SONALI P. MAJMUDAR, MD
ADULT & PEDIATRIC
ALLERGY, ASTHMA, AND IMMUNOLOGY SOLUTIONS

Today's Date: _____

PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____
Parent/Guardian (If Minor):_____
SS#: _____ Email: _____
Address:_____
Phone # _____ **(Home or Cell)** Alternate #: _____
Whom may we thank for referring you? _____

PRIMARY INSURANCE

Insurance Company:_____ Policy #: _____
Subscriber: _____ Group #:_____
Date of Birth:_____ SS# of Subscriber: _____

SECONDARY INSURANCE: ☐ YES ☐ NO

Insurance Company:_____ Policy #: _____
Subscriber: _____ Group #:_____
Date of Birth:_____ SS# of Subscriber: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Sonali P. Majmudar, MD all insurance benefits,
Name of Insurance Company
if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

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REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I, _____, hereby request the office to keep confidential, any communications regarding my protected health information (PHI). To accomplish this request, please adhere to the following:

Phone:

Home**:** _____

Cell: _____

Leave messages on answering machine: _____ YES _____ NO

Leave messages with any other individual: _____ YES _____ NO

Individual's name: _____ Relationship: _____

Individual's name: _____ Relationship: _____

Mail:

Written communication can be sent to me at this address:

_____

_____

Other request for confidential communications:

_____

_____

_____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have a right to revoke this authorization in writing except to the extent that Dr. Majmudar has acted in reliance upon this authorization. My written revocation must be submitted to Dr. Majmudar.

Signature: _____ Date: _____

1585 N. BARRINGTON ROAD, SUITE 503, HOFFMAN ESTATES, ILLINOIS 60169
600 S. RANDALL ROAD, 2ND FLOOR, ALGONQUIN, ILLINOIS 60102
TELEPHONE: (847) 781-3002 FAX: (847) 781-3694

SONALI P. MAJMUDAR, MD

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Sonali P. Majmudar MD, originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, billing information and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionsals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals, and
- A means by which payment for services can be made

I understand and have been provided with a NOTICE OF INFORMATION PRACTICES that provides a more complete description of information uses and disclosures. I understant that I have the right to review the notice prior to signing this consent. I understand that the origanizaton reserves the right to change its notice and practies and will provide a copy of any revised notice. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understant that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I have the right to request restrictions on the use of my health information. I understand that my request is not agreed to by Sonali P. Majmudar MD, unless Sonali P. Majmudar MD agrees to the request in writing.

I understand that for convenience or necessity I would like my health information available to the following friends or family members:

_____ _____

_____ _____

_____ _____

I fully understand and accept the terms of this contract.

_____ _____

Patient Signature Date

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PATIENT HISTORY FORM

TODAY'S DATE __/____/_____ **DATE OF BIRTH__/____/_____**

LAST NAME_____ **FIRST NAME_____**

CHIEF COMPLAINT:
What is the main reason for your visit today? (Describe your problem in detail)

_____
_____
_____
_____
_____
_____

HISTORY OF PRESENT ILLNESS

PLEASE CIRCLE THE SYMPTOMS THAT YOU HAVE:

SNEEZING	ITCHY EYES
WATERY EYES	NASAL CONGESTION
COUGHING WITH EXERCISE	POST NASAL DRIP
COUGHING WITHOUT EXCERSICE	ITHCY EARS
RUNNY NOSE	ITCHY PALATE
HIVES	

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

Spring	Summer
Fall	All year

How long does this problem last?

30 min 1 hour It is always there
Other_____

Is anything else occurring at the same time? Yes No

Nausea Rash Headaches Other_____

Does the problem interfere with your normal functions? Yes No

If yes, please explain_____

PAST MEDICAL & SOCIAL HISTORY

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease,

_____ _____ _____
_____ _____ _____
_____ _____ _____

List any personal past **illnesses** and /or **surgeries**:
Illness or surgery Date

_____
_____
_____

Do you Smoke? Yes No
If yes, how much?_____
Do you Drink? Yes No
If yes, how much?_____
Marital Status: Married Single Divorced Widowed
Type of Flooring: Carpet ☐ Hardwood
Heating & Air Conditioning: ☐ Central ☐ Forced

Are you on any **medications**? Please list:

_____
_____
_____

Are you on a special diet? Please explain:

_____
_____

Do you have pets? Yes No
List_____
Occupation:_____
Type of bedding: ☐ Feather Non-Feather

REVIEW OF SYSTEMS

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING SYSTEMS?
CIRCLE **YES** OR **NO. PLEASE EXPLAIN ANY YES ANSWERS.**

CONSTITUTIONAL SYMPTOMS
FEVER Y N
CHILLS Y N
HEADACHE Y N
OTHER_____

EYES
BLURED VISION Y N
DOUBLE VISION Y N
PAIN Y N
OTHER_____

NEUROLOGICAL
TREMORS Y N
DIZZY SPELLS Y N
NUMBNESS/TINGLEING Y N
OTHER_____

ENDOCRINE
EXCESSIVE THIRST Y N
TOO HOT/COLD Y N
TIRED/SLUGGISH Y N
OTHER_____

GASTROINTESTINAL
ABDOMINAL PAIN Y N
NAUSEA/VOMITING Y N
INDIGESGTON/HEARTBURN Y N
OTHER_____

CARDIOVASCULAR
CHEST PAIN Y N
VARICOSE VEINS Y N
HIGH BLOOD PRESSURE Y N
OTHER_____

PSYCHOLOGIC
AREYOU GENERALLY SATIFIED WITH YOUR LIFE? Y N
DO YOU FEEL SEVERELY DEPRESSED? Y N
HAVE YOU CONCIDERED SUICIDE? Y N
OTHER_____

INTEGUMENTARY
SKIN RASH Y N
BOILS Y N
PERSISTENT ITCH Y N
OTHER_____

MUSCULOSKELAETAL
JOINT PAIN Y N
NECK PAIN Y N
BACK PAIN Y N
OTHER_____

EAR/NOSE/THROAT/MOUTH
EAR INFECTION Y N
SORE THROAT Y N
SINUS PROBLEMS Y N
OTHER_____

GENITOURINARY
URINE RETENTION Y N
PAINFUL URINATION Y N
UNIARY FREQUENCY Y N
OTHER_____

RESPIRATORY
WHEEZING Y N
FREQUENT COUGH Y N
SHORNESS OF BREATH Y N
OTHER_____

HEMATOLGIC/LYMPHATIC
SWOLLEN GLANDS Y N
BLOOT CLOTS Y N
OTHER_____

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