Patient Information Form

Full Name _____ Soc. Security # _____ DOB _____

Primary Address _____ City _____ Zip _____

Cell Phone (____)_____ Home Phone (____)_____ E-Mail Address_____

Sex:☐ M ☐ F Marital Status: ☐M ☐S ☐W ☐D Race: _____ Height: _____ Weight: _____

Employer _____ Employer Phone Number (____)_____

Spouse's Name _____ Spouse's Phone Number (_____)_____

☐ Consent to leave confidential information by voicemail containing detailed medical information on the phone number(s) provided. This information may include, but not limited to, demographic information (partial or full name, date of birth, address, etc.), billing information, medical information (diagnosis, medications, test results, etc.).

ONLY IF PATIENT IS A MINOR – Information of Person responsible

Name _____ Relationship _____ Phone (____)_____

Additional Address_____ City _____ Zip _____ Phone (____)_____

Employer Name _____ Employer Phone _____

Employer Address _____

Name of Emergency Contact: _____ Relationship _____

Work Address _____Cell Phone (_____)_____

Do you have an Advance Directive? Yes __ No __ Do you have an authorized Power of Attorney? Yes __ No __

(Please give us a copy to scan into your chart)

Please list your Primary Care Physician: _____ Where do they practice? _____

How did you hear about us? _____

Which Pharmacy do you use? _____

Where would you like to get your Lab Work done? ☐Cleveland Clinic ☐ UH ☐ Quest Diagnostics

Where would you like to get your Imaging done? ☐Cleveland Clinic ☐ UH ☐ Private Facility

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Circle – How would you describe your **OVERALL HEALTH**: excellent fair poor

List **MEDICATIONS & SUPPLEMENTS** with the **SPECIFIC DOSAGES**: _____

_____

_____

_____

List **ALLERGIES** with the **SPECIFIC REACTION** you get: _____

_____

_____

_____

List **MEDICAL DIAGNOSES** & **YEAR** diagnosed with it: _____

_____

_____

_____

List **PREVIOUS SURGERIES** with **YEAR**: _____

_____

_____

_____

List **FAMILY MEDICAL HISTORY** with **AGE OF DIAGNOSIS** & IF RELATIVE **LIVING OR DECEASED**: _____

_____

_____

_____

Ever had genetic testing performed? _____

History of **SMOKING TOBACCO? ____** For how many **years**? _____ How much **packs per day**? _____

Have you ever been screened for lung cancer by a low dose CT-scan? _____

If so, results? _____

History of **DRINKING ALCOHOL**? _____ Type of drink & frequency? _____

History of **DRUG ABUSE** (includes marijuana, IV drugs, street drugs, etc)? _____

Type of drug & frequency? _____

Describe **OVERALL DIET**: _____

General **EXERCISE ROUTINE**: _____

Do you have any concerns regarding **SAFETY** at home? _____

Do you have a household smoke detector? _____

Do you keep firearms in home? _____ Are they locked in a safe place? _____

Do you wear seatbelts in the car? _____

Birth Gender? _____ What gender or pronoun you identify as? _____

In a relationship? _____ Do you prefer male, female, or both? _____ Sexually active? _____

Are you pregnant or trying to get pregnant? _____

Do you use any form of contraception? _____

Does your partner use any form of contraception? _____

Would you like STD screening (mainly for Gonorrhea, Chlamydia, Syphilis, or HIV)? _____

Any known exposure to HIV in a sexual partner? _____

Ever been hospitalized? Is so, what for and what year? _____

_____

_____

_____

Any implantable devices and year implanted? _____

_____

WATER intake in ounces daily: _____

Do you consume **CAFFEINE**? _____ If so, how often? _____

Do you consume **JUICE OR SODA**? _____ If so, how often? _____

Daily Hours of **SLEEP**: _____

Have you been to the **DENTIST** in the last year? _____

Have you been to the **EYE DOCTOR** (optometrist or ophthalmologist) in the last year? _____

Do you have any concerns regarding **SAFETY** at home? _____

Do you have **OTHER MEDICAL PROVIDERS**? If so, list name and specialty? _____

_____

_____

Do you have an **ADVANCED DIRECTIVE/LIVING WILL** on file? _____

History of **HIGH CHOLESTEROL**? _____ Ever been treated for it? _____

History of **HIGH BLOOD PRESSURE**? _____ Ever been treated for it? _____

History of diabetes or prediabetes? _____ Ever been treated for it? _____

History of being tested for hepatitis, exposure to someone with hepatitis? _____

Feeling down, depressed or hopeless? _____

Have you lost interest or pleasure in doing things? _____

Mark X if you have completed the following vaccines:

__childhood vaccines

__influenza

__covid (**CIRCLE** Moderna, Pfizer, J&J, or other_____)

__covid booster (**CIRCLE** Moderna, Pfizer, J&J, or other _____)

__tetanus (within last 10 years)

__shingles

__pneumonia

Have you completed a colonoscopy in the past? _____

If so, year completed & was the test abnormal?_____

_____

FOR MALES ONLY:

*Ever been screened for prostate cancer? If so, when & was the test abnormal?*_____

_____

_____

*Ever been screened for an abdominal aortic aneurysm? If so, when & was the test abnormal?*_____

_____

_____

FOR FEMALES ONLY:

Do you have periods? _____ *Date of last menstrual period?* _____ *How long do they last for?* _____

Number of total pregnancies, vaginal or C-Section, and year? _____

_____

_____

How many total live births and year? _____

How many abortions and year? _____

Have you ever completed a pap smear test? _____ *Last pap test approx. date?* _____

*If so, has it ever been abnormal or HPV positive?*_____

Have you had a procedure completed for an abnormal pap smear test? _____

Have you ever completed a mammogram? _____ *What year was last one done?* _____

Was mammogram abnormal? _____

If 65 years or older, have you completed a DEXA scan? _____

If so, what year was DEXA scan completed & was it abnormal? _____

Office Policies

Referral Process
It may be necessary for our office to refer you to a specialist to manage your care. In order for a referral to be made, you must be evaluated first in our office. If you need to request a referral from us, phone us at least one week prior to your appointment. As part of the referral process, we may need to share your medical information with another provider or specialist. Your privacy is protected as only minimal information is shared.

Medication Refills
Please bring your medications to your appointments. Should you need refills prior to your next appointment, first call your pharmacy. They can request a refill from our office. Please give us at least 48 hour notice prior to your medication running out, 2 weeks notice if it's a mail-order pharmacy. Pain medicines may require an appointment.

Billing
Please bring your insurance card(s) to each visit. All co-pays and deductibles are the patient's responsibility and expected to be paid on the day of service prior to being evaluated by the provider.

Scheduling Appointments
Patients are seen by appointment only, except in the case of an emergency, which may cause delays. We ask for your understanding, knowing that if you ever require urgent care, we will give you prompt attention. To schedule appointments, please call (330) 422-4377. In the event that you are unable to keep your appointment time, please call at least 24 hours in advance to reschedule. **There will be a $25 charge for no show appointments**. If you miss 2 or more appointments due to a "no show" appointment, your chart will be reviewed and you may be discharged from this practice.

Hospital/Emergencies
Both of our physicians have hospital privileges at Cleveland Clinic South Pointe Hospital. Dr. Aarondeep Deol also has hospital privileges at UH Portage Medical Center. If you have a life-threatening illness, call 911 or go to the nearest Emergency Room and have a family member call our office.

After Hours/On Call Policy
Our office hours are Monday through Friday 9am-5pm. Please call the main office phone (330) 422-4377 if you need medical attention after hours that cannot wait until morning. If you have a non-urgent request, you can leave a message for staff to be returned the next business day. If it is an urgent request, you can use the Spruce app to contact the doctor. After speaking with you, you may be prescribed medication, advised to follow up in the office, or advised to pursue further urgent or emergent care.

UH Twinsburg Urgent Care - 8819 Commons Blvd., Suite 101, Twinsburg, Ohio 44087 P: 234-837-5418
Cleveland Clinic Emergency Department - 8701 Darrow Rd, Twinsburg OH 44087 P:330-888-4176

By signing on the next page, I agree to the above policies.

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Please read and sign at the bottom to agree to the following statements:

I hereby authorize the release of medical information to insurance carriers, referring providers, and healthcare systems concerning my illness and treatment, when necessary. I hereby assign to the doctor all payments for medical services rendered to me or my dependent. I understand I am responsible for any amount not covered by insurance.

Acknowledgement of Treatment

I request and authorize Dr. Aarondeep Deol, Dr. Nazmine Deol, staff, and resident physicians, to perform general treatments and procedures as may be deemed necessary in my care.

Notice of Privacy Practices Acknowledgement

I, the undersigned, acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read, or have been offered a copy, and understand the notice (available upon request).

Medicare One Time Direction of Payments

If applicable, I give my permission to ask for Medicare payments for my medical care. I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests. I understand that the Health Care Financing Administration (HCFA) is the government Medicare agency.

_____ Date: ____/____/____

Signature of Patient or Personal Representative

Personal Representative's relationship to the patient: _____