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: _____

☐ Retired Occupation prior to retirement: _____

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

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

Last Annual Physical? _____Preferred Pharmacy? (our office does not send to CVS)_____

☐ 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? ___ How often? _____ Illicit/Recreational Drug use? _____ What Kind? _____ How often? _____

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

Name of Doctor who manages your diabetes: _____ Date last seen: _____

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: _____

Medical Diagnosis History:	Year of Diagnosis:

Medication:	Dosage:

Surgery History:	Year Occurred:

Family Medical History

Relationship:	Disease:	Approx. age of diagnosis:

What brings you in today? _____

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 _____ Employer _____ Phone (____)_____

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

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 1 week notice prior to your medication running out, 2 weeks' notice if it is 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 $65 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 $50 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

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. For urgent request, please contact our main office number rather than Spruce. If it is an urgent request and we are unable to address your concern, please go to the emergency department as soon as possible. For non-urgent request, you can leave a message for staff to be returned within the next 3-5 business days.

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.

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.

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

Personal Representative's relationship to the patient: _____