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

Occupation: _____ Employer: _____

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

Primary Care Physician name: _____ Date Last Saw PCP? _____

Last Annual Physical? _____ Preferred Pharmacy? _____

☐ 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.).

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

Alcohol Use? ☐ Yes ☐ No How often?_____

Illicit/Recreational Drug use? ☐ Yes ☐ No What Kind? _____ How often? _____

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

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: _____

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

Name _____DOB _____ Relationship _____ Phone (____)_____

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

Employer Name _____

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Medical Diagnosis History:	Year of Diagnosis:

Medication:	Dosage:

Surgery History:	Year Occurred:

Family Medical History

Relationship:	Disease:	Approx. age of diagnosis:

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

Ever been hospitalized? ☐ Yes ☐ No (**If yes**, what for and what year? _____)

Any implantable devices? ☐ Yes ☐ No (**If yes**, Year implanted?_____)

Do you have any concerns regarding **SAFETY** at home? ☐ Yes ☐ No (**If yes**, explain:_____)

Household smoke detector? ☐ Yes ☐ No

Firearms in home? ☐ Yes ☐ No If yes, are they locked in a safe place? ☐ Yes ☐ No

What gender or pronoun you identify as? _____ In a relationship? ☐ Yes ☐ No

Prefer ☐ Male ☐ Female ☐ Both ☐ Other: _____ Sexually active? ☐ Yes ☐ No

Pregnant or Trying to get pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No

Any form of contraception (including hysterectomy & vasectomy)? ☐ Yes (type: _____) ☐ No

Describe **OVERALL DIET**: ☐ Well-balanced ☐ Typical American Diet ☐ Vegetarian/Vegan ☐ Other _____

Regular **EXERCISE ROUTINE**?: ☐ Yes ☐ No Daily Hours of **SLEEP**: _____ **WATER** ounces daily: _____

Do you consume **CAFFEINE**? ☐ Yes ☐ No If yes, how often? _____

Do you consume **JUICE OR SODA**? ☐ Yes ☐ No If yes, how often? _____

In the last year visited: **DENTIST**? ☐ Yes ☐ No **EYE DOCTOR**? ☐ Yes ☐ No

OTHER MEDICAL PROVIDERS? If so, list name and specialty? _____

_____

Do you have an **ADVANCED DIRECTIVE/LIVING WILL/DPOA** on file? ☐ Yes ☐ No

History of **HIGH CHOLESTEROL**? ☐ Yes ☐ No Ever been treated for it? ☐ Yes ☐ No

History of **HIGH BLOOD PRESSURE**? ☐ Yes ☐ No Ever been treated for it? ☐ Yes ☐ No

History of **DIABETES** or **PREDIABETES**? ☐ Yes ☐ No Ever been treated for it? ☐ Yes ☐ No

Feeling down, depressed or hopeless? ☐ Yes ☐ No

Have you lost interest or pleasure in doing things? ☐ Yes ☐ No

Mark X if you have completed the following vaccines:

__childhood vaccines __influenza __tetanus (within last 10 years) __shingles __pneumonia

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

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

__none (reasoning: _____)

Would you like STD screening (mainly for Gonorrhea, Chlamydia, Syphilis, or HIV)? ☐ Yes ☐ No

History of being tested for HEPATITIS or exposure to someone with hepatitis? ☐ Yes ☐ No

Have you ever been screened for lung cancer by a low dose CT-scan? ☐ Yes ☐ No If yes, results? _____

Have you completed a colonoscopy in the past? ☐ Yes (If yes, Year? _____Abnormal? _____) ☐ No

FOR MALES ONLY:

Ever been screened for prostate cancer? ☐ Yes (If yes, Year? _____Abnormal? _____) ☐ No

Ever been screened for an abdominal aortic aneurysm? ☐ Yes (If yes, Year? _____Abnormal? _____) ☐ No

FOR FEMALES ONLY:

Do you have periods? ☐ Yes ☐ No *Date of last menstrual period?* _____

Do they occur monthly? ☐ Yes ☐ No (describe: _____)

*Number of total pregnancies?*_____ *Total live births & year?* _____

Vaginal or C-Section & year? _____

How many abortions & year? _____

Have you ever completed a pap smear test? ☐ Yes ☐ No *Last test date?* _____

Abnormal or HPV positive? (If yes, *Year?* _____ *Abnormal?* _____*) Colposcopy test completed?* ☐ Yes ☐ No

Have you ever completed a mammogram? ☐ Yes (If yes, *Year?* _____ *Abnormal?* _____*)* ☐ No

If 65 years or older, completed a DEXA scan? ☐ Yes (If yes, *Year?* _____ *Abnormal?* _____*)* ☐ No

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.

_____ _____ Date: ____/____/____

Signature of Patient or Personal Representative If not self, Personal Representative's relationship to patient

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 P: 234-837-5418
Cleveland Clinic Emergency Department - 8701 Darrow Rd, Twinsburg OH 44087 P:330-888-4176

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

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: _____