Vijay Patel Family Medicine
1520 GLENWOOD AVE, RALEIGH NC 27608

Phone: 919-782-5288 fax 919-782-5287
apptdrpatel@live.com

Today's Date:

PATIENT INFORMATION

Last name:	First:	Middle:	Marital Status S M D Other________

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F

Full Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist at each visit.)

Person responsible for bill:	Address (if different):		Phone:
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate carrier of primary insurance: (BCBS, etc)

Subscriber's name:	Subscriber's S.S.	Birth date:	Group no.:	Subscriber no.:	Co-pay: $

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Subscriber ID

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Vijay Patel Family Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature   Date

Authorization for Disclosure of Health Information

I hereby authorize (facility or MD name) ______________________________ to release medical information from the records of :

Patient name ______________________________ DOB ___/___/___ SS # ___-___-___

Pt address ______________________________ City ____________ State___ Zip _____

Dates of treatment should include ____________________

Information to be disclosed:

__ Discharge summary/ instructions
__ ECG/EKG(s)
__ Medication record
___ Last three office notes
___ xray reports
___ H&P and allergies
___ Entire chart
___ last two lab reports

Purpose or need for the disclosure is continued medical care. This information is to be disclosed to:

Vijay Patel Family Medicine
1520 Glenwood Ave
Raleigh, NC 27608
P 919.782.5288
F 919.782.5287

My refusal to sign this form will not adversely affect my ability to receive healthcare services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law. I have the right to revoke this authorization by written notice to the healthcare provider listed above.

This authorization expires 90 days from the date signed below.

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), (ARC) and or human immunodeficiency virus (HIV).

Fees: I understand and free that there may be costs associated with this request in compliance with State Copying laws.

______________________________ signature ___/_____/_____ date

Today's date: ______________ *Past due amount:* ____________ *Paid:* ____________

Name: ____ DOB: ______________

Reason for visit: ***please note that excessive requests will require a new visit (this is the #1 reason for excessive wait times, so please think of other).***

____ **new or worsening old problem:** ____

what is it & where: ____
When did it start: ____
Related symptoms: ____
severity (1-10/10): ____
what helps or makes worse ____

____ ***work in issue (1 problem only):*** ______________________________________
____ ***shot(s) only, re:*** ____
____ ***quick script issue, re:*** ______________________________ (has to be pre arranged)
____ **meds and/or results review:** ____ bloodwork ____ radiology ____ other: __________
____ **Procedure only, re:** ____
____ **physical only** ***(problem lists will be pushed to a follow up visit)***
____ **new patient/establish care:** ____________________________________
____ **blood draw w/visit today,** + any labs by request: __________________________

Please update so that we know it is accurate in your e-chart (at least every 6mo If nothing has changed since your last visit please just indicate with N/A):

Phone/Email//Address (each):

Pharmacy of choice (also mail order):

Drug Allergies:

Surgeries:

Family history (parent & siblings):

(Circle) Tobacco drug alcohol: ____ Current ____ Never ____ Former

Medication list: