

Patient Information Form

Welcome To Our Office

Internal Medicine Associates of Montgomery Village

18550 Office Park Drive
Montgomery Village, MD 20886
Telephone (301) 330-2700 Fax (301)990-7170

**IN ORDER TO SERVICE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION.
ALL INFORMATION IS STRICTLEY CONFIDENTAL.**

Today's Date: ____/____/____

Referred by: _____

(Please Print Clearly)

*Patient's Name:

(Last) (First) (Middle Int.) (Nickname)

*Address:

(Street) (City) (State) (Zip Code)

*Date of birth: _____ Sex: M / F Marital Status: S M W D SEP Language:

(MM/DD/YEAR) *Social Security #: _____

*Home () _____ *Work () _____ *Cell () _____

Employer/School: _____ Address: _____

Name of spouse: _____ Address: _____

(Or parent name if under the age of 18, Or Guardian)

Phone: () _____ Cell : () _____ Work: () _____

**Emergency Contact Information: IN ORDER TO SERVICE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION.
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Name: _____ Relationship to patient: _____

Phone: () _____ Cell: () _____ Work: () _____

Address: _____

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Name of Primary Insurance? _____ Policy #: _____

Name of Subscriber? _____ Do you have Secondary Insurance? _____

If yes, insurance: _____ Date of birth of policy holder: _____

Billing name (if other than patient) _____ Relationship: _____

Billing address: _____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENFITS.

*Signed: _____ Date: _____

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO *Internal Medicine Associates of Montgomery Village, Dr. Balnath Bhandary & Dr. Pradeep Srivastava, M.D. P.C.* FOR ANY PROFESSIONAL SERVICES RENDERING BY HIM OR HIS ASSOCIATES.

*Signed: _____ Date: _____

RELEASE OF INFORMATION

I authorized of any medical information necessary to process this claim.

*Signed: _____ Date: _____

Family history if any blood relative has suffered any of the following- please circle the number & indicate which relative

- | | | | |
|-------------------|-------------------|-------------------------|----------------------|
| 1) Epilepsy | 6) Thyroid | 11) Osteoporosis | 16) High cholesterol |
| 2) Migraine | 7) Hay fever | 12) Arthritis | 17) Alcoholism |
| 3) Mental illness | 8) Asthma | 13) Heart Disease | 18) Hepatitis |
| 4) Glaucoma | 9) Anemia | 14) Stroke | 19) Cancer |
| 5) Diabetes | 10) Bleeds easily | 15) High blood pressure | 20) STD : _____ |

List of ANY Allergies you have: _____

Chief complaint for today's visit: _____

List any conditions/ surgeries that we should know about: _____

Medical History: **PLEASE check** any boxes if you have had or current problems:

Constitutional:

- Decreased hearing Ringing in ear Ear infections-frequent Dizzy spells fainting spells
- Failing vision Double or blurred vision Nose bleeds sinus trouble Sore throat -frequent
- Hoarseness Hay fever/allergies Pneumonia Bronchitis chronic cough Asthma/ wheezing
- Cardiovascular:** Shortness of breath: on exertion lying flat Chest pain high blood pressure
- Heart murmur swollen ankle Irregular pulses palpitations Leg pain -when walking Varicose veins/phlebitis Cold numbs feet

Gastrointestinal

- Loss of appetite-recent Difficulty swallowing Heartburn peptic ulcer Nausea / Vomiting
- Gallbladder problems Jaundice/ Hepatitis IBS Abdominal pain Bloating/ discomfort
- Diarrhea constipation Diverticulitis Chrons Disease Colitis Hemmorids Hernia

URINATIONS – Overactive bladder Overnight more than twice More than 8 time/24hrs Urgency to urinate with leakage Decease in force/ flow Painful Stress incontinence – urine leakage With exercise/ movement Urine infections-frequent Bed wetting Blood in urine Kidney stones

Endocrine/ Hematologic/Lymphatic: Weight loss/ gain Anemia Bruise easily Blood transfusions Cancer Diabetes Thyroid disease hormones

Neurological: Seizures Stroke Headaches Numbness Bone fractures/ joint injury Osteoporosis Back pain Foot pain Gout Arthritis prostate problems

SKIN DISORDERS: Hives Rashes Eczema Psoriasis Excessive sweating

Psychiatric: Concentration problems Depression Nervousness Agitation memory loss Moodiness suicidal thoughts Phobias mental illness Sleep problems

IMMUNIZATIONS:

Rheumatic fever Scarlet fever chicken pox Mumps polio German measles Tuberculosis PPD

PERSONAL HISTORY: Herpes AIDS./HIV STD sexual problems Erectile dysfunction

HABITS: Alcohol # _____ per day/ week Caffeine # cups per day _____ smoking-day/week: _____ Exercise recreational drugs: Yes / No

Females: Menstrual flow Reg Irreg. Pain/ Cramps Days of flow: _____ length of cycle: _____
Date-1st day of last period: _____ Date of last pap: _____ Date of last mammogram: _____
Number of: pregnancies: _____ Miscarriages: _____ Live births: _____ C-sections : _____

Additional Notes:

Thank you for entrusting us with your health.