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 ______________________
Ethnic background ______________________ Religion ______________________
Occupation ______________________ Previous occupation ______________________
List other doctors treating you ______________________________________
Is it O..K. 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:

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HAVE YOU EVER HAD:

Condition	No	Yes
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
Blood clots	❒ No	❒ Yes
Gonorrhea or syphilis	❒ No	❒ Yes
Nephritis	❒ No	❒ Yes
Jaundice - Hepatitis	❒ No	❒ Yes
Gall bladder 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: ____________________

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

Condition	No	Yes
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? __________

Condition	No	Yes
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
Change 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 __________

Condition	No	Yes
Difficulty in starting urination	❒ No	❒ Yes
Blood in urine	❒ No	❒ Yes
Lose urine on coughing or sneezing	❒ No	❒ Yes
Discharge from penis	❒ No	❒ Yes
Swelling of any joints	❒ No	❒ Yes
Had X-ray(s) of stomach or colon in the last 10 years	❒ 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:

Procedure	No	Yes	Year done
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 blood relative 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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Rajiv Parikh, M.D. TODAY'S DATE:______________

Patient Information

NAME:______________
ADDRESS:______________
CITY:__________ STATE________ ZIP________
HOME PHONE:______________
SOCIAL SECURITY #:______________
EMPLOYER:______________
ADDRESS:______________
CITY/ST/ZIP:______________
PHONE #:______________

AGE:________ DATE OF BIRTH:______________
SEX:________ MARITAL STATUS:______________
Smoker ?________ If yes, how many per day?________
DRIVERS LICENSE #______________ State________
PERMANENT ADDRESS:______________
CITY/ST/ZIP:______________
HOME PHONE #:______________
WORK PHONE #:______________
REFERRED BY WHOM______________

Responsible Party Information

NAME:______________
ADDRESS:______________
CITY/ST/ZIP:______________
HOME PHONE:______________
SOCIAL SECURITY #:______________

RELATION TO PATIENT:______________
EMPLOYER:______________
ADDRESS:______________
CITY/ST/ZIP:______________
WORK PHONE:______________

Primary Insurance

INSURANCE CO.:______________
ADDRESS:______________
CITY/ST/ZIP:______________
PHONE #______________
Effective dates:__________ through__________
PLAN NAME__________ COPAY $__________

POLICYHOLDER'S NAME:______________
POLICYHOLDER SSN:__________ D.O.B:__________
POLICY #:______________
GROUP #:______________
RELATION TO PATIENT:______________
POLICYHOLDER'S EMPLOYER:______________

Additional / Secondary Insurance

INSURANCE CO.:______________
ADDRESS:______________
CITY/ST/ZIP:______________
PHONE #______________
Effective dates:__________ through__________
PLAN NAME__________ COPAY $__________

POLICYHOLDER'S NAME:______________
POLICYHOLDER SSN:__________ D.O.B:__________
POLICY #:______________
GROUP #:______________
RELATION TO PATIENT:______________
POLICYHOLDER'S EMPLOYER:______________

Miscellaneous

Drug allergies?______________

Effect (Nausea, rash, etc.)______________

In case of emergency, notify______________ Relation to patient______________
Home phone______________ Work phone______________

Assignment & 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 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, 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 and performance 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 ______________

Acknowledgment 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 restriction(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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RAJIV PARIKH MD

1964 E BASELINE ROAD STE A103

Tempe AZ, 85283

NOTICE OF NO SHOW FEE

Please be advised that our office requires 24 hour 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 no show fee each time you do not show up for your scheduled appointment.

If a patient fails to show up for more than three appointments within 6 months 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 up for my scheduled appointment, cancel or reschedule my appointment 24 hours before that scheduled time, I will be charged a $45 no show fee.

______________________________ ______________________

Print Name Date

____

Signature

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Dr. Rajiv Parikh, M.D.

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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