Sarwat Khawar, M.D.

Patient Information

(Please print clearly, and complete all information. Thank you!)

Name (First,M.I.,Last):_____

Date of Birth:_____ Age:_____ Sex: M or F Marital Status: S M W D
Maiden name:_____

Race: _____ Ethnicity: Spanish/Hispanic Origin Non-Spanish/Hispanic Origin
Other:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone Number:_____ Social Security Number:_____
Cell Number:_____

Employer Name:_____ Occupation:_____
Employer Phone Number:_____
Employer Address:_____

Responsible party/Spouse Information

Name:_____ Relationship to Patient:_____
Address:_____
Phone Number:_____ Social Security Number:_____

IN CASE OF EMERGENCY PLEASE CONTACT: Name:_____
Relationship:_____ Phone Number:_____

Insurance Information

Primary:_____ Id Number:_____
Group Number:_____ Subscriber:_____
Relationship to Patient: Self / Spouse / Dependent
Secondary:_____ Id Number:_____
Group Number:_____ Subscriber:_____
Relationship to Patient: Self / Spouse / Dependent

Miscellaneous

Pharmacy Name:_____ Town:_____
Are we allowed to share your medical information to anyone? Yes / No If yes, please complete
Name:_____ Relationship:_____
Phone Number:_____

I hereby assign, transfer, and set over to Sarwat Khawar, M.D. all of my rights, title, and interest to my medical reimbursement benefits under myinsurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I have notified my insurance company that Sarwat Khawar, M.D. is my primary care physician and therfore i will be responsible for payment if my insurance carrier does not cover my office visit and procedures. I understand that i am financially responsible for all charges whether or not they are covered by my insurance.

Patients Signature:_____ Date:_____

Sarwat Khawar MD, FACP

Please complete this entire packet and mail back or bring with you to your scheduled appointment.

Name_____DOB_____Date_____

Please list the full name of all physicians/specialists whom you are currently under the care of:

Previous physician or referring physician: _____

Marital Status: Single □ Married □ Widowed □ Divorced □

With whom do you currently live with? _____

Are you currently working? Yes □ No □What is your occupation: _____

Please list any surgeries you have had and the date:

Have you ever had any complications with anesthesia? If yes, please describe:_____

_____

Please list your diagnosis (medical conditions) both mental and physical given to you by a medical professional:

Date of last Tetanus Shot: _____ Flu Shot_____ Pneumonia Shot_____ PPD_____

Date of last Pap Smear_____ Mammogram_____

Colonoscopy_____ Bone Density Scan_____ Name of your OB/GYN:_____

Do you have any children? _____If so, how many? _____

. Family History:

	Living or Deceased	Please list any health problems, diagnosis, mental problems or substance abuse for each.
Mother		
Father		
Brother1		
Brother 2		
Brother 3		
Sister 1		
Sister 2		
Sister 3		

Do you smoke? _____If so, how many per day? _____Did you ever smoke? _____ If so, how long_____

When did you quit? _____Never smoked_____

Do you drink alcohol? _____If so, how much? _____

Do you wear a seatbelt in the car? _____

Please list all medications you are currently taking:

Name	Dosage (mg, mcg, %, etc.)	Directions (daily, twice a day, weekly, etc..)

If you need more room please use the back of the page.

Do you have any allergies to medications? Please list and specify your reaction_____

_____

***Make sure you contact your insurance company and change the primary physician listed. Please obtain reference number incase the billing department asks for it.**

****Please bring all of you medication bottles with you to your appointment. As well as your insurance card(s).**

*****Please bring the following advance directives if you have them: Health Care Proxy, Do not Resuscitate Order, Do not Intubate Order, Living Will.**

******Please arrive 15 minutes early to your scheduled appointment to allow us time to review your paperwork. Thank You**

Name_____ DOB_____ Date_____

Please <u>circle</u> if you are <u>currently</u> experiencing any of the following:

Ear pain, discharge, difficulty hearing

Chest pain, palpitations, shortness of breath on exertion

Cough, phlegm, shortness of breath, wheezing

Abdominal pain, nausea, vomiting

Pain or difficulty urinating

Dizziness, numbness, tingling, weakness

Depression, mood issues

Change in appetite, weight loss

Any signs/symptoms of infection, enlarged/tender lymph nodes, fever, ect