PARKPLACE
Family Practice • Internal Medicine

Patient Information

Name_____DOB_____

Patient Social Security #_____ Male☐ Female☐

Phone Number_____ Cell_____

Address_____

City_____ State_____ Zip_____

Email address_____

Name of Parent/Guardian (if under 18)_____

Primary Insurance_____

Contract #_____

Subscriber (if not patient) _____DOB_____

Relationship to Patient: Mother☐ Father☐ Spouse☐

Address (if different from patient) _____

Secondary Insurance_____

Contract #_____

Emergency
ContactName_____ Phone_____

Pharmacy Name _____ Phone_____

Patient authorization: Request payment of authorized medical services to be paid to my doctor directly by my insurance. I understand that in the event my insurance fails to pay for any service provided by the doctor, I will be fully responsible for all the charges, co-pay and deductibles any service which are denied by my insurance.

I have read and understand my obligation:

Signed_____ Date_____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have received the

Notice of Privacy Policy from Raj Goswami, MD. and Ram Goswami, MD.

_____

Patient Name – Please Print

_____

Patient Signature

_____

Date

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Authorization for Release of Medical Information

As a patient of this office, I hereby authorize the release of any medical information pertaining to myself or the patient listed below to the following:

1. Physician's offices or staff for the purpose of coordination of continued treatment.
2. Hospitals and/or other treatment facilities for the purpose of coordination or management of healthcare including special procedures, testing, consultations and referrals.
3. My insurance companies, including any disability companies for the purpose of payment of my claims or for the purpose of obtaining disability benefits.
4. Nearest relative_____ in the event I am unable to receive personal health information.

_____

PATIENT NAME, PLEASE PRINT

_____

PATIENT SIGNATURE/LEGAL GUARDIAN SIGNATURE

_____

DATE

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Consent to Treatment

I hereby authorize Park Place Family Practice and Internal Medicine to treat

_____

PATIENT NAME, PLEASE PRINT

for the health conditions which he/she presents to this office. I understand such treatment may include examination, lab work, special testing, etc. I also understand that all medical treatment shall be discussed with Ram Goswami, MD & Raj Goswami, MD.

In the event that said patient is a minor or incapable of understanding his/her treatment regimen,

_____

PARENT/LEGAL GUARDIAN/DPOA NAME, PLEASE PRINT

shall be given full rights to make such consent.

_____

PATIENT NAME, PLEASE PRINT

_____

PATIENT SIGNATURE/LEGAL GUARDIAN SIGNATURE

_____

DATE

PATIENT HISTORY FORM

Patient Name: _____ Patient Date of Birth: _____

*Please fill out **all** information **as best and detailed** as you can*

What is the reason(s) for your visit today?

_____

_____

Please list all medications you are currently taking, (list over the counter medications as well):

	Medication	**Dosage**	**Frequency**	**Reason for medication**
EXAMPLE:	Lisinopril	10 mg	Once a day	High blood pressure
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Additional medications:

_____

_____

Do you have any known allergic reactions to medications? If yes, please list below along with reaction:

	Medication	**Reaction**
EXAMPLE:	Lisinopril	Diarrhea, hives, vomiting
1.		
2.		
3.		
4.		
5.		

Medical History (Check all that apply)

Hypertension ☐
Hyperlipidemia ☐
Diabetes Type I ☐
Diabetes Type II ☐
Heart Attack ☐
Stroke ☐
Seizures ☐
Asthma ☐
COPD ☐
Emphysema ☐
Migraines ☐
Afib ☐

Anxiety ☐
Depression ☐
Cancer ☐
Arthritis ☐
Diverticulitis ☐
Anemia ☐
Heart Failure ☐
Fibromyalgia ☐
Allergies ☐
HeartDisease ☐
Hyperthyroidism ☐
Hypothyroidism ☐

Additional Medical History Not Listed Above: _____

_____

Please list past surgeries below and the year it was done:

	Year	Surgery
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Please list past hospitalizations below and the year:

	Year	Reason for Hospitalization
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Please fill out family history as best as you can:

Member	Current Age or Age of Death	Deceased?	Medical History
Mother	_____	☐	_____
Father	_____	☐	_____
Maternal Grandmother	_____	☐	_____
Maternal Grandfather	_____	☐	_____
Paternal Grandmother	_____	☐	_____
Paternal Grandfather	_____	☐	_____
Siblings	_____	☐	_____
Children	_____	☐	_____

How many brothers do you have? _____ Healthy? _____
How many sisters do you have? _____ Healthy? _____

Please fill out your social history below:

ALCOHOL HISTORY

Did you have a drink containing alcohol in the past year? _____
If YES, how often did you have a drink containing alcohol in the past year? _____
If YES, how many drinks did you have on a typical day when you were drinking in the past year? ___If YES, how often did you have six or more drinks on one occasion in the past year? _____

DEPRESSION HISTORY

Do you feel depressed? _____ **(If NO, do not fill out the following 7 questions below)**
If YES, do you have little interest or pleasure in doing things? _____
If YES, are you feeling down, depressed, or hopeless? _____
If YES, do have a poor appetite or overeating? _____
If YES, do you feel bad about yourself or feel you have let yourself or your family down? ____
If YES, do you have trouble concentrating on things, such as reading the newspaper or watching television? _____
If YES, are you 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? _____
If YES, thoughts that you would be better off dead, or of hurting yourself in some way? _____

SEXUAL HISTORY

Have you been sexually active in the past 12 months? _____
If YES: with men only ○ with women only ○ with both men and women ○
Do you use protection? _____
Have you ever had a sexually transmitted disease? _____ If YES, please list: _____
WOMEN: When was your last menstrual period? _____

SMOKING HISTORY

Circle one of the following: I am a current smoker☐ former smoker☐never smoker☐
Do you smoke cigarettes? _____ If YES, how many per day? _____
Do you smoke marijuana? _____ If YES, how often? _____
If CURRENT or FORMER smoker, how many years did you smoke for? _____
If FORMER smoker, when did you quit smoking? _____
If CURRENT smoker, are you ready to quit yet? _____