

New Patient Information Form

Full Name _____ Soc. Security # _____ DOB _____

Primary Address _____ City _____ Zip _____

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

Sex: Male Female Other _____ Marital Status: Married Single Widowed Divorced

Race: _____ Height: ____ ft ____ in Weight: _____ lbs Employer _____

Consent to leave confidential information by phone, text, email, mail, or 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.).

Emergency Contact Name: _____ Relationship _____ Phone (____) _____

Primary Care Physician name: _____ Where do they practice? _____

Which Pharmacy do you use? _____ How did you hear about us? _____

Where would you like to get your Lab Work done? Cleveland Clinic UH Other _____

Where would you like to get your Imaging done? Cleveland Clinic UH Other _____

Tobacco Use? Yes No Quit, year quit? _____ Years used? _____ # of packs per day? _____

Alcohol Use? _____ How often? _____ Illicit/Recreational Drug use? _____ What Kind? _____ How often? _____

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

Diabetic? Yes No (If yes: Year diagnosed? _____ Last A1C? _____ Last Diabetic Foot Check date? _____)

Medical History of Diagnosis:

Year of Diagnosis:

Flip ->

Medication:

Dosage:

Surgery History:

Year Occurred:

Family Medical History

Relationship:

Disease:

Approx. age of diagnosis:

What brings you in today? _____

Have you tried any treatments? _____

How long has this problem been going on for? _____ Is this your first time having this problem? _____

Information of Insurance Policy Holder *(if self, skip section)*

Name _____ DOB _____ Relationship _____ Phone (____) _____

Address (if Different than Above) _____ City _____ Zip _____ Phone (____) _____

Employer Name _____ Employer Phone _____

By Signing here, I state that the above information has been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health.

Signature of Patient or Personal Representative

If not self, Personal Representative's relationship to patient

Date: ____/____/____

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.

- If a patient has a **no-copay/high-deductible plan**, then the patient is expected to pay **\$50** that will go towards their office visit at the time of service or, if known by the provider, the **full contracted insurance rate** for the office visit at the time of service.
- If the patient needs the provider to complete paperwork (e.g. FMLA paperwork) outside of an office visit, then a **\$35 fee** is required for completion.

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
Cleveland Clinic Emergency Department - 8701 Darrow Rd, Twinsburg OH 44087

P: 234-837-5418
P:330-888-4176

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

Flip ->

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: _____