colitis.....□No □Yes
Pain on urinating.....□No □Yes
How often do you get up at night to urinate?# of times_____
Difficulty in starting urination.....□No □Yes
Blood in urine.....□No □Yes
Lose urine on coughing or sneezing.....□No □Yes
Discharge from penis.....□No □Yes

Blood Clots.....□No □Yes
Gonorrhea or syphilis.....□No □Yes
Nephritis .....□No □Yes
Jaundice- Hepatitis.....□No □Yes
Gallbladder disease.....□No □Yes
Anemia.....□No □Yes
Childhood diseases.....□No □Yes
Scarlet fever .....□No □Yes
Blood Transfusion.....□No □Yes
Stroke.....□No □Yes
Any others not listed?_____

Swelling of any joints.....□No □Yes
Had X-ray(s) of stomach or colon in the last 10 year.....□No □Yes
Had X-ray(s) of gallbladder in the last 10 years.....□No □Yes
Discoloration of fingers when exposed to cold.....□No □Yes

FOR WOMEN ONLY:

Date of last Pap_____
Age at onset of menstruation:_____
Onset date of last period:_____
Number of days between periods:_____
Number of days of flow:_____Heavy?_____
Method of birth control_____
Age at onset of intercourse_____
Age at menopause_____
Abnormal Paps?_____

PREGNANCIES

Total number of pregnancies_____
Number of live births_____
Number of prematures_____
Number of miscarriages_____Stillbirths_____
Number of abortions_____
Number of living children_____
Any complications?_____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD:

Breast Biopsy □No □Yes_____Year done_____
Breast Implants □No □Yes_____Year done_____
Mammogram □No □Yes_____Year done_____
Breast Surgery □No □Yes_____Year done_____
Colposcopy □No □Yes_____Year done_____
Cone biopsy □No □Yes_____Year done_____
Has a <u>blood relative</u> had breast cancer? □No □Yes
Relationship:_____
Date of last mammogram:_____
Do you perform breast self-exam? □No □Yes
Other important information:_____
_____

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TODAYS DATE:_____

Patient Information

NAME _____ AGE_____DATE OF BIRTH_____
ADDRESS_____ SEX_____ MARITAL STATUS_____
CITY_____ STATE_____ ZIP_____ Smoker?_____ If yes, how many per day?_____
HOME PHONE_____ DRIVERS LICENSE #_____State_____
SOCIAL SECURITY #_____ PERMANENT ADDRESS_____
EMPLOYER_____ CITY/ST/ZIP_____
ADDRESS_____ HOME PHONE #_____
CITY/ST/ZIP_____ WORK PHONE #_____
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 SSN_____DOB_____
CITY/ST/ZIP_____ POLICY #_____
PHONE #_____ GROUP #_____
Effective Dates_____through_____ RELATION TO PATIENT_____
PLAN NAME_____COPAY $_____ POLICYHOLDER'S EMPLOYER_____

Secondary Insurance

INSURANCE CO._____ POLICYHOLDER'S NAME_____
ADDRESS:_____ POLICYHOLDER SSN_____DOB_____
CITY/ST/ZIP_____ POLICY #_____
PHONE #_____ GROUP #_____
Effective Dates_____through_____ RELATION TO PATIENT_____
PLAN NAME_____COPAY $_____ POLICYHOLDER'S EMPLOYER_____

Assignment and Release

The patient acknowledges that all of the above information is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all services rendered and that he/she is contractually bound to pay for said services, including all costs of collection and a reasonable attorney's fee collection should be necessary. Patient hereby waives his/her confidentiality rights should collection action become necessary. I herby authorize and request that payments under my insurance plan be made directly to Rajiv Parik, MD for any services furnished to me. I also authorize the release of any information required to process insurance claims including any information relating to alcohol, drug abuse, and/or AIDS.

I hereby consent to the administration of all diagnostic procedures and/or treatments which in the judgement of my physician may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral and that I have the option to decline such treatment or seek further information.

Signature_____ Date_____

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

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Patient Name:_____ Date:_____

Patient's Date of Birth_____

Authorization, Assignment of Benefits & Release

I acknowledge that the information supplied on the patient registration form is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services, including all costs of collection and a reasonable attorney's fee should collection become necessary. Patient hereby waives his/her confidentiality rights should collection action become necessary. I hereby authorize and request that payments under my insurance plans be made directly to Rajiv Parikh, M.D. for any services furnished to me.
I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgement of Dr.Parikh may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral and that I have the option to decline such treatment or seek further information.
I also authorize the release of any information required to process insurance claims including any information relating to alcohol abuse, drug abuse, and/or AIDS/HIV.

Financial Arrangements

For your convenience, our office participates in a wide range of insurance plans. If you are not covered under one of the plans with which we participate, payment is expected at the time of service. Please check the option which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

- ☐ Bill my insurance (A copy of your insurance card is required)
- ☐ Cash
- ☐ Personal check w/valid driver's license
- ☐ Credit Card □ Visa □ MasterCard
  Card #_____ Expiration Date_____

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Rajiv Parikh, M.D.'s "Notice of Privacy Policies", detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I place no additional restrictions(s) concerning my personal medical information:

_____

This authorization may be revoked in writing by me at any time.

Signed:_____ Date:_____

Signature_____ Date:_____
(if patient is a minor- signature of parent/guardian)

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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.

I _____ understand that if i do not show for my scheduled appointment, cancel or reschedule my appointment 24 hours before that scheduled time, I will be charged a $45.00 no show fee.

_____ _____

Print Name **Date**

_____

Signature

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CONSENT TO DISCLOSE MEDICAL INFORMATION

I,_____give
(Name of Patient)
Permission 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)
_____ pick up documents
(Initials)

I understand that a record of this consent will be kept in my file and can be retracted with written consent stating otherwise.

_____
Signature of Patient

_____
Date

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"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_____