I Care Internal Medicine
Patient Information

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Marital Status: _____

Primary Language: _____ Sex: _____

*Race: _____ *Ethnicity: _____
☐ Decline ☐ Decline

Insurance Information

Primary Insurance: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship to patient: _____

I hereby assign my insurance benefits to be paid directly to Mohammad Jamil M.D. I certify that the information above is true and correct to the best of my knowledge. I will notify the practice of any changes to this information. I understand that I am financially responsible for all charges which my insurance does not cover including copays; deductibles; coinsurance and non-covered services. Further I agree that if I do not pay these charges after 90 days of the initial statement and collection action is instituted, an additional 33% of the amounts due will be added to the outstanding balance.

Signature: _____ **Date**: _____

MOHAMMAD JAMIL, P.C., dba I CARE INTERNAL MEDICINE
(623) 670-7772

Effective Date of Notice: April 6, 2022

PRIVACY NOTICE ACKNOWLEDGMENT AND COMMUNICATION CONSENT

Patient Name:_____ DOB: _____/_____/_____
PRINT NAME

Please list the pharmacy you would like to use including cross streets OR phone number:

_____

List Email Address BELOW for use with our secure patient portal: https://health.healow.com/icareim

_____

☐ ***I do not have an email*** ☐ ***I do not wish to share my email or access my records via portal***

We must call you at times to give you what is classified as protected health information. Please let us know how we can contact you with this information and if we can leave a message.

Can we leave detailed or confidential messages on your voicemail?
Yes ___ No ___ Voice Number:_____

Can we mail test results to your home?
Yes ___ No ___

Can we send you text reminders?
Yes ___ No ___ Cell Number: _____

Can we lookup/import your prescription history electronically from your pharmacy?
Yes ___ No ___

Exclusions/Alerts (Please note any information that you do not want released to authorized individuals:

_____

We must call you at times to give you what is classified as protected health information. Can we speak to anyone other than you regarding lab results, radiology results or other issues regarding your health?

NAME	RELATIONSHIP	PHONE NUMBER
1)		
2)		

Must Sign Below for all information given:
My signature below authorizes communication consent as well as acknowledges that I have received a copy of the Mohammad Jamil, P.C., Notice of Privacy Practices.

I also acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in both the statewide and nationwide Health Information Exchange (HIE), or I previously received this information and decline another copy.

_____ _____
Patient Signature or Authorized Person to Sign DATE If not patient: Print name and relationship to patient (parent, legal guardian, personal representative, etc.)

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

_____ Individual Refused to Sign _____ Communication Barrier _____ Care Provided was Emergent
_____ Other: _____ _____ ____/____/_____
Employee Name Date

Mohammad Jamil, M.D.
www.icareimaz.com
Tel 623-670-7772

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: **Date of Birth:** **Todays Date:**

The reason(s) for today's visit:

List all medical conditions you are being treated for or have been diagnosed with:
Patients Age 65+: Have you had any falls in the last 1 year? ☐ NONE ☐ 1 with injury ☐ 2+ with injury ☐ 1 without injury ☐ 2+ without injury

Please list the most recent date for the following: If you have never had the test/procedure please write N/A		
TEST/EXAM TYPE	Date of last exam: SPECIFY: Month / Day / Year	
Bone Density (age 65+)	Date of last exam:	
Pap Smear- Females (Age 21+)	Date of last exam:	Doctor or Clinic Name:
Mammogram-Females (age 40+)	Date of last exam:	
Colon Cancer Screening: (age 45+) Colonoscopy, Cologuard, or FIIT Test	Date of last exam:	Doctor or Clinic Name:
Pneumonia Vaccine (age 65+)	Last vaccine date:	
Shingles Vaccine (age 50+)	Last vaccine date:	
Influenza Vaccine (age 18+)	Last vaccine date:	

Surgeries: (You may use the back for additional surgeries) ☐ **NONE**	
Surgery Type	Year

NAME:_____ DOB:_____ Date:_____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers: ☐ **NONE**		
Name the Drug	Strength (mg, mcg, mL, etc)	Frequency taken?

Allergies to medications: ☐ **NO KNOWN ALLERGIES**	
Name the Drug	Reaction You Had

Marital Status	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Occupation					
Social	Do you use tobacco?			☐ Never	☐ Yes
	☐ Cigarettes ____ pks./day or week	☐ Chew ____ /day or week	☐ Pipe - ____#/day or week	☐ Former-Year Quit _____	
	☐ # of years	☐ Cigars #_____/Week			
	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Do you use marijuana or THC products?			☐ Yes	☐ No
	Do you drink alcohol?			☐ Yes	☐ No
	How often do you have a drink containing alcohol?	☐ Never ☐ Monthly or less ☐ 2-4x/month ☐ 2-3x/week ☐ 4+/week			
	How many standard drinks containing alcohol do you have on a typical day that you are drinking?	☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+			
	How often do you have six (6) or more drinks on one occasion?	☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily			
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No

SIGNIFICANT HEALTH PROBLEMS	
Mother	
Father	
Siblings	
Children	
Paternal Grandfather	
Paternal Grandmother	
Maternal Grandfather	
Maternal Grandmother	

iCARE INTERNAL MEDICINE

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Today's Date: _____

Name _____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐

PLEASE ADD SCORE FOR 1 & 2. If total score is 3 or higher proceed to questions 3-9. If your score is 2 or less stop here.

3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

List any other providers and / or specialists you are currently seeing:

Providers first and last name or clinic name Diagnosis treated or Specialty

- _____
- _____
- _____
- _____
- _____
- _____

Provider Reviewed:_____ Date:_____

Upon establishing care, our office will serve as your Primary Care Provider.
Please review our office policies:

Controlled Medications: All narcotic medications will be discussed by appointment only and prescribed at your provider's discretion. Controlled medications being refilled require an appointment every 1-3 months and will only be refilled at the discretion of Dr. Jamil.

Medication refills: Office visits are required every 1-4 months to monitor the conditions in which you are being treated. At your scheduled office visit, the provider will discuss appropriate monitoring intervals for your medications. Please allow up to three business days for any requests not made during your office appointment. We do not refill medications outside of our business hours.

No Shows or Cancellations: As a courtesy to other patients needing appointments, please give us at least 24 hours' notice if you will not be able to make your scheduled appointment time. Excessive abuse of the policy will be subject to a *$25 fee for each no show* and/or discharge from the practice.

Payment: All CO-PAYS, DEDUCTIBLES and BALANCES OWED are due at the time of your appointment. Balances that remain unpaid after 90 days of the initial statement will be subject to being transferred to a collection agency and a 33% fee will be added to the amount owed. However, we do accept monthly payment plans and suggest initiating this so that your account is not sent to collections.

Forms: Disability, FMLA, attorney forms, etc. will be reviewed by appointment only. We do not currently charge for this service; however, you must bring these forms with you at the time of visit or return for another visit with the required form(s). Please allow up to 7 business days for completion of these forms.

Inappropriate Behavior: Inappropriate language (profanity, vulgarity), threats, behavior, and/or harassment (unwelcome contact, whether verbal, nonverbal, physical, or visual that is based on a person's status such as sex, color, race, ancestry, national origin, age, disability, job status or personal characteristics) will not be tolerated and will be grounds for immediate dismissal from practice.

New Medications: We do not prescribe new medications without first evaluating a patient. This includes pain medications, antibiotics, medications from other providers or clinics or any other medications that have not already been prescribed by the physician.

Referrals: New referral requests require an office visit to discuss. For continued care referrals, you must be current in your care with Dr. Jamil. If your insurance does not require a referral, you may self-refer. Some clinics may require a formal referral from our office regardless of insurance.

Preventive Care: As your PCP, we will address your preventive screening exams and tests during an Annual Physical or Annual Wellness Visit (Medicare). Most insurances will cover one visit a year at 100% with $0 cost to you.

Please inform us of any changes to your health history, pregnancy, new medications or any new surgeries at each visit.

Thank you for your cooperation and understanding of our policies.

Name:_____ Date of Birth:_____

Signature:_____ Date:_____