

Internal Medicine and Pediatrics of Bloomfield, PC
Steve Kallabat, MD
Azrael Paredes, MD
Jamie Chioini-Baines, DO

Annual Registration Form

PEDIATRIC**ADULT**

Last Name _____ First Name _____ MI _____

Date of Birth ____/____/____ Age _____ Gender: **Male** **Female**

Address _____ City _____ State _____ Zip _____

Cell Phone (____) _____ Home Phone (____) _____

Emergency Contact: _____ Relationship _____ Phone _____

Can we discuss your medical/financial information with anyone? **Yes** or **No**

If so, who? _____ Relationship _____ Phone _____

Local Pharmacy Name _____ Address _____ Phone _____

Mail Order Pharmacy _____ Address _____ Phone _____

Primary Insurance: _____

Subscriber Name: _____ DOB _____

Patient relationship to subscriber: **Self Spouse Parent Child Other** _____

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements, including payments due at the time of service as well as any referrals or prior authorizations needed. It is the insurance company that makes the final determinations, once this decision is made, we will not resubmit any claims.

Co-payments: All co-payments must be paid at the time of service as required by your insurance company, we cannot waive these fees.

Deductibles: Patients who have a high deductible insurance policy will be required to pay for the office visit, in full, at the time of service. The patient will also be responsible for any additional fees incurred associated with the office visit.

Premium Fee: An afterhours fee of \$30 will be charged to your account for visits after 5pm Monday thru Friday and on the weekends.

Statement Fee: Any payments missed at the time of service are subjected to a billing fee of \$10. A \$25 fee will be attached to each additional statement sent for unpaid balances. After the third consecutive statement, we will no longer be able to see you in our office, and you will be sent to collections.

Missed Appointments: Patients who do not cancel 24 hours prior to their appointment will be charged a no show fee. If this fee is not paid before the next visit, we reserve the right to refuse treatment. Two consecutive missed appointments are grounds to be discharged from the practice. No show fees are as follows: Office Visits- \$25, Well Child Visit -\$50, Adult Physical Exam-\$100.

Patient Signature/Guardian Signature _____ Date _____

Internal Medicine and Pediatrics of Bloomfield, PC

Review of Body System (Patient to fill out)

[] scanned

HEART (CARDIOVASCULAR SYSTEM)

| |
|-----------------------|
| chest pain |
| palpitations |
| dizziness/lightheaded |
| leg swelling |

| |
|---|
| cramping in legs while walking |
| awakening in the night with sudden difficulty breathing |
| loss of consciousness |
| difficulty breathing while laying down |

LUNGS (PULMONARY SYSTEM)

| |
|---------------------------------------|
| cough |
| difficulty breathing |
| chronic cough (longer than one month) |

| |
|------------------------------------|
| cough with blood |
| excess sputum production |
| difficulty breathing with exertion |

| |
|----------|
| wheezing |
|----------|

BOWELS (GASTROINTESTINAL SYSTEM)

| |
|------------------------|
| abdominal pain |
| abdominal mass |
| change in bowel health |
| constipation |

| |
|-----------------------------|
| bright red or maroon stools |
| difficulty swallowing |
| vomit with blood |
| dark black stools |

| |
|-----------|
| nausea |
| heartburn |
| vomiting |
| diarrhea |

NERVOUS (NEUROLOGICAL SYSTEM)

| |
|---------------------|
| decreased memory |
| difficulty speaking |
| difficulty walking |
| numbness in limbs |

| |
|-----------------------|
| headaches (other) |
| headaches (migraines) |
| seizures |
| vertigo (spinning) |

| |
|----------------------|
| loss of coordination |
| visual changes |
| weakness |
| tremor |

MUSCULOSKELETAL (MUSCLE & BONE)SYSTEM

| |
|-----------------------------|
| joint redness |
| joint deformity |
| chronic/long term back pain |

| |
|-------------------|
| morning stiffness |
| joint pain |
| joint swelling |

| |
|-----------------------------|
| muscle ache |
| muscle fatigue/weakness |
| chronic/long term neck pain |

URINARY TRACT SYSTEM

| |
|---------------------------------|
| urinating frequently |
| awakening frequently to urinate |

| |
|-----------------|
| urinating blood |
| urinary leakage |

| |
|-------------------|
| painful urination |
| weak urine stream |

EAR, NOSE, AND THROAT

| |
|----------------------|
| runny nose |
| nose bleeds |
| nasal congestion |
| snoring |
| hearing loss/muffled |

| |
|---------------------|
| red eyes |
| itchy/watery eyes |
| oral lesions |
| excessive sneezing |
| ringing in the ears |

| |
|------------------|
| sore throats |
| bad breath |
| enlarged tonsils |
| ear aches |
| vertigo |

SKIN (DERMATOLOGY)

| |
|-----------------------|
| rash |
| new skin lesion |
| keloid/scar formation |

| |
|-----------------|
| dark moles |
| easy bruising |
| loss of pigment |

| |
|----------------------|
| growing skin lesions |
| slow healing cuts |
| loss of hair |

GYNECOLOGIC/UROLOGIC

| |
|--|
| menopausal |
| painful menstruation |
| breast mass/lump |
| vaginal discharge |
| 1st day of last menstrual period ___/___/___ |

| |
|------------------------|
| change in menstruation |
| cyclical mood changes |
| nipple discharge |
| penile discharge |
| testicular pain |

| |
|----------------------------|
| excessive bleeding |
| breast tenderness |
| vaginal dryness/irritation |
| penile lesion |
| testicular mass |

PSYCHIATRY

| |
|-------------------------|
| depression |
| personality disorder |
| post-traumatic syndrome |

| |
|-----------------------------|
| anxiety state |
| obsessive/compulsive |
| alcohol/substance addiction |

| |
|----------------|
| manic episode |
| hallucinations |

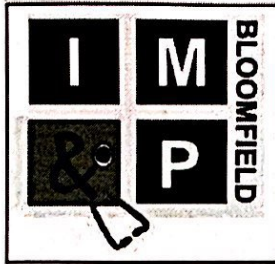
ENDOCRINE/GLANDULAR SYSTEM

| |
|--------------------|
| weight gain |
| increased appetite |
| fatigue |

| |
|------------------------|
| weight loss |
| tremors/shaky |
| increased perspiration |

| |
|-----------------------|
| increased thirst |
| stretch marks |
| excessive hair growth |

Patient signature: _____ Date: _____



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HEALTH MAINTENANCE FORM

NAME: _____ **DOB:** _____

Please update any changes in last year or since last appointment:

New surgeries: _____

New medicines: _____

New drug allergies: _____

Do you take daily baby Aspirin 81 mg? YES NO

Are you a current smoker? YES NO

FEMALE:

Please provide the following date of service for last:

STD Screen: _____

PAP: _____

Performing Physician: _____

Mammogram: _____

Colonoscopy: _____

Performing Physician: _____

DEXA Osteoporosis Scan: _____

Cardiac Calcium Score: _____

MALE

Please provide the following date of service for last:

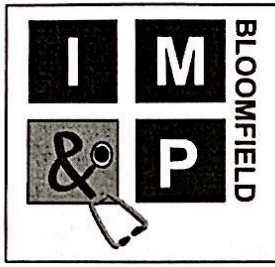
STD Screen: _____

PSA test/rectal exam: _____

Who Performed Your Colonoscopy: _____

DEXA Osteoporosis Scan: _____

Cardiac Calcium Score: _____



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Annual Adult Wellness Exam

The purpose of an adult wellness exam is to address therapeutic lifestyle changes to optimize overall health. Annual wellness exams may also be called a physical, yearly check-up, or preventive visit. This discussion includes:

- BMI (Body Mass index, height, and weight)
- Nutrition/ diet
- Nutrients/ Vitamins
- Importance of Exercise
- Blood Pressure
- Review of Female Screening Guidelines: (pap smear for cervical cancer, STD screening, self breast exams, mammograms screening for breast cancer, DEXA screening for osteoporosis)
- Review of Male screening Guidelines: (STD screening, testicular cancer screening, prostate cancer screening)
- Guidelines for Screening for colon cancer by colonoscopy
- Immunization review: Tdap, Hepatitis A and B, Shingles, Pneumonia, HPV,
- Fasting Labs: CBC, BMP, Lipid Panel, TSH
- Screening for cardiac disease: EKG
- Screening for pulmonary disease: PFT
- Other screenings:
 - One time Hepatitis C screening for adults born between 1945-1965
 - Smokers: Guidelines for Low Dose CT screening for Lung Cancer
 - High Risk Cardiac Disease: Cardiac CT for Calcium Scoring
- Medication List Update
- Patient Portal sign up reminder for lab result explanations

An Adult Wellness Exam does not include discussion of new problems or detailed review of chronic conditions. Insurance does not pay for this benefit at the time of your yearly physical. We ask that the discussion be focussed on the above wellness topics. We'd be happy to see you for a follow up appointment to discuss any new or existing problems you may have.

I agree with the above policy and if I have other health issues, I will make a separate appointment to discuss these issues.

Signature: _____

Date: _____