PATIENT REGISTRATION FORM

Revised 04/2012

PATIENT INFORMATION

Name: (First, MI, Last)		Sex	Home Phone:	
Address: (Street#)			Social Security #:	
City, State		Zip	DOB	Marital Status
Employer	Job Title		Work phone #:	Cell phone #:
Name and phone number of emergency contact				
Email Address:			May we correspond by email? ☐ Yes ☐ No	

REFERRING PHYSICIAN INFORMATION

Referred by:	Office Phone #:
Address	

FINANCIAL RESPONSIBILITY

Name of person financially responsible: (if patient is a minor)		Relationship to Patient:
Address: (Street#, City, State, Zip) ** If different than patient**		
Phone #	DOB	Social Security #

INSURANCE INFORMATION

Primary Insurance carrier	Group #	ID #	
Policy Holder's Name (First, MI, last)	PCP Co-pay amount	Specialist Co-pay amount	
Address: (Street#, City, State, Zip) ** If different than patient**			
Phone #	Relationship	DOB	Sex
Employer	Social Security#	Effective date of insurance	
Secondary Insurance carrier	Group #	ID #	
Policy Holder's Name		Relationship to patient	

_____ _____

Patient Signature Date

ADULT PATIENT HEALTH HISTORY

The information completed on this questionnaire will become a confidential part of your medical record.

Today's Date: ____/____/____

Name: _____ Date of birth: ____/____/____
Last First Middle

Reason for visit: _____

Current symptoms: _____

MEDICAL HISTORY

ILLNESSES:

Check major, significant illnesses which apply to you:

- ☐ Anemia
- ☐ Asthma
- ☐ Arthritis
- ☐ Bleeding/Blood Disorder
- ☐ Breast cancer
- ☐ Cancer(s) _____
- ☐ Cataracts
- ☐ Colitis
- ☐ Depression
- ☐ Constipation
- ☐ Emotional/Mental Illnesses
- ☐ Emphysema
- ☐ Epilepsy/seizures
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Problems
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Mononucleosis
- ☐ Polymyalgia Rheumatica (PMR)
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis/TB
- ☐ Rheumatoid Arthritis
- ☐ Lupus

SURGICAL:

List the year of any operations/procedures you have had.

	Date		Date
Appendix Surgery	_____	Hip Surgery	_____
Breast growth removal	_____	Hysterectomy	_____
Carpal tunnel	_____	Knee Surgery	_____
Cataract Removal	_____	Nasal/Sinus Surgery	_____
Cesarean section delivery	_____	Plastic Surgery	_____
Colonoscopy (looking into bowel)	_____	Polyp removal from intestine	_____
D & C	_____	Prostate surgery	_____
Gall bladder surgery/laparoscopy	_____	Thyroid surgery	_____
Gastroscopy (looking into stomach)	_____	Tonsils/Adenoids removed	_____
Heart catheterization/surgery	_____	Tubal Ligation	_____
Hernia	_____	Vasectomy	_____
		Other	_____

MEDICATIONS

List all medications you are currently taking which have been ordered by a doctor (including inhalers) and all over the counter drugs, vitamins or herbs. Please list prescribed medications first,

YOUR PHARMACY NAME AND LOCATION: _____ Phone_____

Name of Medicine/Dose/Frequency:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

IMMUNIZATIONS:

Date of most recent:

_____ Flu (once annually)
_____ Pneumonia (Once every 5 years)
_____ Tetanus
_____ Shingles

ALLERGIES

☐ Medications: List/Describe: _____

_____

☐ Food ☐ Animals ☐Latex ☐Tape ☐ Pollens ☐ Eggs ☐ Iodine ☐ Nuts
Other: _____

SOCIAL HISTORY

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Partner

What is your smoking status? ☐ Never ☐Past ☐Current

a. Year Quit: _____
b. Number of years smoked: _____
c. Average number of packs/day: ____ ☐ Chewing tobacco ☐Cigarettes
d. Would you like help to quit? ☐ Yes ☐ No

On average, how many alcoholic drinks (1 drink = 12 oz. beer, 10 oz. wine cooler, 5 oz. wine, 1.5 oz liquor) do you consume? ☐ Non-drinker ☐ 1-2 per week ☐ 1-2 per day ☐ 3 or more per day ☐ other_____

a. Do you drink every day? ☐ Yes ☐ No
b. Have you ever thought you had a problem with drinking? ☐ Yes ☐ No

Any street drug use? ☐ Yes ☐ No If yes, substance? _____, how long? _____

FAMILY HISTORY

RELATIVE'S DEATHS:

List the cause of death and age at death if applicable:
Father: _____ Mother's father: _____ Father's father: _____
Mother: _____ Mother's mother: _____ Father's mother: _____
Any Sibling: _____

FAMILY ILLNESSES:

Check any illnesses which have occurred in a blood related brother (b), sister (s), mother (m), father (f) or grandparent (g):

	WHO		WHO
☐ Alcoholism/Substance Abuse	_____	☐ Emotional/Mental Illness/Suicide	_____
☐ Alzheimer's/Dementia	_____	☐ High Blood Pressure	_____
☐ Cancer (Breast)	_____	☐ Heart attack prior to age 50	_____
☐ Cancer (Colon)	_____	☐ Osteoporosis	_____
☐ Cancer (Prostate)	_____	☐ Stroke	_____
☐ Cancer (other) _____	_____	☐ Arthritis	_____
☐ Diabetes	_____		

OTHER PHYSICIANS:

List any other doctors (specialists, etc.) you have seen:

_____
_____

Review of Systems

Name: _____ Date: _____

DOB:_____

Please circle yes or no. If yes, please explain:

Neurological

Y or N Do you have numbness or tingling in the hands or feet? If yes, is it at night? _____

Y or N Do you have memory loss?

Y or N Do you have double vision?

Y or N Do you have slurred speech?

Y or N Do you have temporary loss of vision?

Y or N Have you ever had a loss of use of an arm or leg?

Rheumatologic (arthritis) questions:

Y or N Fatigue?

Y or N Malaise (feeling ill)?

Y or N Recent weigh loss or gain (in the last 6 months)?

Y or N Recent chills ,fever, or increased temperature?

Y or N Night sweats (drenching bed sheets by perspiring)?

Y or N Insomnia (inability to sleep)?

Y or N Morning stiffness? For how long?

Y or N Muscle weakness (difficulty walking stairs, getting out of chair or lifting light packages)?

Y or N Joint pain?

Y or N Joint swelling? Which joints?

Y or N Have you ever had a swollen joint as a child or teenager?

Y or N History of broken bones?

Y or N Headaches ? How often?

Y or N Scalp tenderness when combing hair?

Review of Systems

Y or N Jaw pain?

Y or N Neck pain?

Y or N Low back pain?

Y or N Do your hands change color in the cold weather?

Y or N Sun sensitivity (skin rash when exposed to the sun)?

Infectious disease- Please circle if you have had:

Measles	Chicken pox	Hepatitis
Influenza	Diphtheria	Scarlet Fever
Mononucleosis	Rheumatic Fever	Fungus
Mumps	Whooping cough	
Polio	Typhoid Fever	
Tuberculosis	Parasites	

Have you ever been tested for:

HIV _____

Hepatitis_____

Tuberculosis _____ Date of last tuberculin test: _____ Result: Pos or Neg

Cardiac (heart):

Y or N Chest pain?

Y or N Shortness of breath? If yes, with exercise? _____

Y or N Angina pectoris?

Y or N Have you ever been told you have a heart murmur? EKG_____

Y or N Heart attack? Stress test _____

Y or N Do your ankles swell? Cardiac Cath_____

Y or N High blood pressure?

Review of Systems

Pulmonary (lung or breathing)problems

Y or N Morning cough?

Y or N Morning sputum (phlegm production)?

Y or N Hemoptysis? (coughing up bloody phlegm)?

Y or N History of asthma?

Y or N Chest pain?

Y or N Have you ever had pleurisy of pneumonia?

Y or N Do you smoke? If so, Cigarettes, Cigar or Pipe (circle one)

Y or N Have you ever smoked? If so When_____ How much_____ How long_____

Date of last chest x-ray? _____

Urinary

Y or N Do you have frequent urinary tract infections?

Y or N Have you ever had prostatitis?

Y or N Do you have burning with urination?

Y or N Do you ever have blood in your urine?

Y or N Do you wake up during the night to urinate?

Y or N Have you ever had kidney stones?

Menstrual history (females only)

Age of onset of menstruation: _____

Age of onset of menopause: _____

Last pelvic exam: _____

Last Pap Smear:_____

Y or N Have you had a mammogram (X-rays of the breast)? _____

Y or N Have you had a hysterectomy? If so, why? _____

Y or N Have you ever had vaginal ulcers (herpes)?

Review of Systems

Sexual History

Y or N Do you have pain with intercourse?

Y or N Do you have impotence?

Y or N Do you have loss of libido (interest)?

Y or N Have you ever had venereal disease?

Y or N Have you ever had penile drip? (Men only)

Gastrointestinal

Y or N Do you have stomach pain after eating?

Y or N Do you take antacids?

Y or N Have you ever had bowel disease such as Crohn's or regional enteritis?

Date of last colonoscopy_____

Y or N Do you have abdominal cramps?

Y or N In the morning?

Y or N At night?

Y or N Do you have diarrhea? How often? _____

Y or N Do you have hemorrhoids?

Y or N Do you have problems with constipation?

Y or N Do you drink alcohol?

How much _____drinks per_____ day or week (circle)

For how many years_____

Y or N Have you ever had gallbladder disease?

Y or N Have you had pancreatic disease?

Review of Systems

Psychological history

Have you had a change in your lifestyle recently such as:

__ Divorce

__ Separation

__ Marriage

__ Move

__Change in job

__Childbirth

__ Change in household (relatives moving in etc.)

__ Death of a loved one

__Business set back

Patient signature:_____ Date:_____

Physician signature: _____ Date: _____

Review of Systems

NADIA AKHMED , M.D.

PATIENT HIPAA COMMUNICATION FORM

Patient Name:_____ Date of Birth_____

FAMILY & FRIENDS: It is the Policy of Arthritis & Internal Medicine not to release confidential medical information regarding your treatment to family members or friends, except for (1) Parent/legal guardian, (2)other persons authorized by the patient, (3) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (4) in emergency situations, or (5) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caregivers, please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information, as requested, regarding your care and treatment. **Updates to this form must be made in person.**

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

ASSIGNMENT, RELEASE AND ACKNOWLEDGEMENT

- I give my permission and consent for treatment.
- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance.
- I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan
- I authorize the provider, designated representative, or automated robot to contact me by home/cellular telephone about appointments, billing and medical care.
- I authorize my provider to release any medical information required to process this claim
- I acknowledge that I have viewed and been offered a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Responsible Party **Date**

Arthritis & Internal Medicine
Dr. Nadia Akhmed
Dr. Mini Bhaskar

3168 Braverton Street, Suite 330
Edgewater, MD 21037
Phone: 410-956-3090

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

April 21 2022

This Notice of Privacy Practices applies to the following organizations.

Arthritis and Internal Medicine, LLC
Dr. Nadia Akhmed
Dr. Mini Bhaskar
3168 Braverton Street, Suite 330
Edgewater, MD 21037

Privacy Officer: Charlotte Mrazik
(410) 956-3090